

HOW TO GET THE CARE YOU NEED



A guide to Medica for self-insured members.

# HOW TO GET THE CARE YOU NEED

## A member guide to Medica

### Welcome! Medica is here for you.

Welcome to Medica. We are happy to serve you. Your health care 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.

**Please note:** Throughout this booklet, all self-insured enrollees will be referred to as “members” rather than the formal title of “self-insured enrollees.”

Please take a few minutes to review this guide. You may not need all of this information today, but you may need to know about it in the future.

### File it!

Please keep this guide handy. It may help whenever you have questions about your health care. 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 folder are:

- Your coverage document, which may be called a “Plan Document” or “Summary Plan Description”
  - Note: This document is also available for most members on the Web by going to **medica.com** and clicking on the *myMedica* link.
- Your “Explanation of Benefits” or “Summary of Benefits”
- 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 plan. If any information contained in this member guide conflicts with your coverage document, your coverage document will govern in all respects.*

## Do you need help?

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

Check with your plan administrator, go to **medica.com** and click on the *myMedica* link. Or call Medica Customer Service or the number on the back of your Medica ID card for help.

### Medica Customer Service

**Self-Insured Members call:**  
952-945-8000 or 1-800-952-3455

**Passport from Medica<sup>SM</sup> Members call:**  
1-800-228-1403

**Definity<sup>SM</sup> by Medica Members call:**  
1-800-228-1403

**TTY for hearing-impaired callers**  
TTY National Relay Center: 1-800-855-2880

See the *Important phone numbers* section at the back of this guide. It tells what hours Customer Service is available.

Please have your Medica ID card handy when you call.

## Do you need member documents?

If you wish to receive a *Provider Directory* or a copy of your coverage document, please contact your employer’s plan administrator or Customer Service.

Please read and save this document.

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## HOW DO I KNOW WHAT MY COVERAGE INCLUDES?

Your coverage document will tell you what your coverage includes. The title of this document depends upon your plan. It will be called a “Plan Document” or “Summary Plan Description.” The coverage document is a book that describes what is and is not covered by your health care plan. It also explains what portion, if any, you will be expected to pay. Throughout the remainder of this guide, we use the term “coverage document” to refer to that book. Most members can access their coverage document at any time by going to **medica.com** and clicking on the *myMedica* link.

In most cases you can find answers to questions about your health care benefits in your coverage document. If you need help with a question or cannot find what you need, a Medica Customer Service representative can help you. Please see the phone numbers in the *Important phone numbers* section of this guide or the numbers listed on the back of your Medica ID card.

### Deductibles, copayments or coinsurance may be required.

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

- **Deductible** – a fixed dollar amount you must pay annually before your insurance starts to pay (for example, \$500).
- **Copayment** – a fixed dollar amount you must pay for a given service when you receive services (for example, \$15).
- **Coinsurance** – the percentage of the covered amount you must pay for a given service (for example, 20% coinsurance).

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

You will find the most common copayment or coinsurance amounts on your Medica ID card. You will also find a complete listing of all your copayments or coinsurance in your coverage document or by calling Medica Customer Service. See the *Important phone numbers* section of this guide.

### How to submit claims from providers.

Claims will be submitted on your behalf by network providers. Claims for services received from a non-network provider must

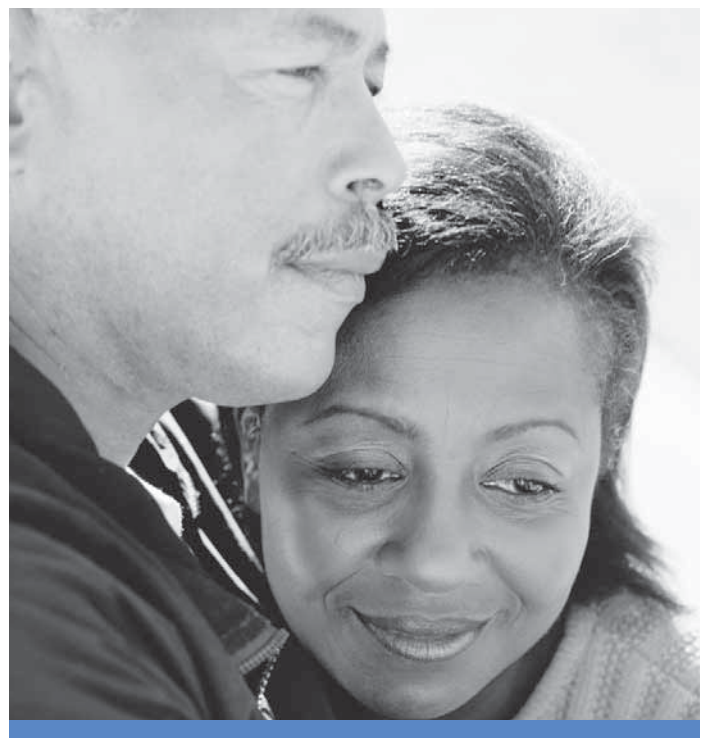
be submitted on an itemized claim form to the address on the back of your Medica ID card. Most non-network providers will have the proper form available for submitting a claim; however, if your provider does not have an itemized claim form, please contact Medica Customer Service. Or go to **medica.com** and click on the *myMedica* link to obtain one.

Claims from non-network providers should be submitted to:  
Medica Claims  
PO Box 30990  
Salt Lake City, UT 84130

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

### How to get coverage for hospital services.

Perhaps you and your primary care provider or specialist have decided you need to receive services at a hospital. Coverage for outpatient and inpatient hospital care varies by plan. In some cases—such as care for children or transplant services—you may need to go to specialty hospitals. If you are out of Medica’s service area and require hospitalization, you should notify Medica as soon as reasonably possible. To learn how to receive your highest level of coverage, you should refer to your coverage document. You may also contact Medica Customer Service for more information regarding your benefit levels and to make sure that the hospital you plan to use is in Medica’s network.



## Post-mastectomy coverage is available.

The *Women's Health and Cancer Rights Act* is a federal law passed in 1998. It 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 or enrollees with written notice that this coverage is available.

Women who have breast cancer often have a mastectomy to remove all or part of the breast. Medica members who have undergone a mastectomy are covered for mastectomy benefits.

See your coverage document. It will tell the specific benefit levels for the following services:

- 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 deductibles, copayments or coinsurance for other benefits in your plan. To determine the amount you would have to pay, see your coverage document.

## MEDICA CONNECTS YOU TO THE CARE YOU NEED.

At Medica, we will do our best to make sure you receive the very best health care for yourself and your family. 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 have chosen to see on a regular basis.

### Find a Doctor.®

*Find a Doctor*® is a fast, easy online tool you can use to search the most up-to-date list of Medica network health care providers. You can search for primary care physicians, specialists, clinics, hospitals and a range of other types of care providers.

Access *Find a Doctor* at **medica.com**. Select the type of member you are from the list. Then, follow the instructions and use icons to search for providers that are conveniently located and meet your needs.

Please contact the provider's office to confirm that they are part of your health plan network before your first visit. If you have questions regarding whether your provider or clinic participates in your health plan, your benefits and/or coverage, please call the Customer Service number on the back of your Medica member ID card.

### How providers are added to our network.

When a provider wants to join the Medica network, we look at that provider's education and experience. A special committee looks at how well the provider has performed in the past. Our board of directors reviews this information and makes the final decision to sign a contract with a provider.

If you are interested in your own provider's background, contact the State Board of Medical Practice or State Board of Medical Examiners. Look under “State Government” in your telephone directory, or check your state's official government Web site.

### Choosing a primary care provider.

There are four types of primary care providers. Some work only with women or children. The descriptions below can help you decide which type of primary care provider to choose for your needs.

**Family Practice**—Doctors who specialize in providing care for the whole family, encompassing all ages, both sexes, each organ system and every disease entity. This specialty provides continuing, comprehensive health care for the individual and family.

**Internists**—Doctors whose training focuses on adult diseases, 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 16.

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

If you want to learn about the professional qualifications of a primary or specialty provider, you can contact the State Board of Medical Practice or State Board of Medical Examiners.

## Making appointments.

When you need to see a provider for preventive care, or when you are sick, simply contact your primary care provider to make an appointment. You may be asked to show your Medica ID card at each visit.

## Specialty care.

Perhaps you and your primary care provider have decided you need to see a specialist. Coverage for specialty care varies by plan. Some plans require a referral from your primary care provider, while others do not.

Medica has outlined procedures for seeing specialists of many kinds. To be sure that you receive maximum coverage, you should read your coverage document and follow the steps outlined there.

You can also call Medica Customer Service to get a quick answer about your benefit levels. The phone numbers are in the *Important phone numbers* section of this guide or on the back of your Medica ID card.

## Behavioral health services: mental health and substance abuse care.

If you or a family member need mental health or substance abuse services, you should follow the steps that are outlined in your coverage document. You can also call Medica Customer Service or Medica's designated mental health and substance abuse care provider for assistance. See your coverage document for phone numbers.

**If you have an emergency, call 911.**

## Care after regular clinic hours.

When you can, you should make an appointment to see your primary care provider. 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 needed care.

If after-hours care from your regular clinic isn't available, you can visit one of the urgent care or retail health clinics in the Medica network. These are listed in your *Provider Directory*. For most members, help finding a location close to you is available through the Medica CallLink® nurse line service. The phone numbers will be listed on the back of your Medica ID card.

Urgent care and retail health clinics are also listed on our Web site at **medica.com**.

## Retail health clinics.

Retail health clinics are staffed with licensed providers who can treat minor illnesses for people older than 18 months. Some of the illnesses they can treat are the common cold, sore throat or an ear infection. Retail health clinics are not for life-threatening emergencies. Retail health clinics like MinuteClinic® provide after-hours care and are located in many retail stores, shopping malls and other locations. Find an up-to-date list of locations at **medica.com**.

Retail health clinics usually are open in the evening, Monday through Friday. They are also open during daytime hours 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.

## Urgent care.

Urgent care centers are staffed by doctors and nurses. Urgent care centers provide after-hours care for minor illnesses and injuries like scrapes and cuts, a sore throat or an ear infection. Urgent care centers are not for life-threatening emergencies. For example, if your primary care clinic is closed, urgent care is a good place to go for such things as earaches, strep throat and fevers, ankle sprains, minor lacerations, etc.

Urgent care centers are normally open in the evening, Monday through Friday. Some are also 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.

Urgent care offices are also listed on our Web site at **medica.com**. Choose *Find a Doctor > Member Through Work* and enter your Group Policy Number and ID Number.

## Emergency care.

A medical emergency is a condition that needs treatment right away. An emergency 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.

Emergency room services are usually offered at a hospital. You should go to one if it is an emergency. If your condition doesn't need treatment right away, go to your primary care clinic. If that office is closed, use an urgent care or retail health clinic. Emergency room care may cost you more because it

generally requires a higher copayment or coinsurance. It also may take more of your time. Emergency rooms treat patients with the most serious cases first. Please save use of emergency rooms for medical emergencies so the doctors and nurses are able to treat those situations right away.

### **Medical emergencies may include:**

- Poisoning or drug overdose
- Trouble breathing or shortness of breath
- Pain or pressure in your chest or above your stomach
- Warning signs of stroke: sudden dizziness or change in vision; sudden weakness or numbness; trouble speaking or understanding speech
- You can't stop vomiting
- 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
- You want to hurt other people or kill yourself
- Change in mental status, such as unusual behavior

***If you or a family member has these conditions, go to an emergency room immediately or call 911.***

### **Emergency care when you travel outside of our service area.**

If you travel out of Medica's service area, you may be able to get care from any provider in UnitedHealthcare's Options PPO Network—that's over 560,000 physicians and 5,000 hospitals nationwide—at Medica's in-network level. Just look for the UnitedHealthcare logo on the back of your Medica member ID card to be sure you're eligible for this coverage. To find a UnitedHealthcare network provider, go to **medica.com**, click on *Find a Doctor*, then select what type of member you are. Click on the Travel Program Provider icon.

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

You should carry your Medica ID card with you when you travel. It has many important telephone numbers to help you access

## **Examples: How to decide where to go for care.**

Sometimes you need to make a decision about 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 is a weekday, call your child's clinic and describe your child's behavior to your provider. You may be directed to come into the office.
- 2) If it is evening or the weekend, call Medica CallLink if this service is available to you and talk with a nurse about your child's behavior. You may be directed to go to the closest urgent care facility or retail health clinic. The Medica CallLink nurse can help you find a facility close to your home.

### **Sore throat.**

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

Options:

- 1) If it is a weekday, call your clinic and describe your symptoms to your provider. You may be directed to come into the office.
- 2) If it is evening or the weekend, call Medica CallLink if this service is available to you and talk with a nurse about your symptoms. You may be directed to go to the closest urgent care facility or retail health clinic. The Medica CallLink nurse can help you find a facility close to your home.

### **Asthma.**

Your 7-year-old son has asthma. He has been playing in the back yard with his friends all day. He is coughing, wheezing and is complaining that his chest feels tight.

Immediately help him take his quick-relief medicine and call his doctor or, if needed, take him directly to the emergency room.

advice about your health care and coverage. Medica members who are ill can call the Medica CallLink nurse line for health care advice. This is our 24-hour nurse line service provided through Optum.® The phone numbers will be listed on the back of your Medica ID card if this service is available to you.

If you are admitted to a hospital while out of Medica's service area, notify Medica as soon as possible by calling Medica Customer Service. The phone number is on the back of your Medica ID card.

### Medica CallLink, our 24-hour nurse line.

Often, the help you need may be available by phone! Medica CallLink nurses answer thousands of calls each year from Medica members. This service, available to many Medica members, provides quick help that is only a phone call away.

If this service is available to you, the Medica CallLink nurse line\* toll-free phone number is on the back of your Medica ID card. You can call to talk with an experienced registered nurse. You can ask health care questions and learn self-care tips. They can also recommend when you should make an appointment with your doctor, or go to an emergency room or urgent care center.

You can also get help finding a provider or, if necessary, an urgent care facility, in Medica's network.

Medica CallLink nurse line also has a Health Information Library. Enter the PIN number 438 to listen to recorded health and well-being messages. Topics range from *Aging Well* to *Women's Health*.

\* *This service may not be available for all plans.*

Medica CallLink nurse line is staffed 24 hours every day. The phone numbers are listed on the back of your Medica ID card if this service is available to you.

**The information offered by Medica CallLink nurse line 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.

Health improvement is a journey, and you are a whole, unique person, not a disease or a symptom. The health and wellness coaching program offers support for individuals who want to make health behavior changes and manage health conditions.

The program is based on a holistic mind/body approach to medicine that considers perceptions about health, thoughts and emotions, and underlying health habits and lifestyles. It provides a way for participants to find the strength within themselves to make desired life changes. Through coaching conversations, participants learn to build upon their strengths and increase their motivation and confidence to take charge of their own health.

### You may be invited to participate in this program.

Your doctor may refer you to the program to help you in your health improvement efforts. Medica also uses medical and pharmacy claims to identify members who may benefit from this program. If you could benefit from the program, you may be contacted through the mail and by telephone and invited to participate. You may choose whether or not to participate. Your individual information will be kept confidential and will not be shared with your employer or plan sponsor.

If you want to make health behavior changes (such as: lose weight, exercise more, take your medications regularly, eat better or reduce stress); or would like to better manage your health condition(s) (such as: depression, low back pain, diabetes, heart disease, high cholesterol, high blood pressure, chronic pain, etc.), you may also call the program and ask to participate.

Call Medica's health and wellness coaching program toll-free at: **1-866-905-7430**.

### Another great resource for health questions: The Medica Health Handbook.

As a Medica member, you should have received information for how to request a copy of the *Medica Health Handbook*. This health reference guide has information on a variety of subjects. It suggests how to handle routine medical conditions at home. It also suggests when to seek care from your health care provider.

The handbook offers useful ideas for preventive care and mental wellness. It also has information about healthy eating and physical activity. It describes the best home care for a variety of health problems. It also covers procedure precautions. It is available in several languages.

Most members may now access an online version of the *Medica Health Handbook* at **medica.com**—click on the *My Health Manager from Medica<sup>SM</sup>* link.

Or, you can request a copy from Medica Customer Service. See the *Important phone numbers* section of this guide.

## MEETING YOUR INDIVIDUAL HEALTH CARE NEEDS.

No two Medica members are alike or have exactly the same needs. That is why additional services may be available to you. We want to make it easier to access the care you have come to expect from us.

### Interpreter services.

Clear communication is especially important when talking about your health. That is why Medica offers translation and interpreter services for our members. When you call Medica Customer Service and need help in a language other than English, Medica will connect you with an interpreter to better assist you. Medica partners with a language interpreter service, which provides a pool of more than 100 interpreters who assist us in communicating with Medica members.

Our 24-hour nurse line, Medica CallLink, also has Spanish-speaking staff. The phone numbers are listed on the back of your Medica ID card if this service is available to you. Medica members can also call our Health Information Library to hear Spanish language messages about 500 different health topics. Please see the *Important phone numbers* section of this guide.

### TTY services for those who are hearing impaired.

Medica Customer Service has a toll-free telephone line just for TTY use. Call this number to reach a Customer Service representative who can answer your questions. The Customer Service representative can also arrange for a sign language interpreter to go along when you visit your health care provider.

#### **TTY line for Medica Customer Service**

TTY National Relay Center: **1-800-855-2880**

### Tobacco: Help for healthy quitting.

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

Medica offers a tobacco cessation program that provides guidance and support throughout the quitting process, including nicotine replacement therapy, a self-help workbook, and Web and phone-based counseling.

If you use tobacco and are thinking of quitting, you may call the Medica tobacco cessation program at **1-800-934-4824**.

## Pharmacy services: How do I know which medications are covered by my plan?

*Note: some Medica members have pharmacy benefits administered by an organization other than Medica. Please see your coverage document if you are unsure who administers these benefits.*

For most plans, Medica uses a list of preferred drugs (formulary). This is a list of preferred drugs that are covered by your plan, along with a list of medications that require prior authorization from Medica before they are covered. The Medica list of preferred drugs is developed and maintained by the Medica Pharmacy and Therapeutics Committee (P&T Committee). This committee is composed of independent physicians and pharmacists from various medical specialties. They review the medications in all therapeutic categories based on safety, effectiveness and value. The P&T Committee regularly reviews new and existing medications to ensure that the list of preferred drugs meets the needs of our members and providers.

**Please see your coverage document for specific information on your pharmacy benefit and to determine if an exception process for the list of preferred drugs is available to you. If you have any questions on your pharmacy benefit, you may also call the Customer Service number on the back of your Medica ID card.**

### How do I get the most out of my prescription benefit?

To get the most value out of your prescription drug benefit, ask your health care provider to prescribe a medication from the Medica list of preferred drugs. In most cases, members may pay a higher copayment or coinsurance for non-preferred prescription drugs and may be responsible for paying the entire cost.

Generic drugs are another way to get the most for your health care dollar. Generic drugs are closely regulated by the U.S. Food and Drug Administration. They must be identical to brand-name drugs in all the important ways. This includes active ingredients, strength, dosage form and method for administration. Generics work like the comparable brand-name medicines. They just cost less.

Ask your provider to use Medica's list of preferred drugs when writing your prescriptions. Your prescription may also be filled with a generic drug at the pharmacy (if available), unless your prescription states "dispense as is" or "as written." Medica's list of preferred drugs can be found on **medica.com**.

## Continuity of care.

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

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

### **If your health coverage changes or you have special health needs.**

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

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

- An acute condition.
- A life-threatening mental or physical illness.
- Pregnancy beyond the first trimester.
- A physical or mental disability, which means you are not able to engage in one or more major life activities, provided that the disability can be expected to last at least one year, or can be expected to result in death.
- A disabling or chronic condition that is in an acute phase.

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

### **If you have special language or cultural needs.**

If you have special language or cultural needs, you may have a right to continue care with your current provider.

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

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

either directly or through an interpreter, within certain time and distance requirements.

### **Your provider must agree to these requirements.**

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

- Follow Medica’s prior authorization requirements.
- Provide Medica with all necessary medical information related to your care.
- Accept as payment-in-full the lesser of Medica’s network provider reimbursement or the provider’s customary charge for the service.

### **How Medica makes a decision.**

We may require medical records or other supporting documentation to review your request. We consider each request on a case-by-case basis, and, if your request is denied, we will explain the criteria used to make that decision.

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

*Please see your coverage document for more information.*

## **KEEPING YOURSELF AND YOUR FAMILY HEALTHY.**

One of the easiest ways to prevent illness is to make sure all members of your family are fully immunized against such life-threatening diseases as measles and hepatitis B. The charts on the following pages include guidelines for recommended screenings and preventive services for healthy children and adults. These guidelines were adapted from the Institute for Clinical Systems Improvements (ICSI).

Depending on your individual lifestyle and family history, you may need some tests or visits more frequently than others. For this reason, it’s important to discuss these guidelines with your health care provider.

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

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

## Routine Services for Healthy Pregnancies

Visit	Screenings	Counseling and Education	Immunizations, Supplements, Medications
<b>Preconception Visit</b>	<ul style="list-style-type: none"> <li>• Risk profiles</li> <li>• Height and weight, BMI</li> <li>• Blood pressure</li> <li>• History and physical</li> <li>• Cholesterol / HDL</li> <li>• Cervical cancer screening</li> <li>• Rubella (German measles)</li> <li>• Rubeola (measles)</li> <li>• Varicella (chicken-pox)</li> <li>• Domestic abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-term labor education and prevention</li> <li>• Substance use (drugs / alcohol)</li> <li>• Nutrition and weight</li> <li>• Domestic abuse</li> <li>• List of medications, herbal supplements, vitamins</li> <li>• Accurate recording of menstrual dates</li> </ul>	<ul style="list-style-type: none"> <li>• Tetanus booster*</li> <li>• Rubella / MMR*</li> <li>• Varicella / VZIG*</li> <li>• Hepatitis B vaccine*</li> <li>• Folic acid supplement</li> </ul> <p>(*) if needed</p>
<b>Visit 1</b> 6–8 weeks	<ul style="list-style-type: none"> <li>• Risk profiles</li> <li>• GC / Chlamydia</li> <li>• Height and weight, BMI</li> <li>• Blood pressure</li> <li>• History and physical</li> <li>• Rubella</li> <li>• Varicella</li> <li>• Domestic abuse</li> <li>• Hemoglobin</li> <li>• ABO / Rh / Ab</li> <li>• Syphilis</li> <li>• Urine culture</li> <li>• HIV</li> <li>• Blood lead screening*</li> <li>• Hepatitis B S Ag</li> <li>• Vaginal birth after cesarean* (VBAC)</li> </ul> <p>(*) if needed</p>	<ul style="list-style-type: none"> <li>• Pre-term labor education and prevention</li> <li>• Prenatal and lifestyle education</li> <li>• Physical activity</li> <li>• Nutrition</li> <li>• Follow-up of modifiable risk factors</li> <li>• Warning signs</li> <li>• Course of care</li> <li>• Physiology of pregnancy</li> <li>• Discuss fetal abnormality screen</li> </ul>	<ul style="list-style-type: none"> <li>• Tetanus booster*</li> <li>• Nutritional supplements*</li> <li>• Influenza</li> <li>• Varicella / VZIG*</li> </ul> <p>(*) if needed</p>
<b>Visit 2</b> 10–12 weeks	<ul style="list-style-type: none"> <li>• Weight</li> <li>• Blood pressure</li> <li>• Fetal heart tones</li> <li>• Fetal aneuploidy screening</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-term labor education and prevention</li> <li>• Prenatal and lifestyle education</li> <li>• Fetal growth</li> <li>• Review labs from visit 1</li> <li>• Breastfeeding</li> <li>• Physiology of pregnancy</li> <li>• Follow-up of modifiable risk factors</li> </ul>	
<b>Visit 3</b> 16–18 weeks	<ul style="list-style-type: none"> <li>• Weight</li> <li>• Blood pressure</li> <li>• Fetal heart tones</li> <li>• Fetal aneuploidy screening</li> <li>• OB ultrasound (optional)</li> <li>• Fundal height (uterus size)</li> <li>• Cervical assessment*</li> </ul> <p>(*) if needed</p>	<ul style="list-style-type: none"> <li>• Pre-term labor education and prevention</li> <li>• Prenatal and lifestyle education</li> <li>• Follow-up of modifiable risk factors</li> <li>• Physiology of pregnancy</li> <li>• Second trimester growth</li> <li>• Quickening</li> </ul>	<ul style="list-style-type: none"> <li>• Progesterone*</li> </ul> <p>(*) if needed</p>

## Routine Services for Healthy Pregnancies (continued)

Visit	Screenings	Counseling and Education	Immunizations, Supplements, Medications
<i>...chart continued from previous page</i>			
<b>Visit 4</b> 22 weeks	<ul style="list-style-type: none"> <li>• Weight</li> <li>• Blood pressure</li> <li>• Fetal heart tones</li> <li>• Fundal height</li> <li>• Cervical assessment*</li> </ul> <p>(* if needed)</p>	<ul style="list-style-type: none"> <li>• Pre-term labor education and prevention</li> <li>• Prenatal and lifestyle education</li> <li>• Follow-up of modifiable risk</li> <li>• Classes</li> <li>• Family issues</li> <li>• Length of stay</li> <li>• Gestational Diabetes Mellitus (GDM)</li> <li>• RhoGAM*</li> </ul> <p>(* if needed)</p>	
<b>Visit 5</b> 28 weeks	<ul style="list-style-type: none"> <li>• Pre-term labor risk</li> <li>• Weight</li> <li>• Blood pressure</li> <li>• Fetal heart tones</li> <li>• Fundal height</li> <li>• Cervical assessment*</li> <li>• Gestational Diabetes Mellitus (GDM)</li> <li>• Domestic abuse</li> <li>• Rh antibody status*</li> <li>• Hepatitis B Ag*</li> <li>• GC / Chlamydia*</li> </ul> <p>(* if needed)</p>	<ul style="list-style-type: none"> <li>• Pre-term labor education and prevention</li> <li>• Prenatal and lifestyle education</li> <li>• Follow-up of modifiable risk</li> <li>• Work</li> <li>• Physiology of pregnancy</li> <li>• Pre-registration</li> <li>• Fetal growth</li> <li>• Awareness of fetal movement</li> </ul>	<ul style="list-style-type: none"> <li>• ABO / Rh / Ab*</li> <li>• (RhoGAM)*</li> </ul> <p>(* if needed)</p>
<b>Visit 6</b> 32 weeks	<ul style="list-style-type: none"> <li>• Weight</li> <li>• Blood pressure</li> <li>• Fetal heart tones</li> <li>• Fundal height</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-term labor education and prevention</li> <li>• Prenatal and lifestyle education</li> <li>• Follow-up of modifiable risk factors</li> <li>• Travel</li> <li>• Sexuality</li> <li>• Pediatric care</li> <li>• Episiotomy</li> <li>• Labor and delivery issues</li> <li>• Warning signs / pregnancy-induced hypertension</li> </ul>	
<b>Visit 7</b> 36 weeks	<ul style="list-style-type: none"> <li>• Weight</li> <li>• Blood pressure</li> <li>• Fetal heart tones</li> <li>• Fundal height</li> <li>• Cervix exam</li> <li>• Confirm fetal position</li> <li>• Culture for group B streptococcus</li> </ul>	<ul style="list-style-type: none"> <li>• Prenatal and lifestyle education</li> <li>• Follow-up of modifiable risk factors</li> <li>• Postpartum care</li> <li>• Management of late pregnancy symptoms</li> <li>• Contraception</li> <li>• When to call provider</li> <li>• Discussion of postpartum depression</li> </ul>	
<b>Visit 8–11</b> 38–41 weeks	<ul style="list-style-type: none"> <li>• Weight</li> <li>• Blood pressure</li> <li>• Fetal heart tones</li> <li>• Fundal height</li> <li>• Cervix exam</li> </ul>	<ul style="list-style-type: none"> <li>• Prenatal and lifestyle education</li> <li>• Follow-up of modifiable risk factors</li> <li>• Postpartum vaccinations</li> <li>• Infant CPR</li> <li>• Post-term management</li> <li>• Labor and delivery update</li> </ul>	

These recommendations do not imply that coverage is provided for these services; check your health plan first.

# Guide to Preventive Services & Immunization Schedule for Infants, Children and Adolescents

Disease screening, counseling and education routine recommendations for average-risk individuals birth through age 18. The services below are recommendations for routine preventive care and not authorization for coverage. Check your individual plan first.

Service	Birth	1 Mo.	2 Mos.	4 Mos.	6 Mos.	12 Mos.	15 Mos.	18 Mos.	2-3 Yrs.	4-9 Yrs.	10-12 Yrs.	13-18 Yrs.
<b>Preventive Health Risk Assessment</b> <i>A physical exam and review of development. Review of personal health risk factors including counseling about how to stay healthy.</i>	Yes		Yes	Yes	One exam Between 6-9 months	Yes	Yes		Optional At age 2	One exam Between ages 4-6 and 7-9	One exam At 12 years	1-2 exams
<b>Chlamydia Screening</b> <i>A test of a sample of body fluid or urine to determine whether chlamydia bacteria are present and may be the cause of an infection. Chlamydia is the most common bacterial sexually transmitted disease in the United States.</i>												<b>Girls:</b> All females sexually active ( <i>with or without symptoms</i> )
<b>Cervical Cancer Screening – Pap Smear</b> <i>An exam where a small sample of cells from the surface of the cervix is collected by your health care professional. The sample is then spread on a slide (Pap smear) and mixed with a liquid fixative and sent to a lab for examination under a microscope. The cells are examined for abnormal cell changes, such as dysplasia or cervical cancer.</i>												<b>Girls:</b> Beginning 3 years after first sexual intercourse. Repeat every 3 years after three annual consecutive normal results.
<b>Vision Screening</b> – <i>Normal vision screening performed at schools does not need to be repeated for children of average risk and without symptoms of eye problems.</i>										One screen By age 5		
<b>Hearing Screening</b> – <i>A hearing screen for infants before one year of age to detect congenital hearing loss.</i>	One screen By age 1											
<b>Obesity Screening</b> – <i>A screening where height, weight and Body Mass Index are recorded.</i>												Annually
<b>Infant Sleep Positioning and SIDS Counseling</b> – <i>Place infants to sleep on their backs.</i>	Yes											
<b>Newborn Screening</b> – <i>Performed in the hospital after birth to detect infants with serious health conditions that may not have symptoms.</i>	Yes											
<b>Tobacco Use Screening</b> – <i>If using tobacco products (cigarettes, cigars, pipe or chew) discuss tobacco cessation and treatment options. Discuss second hand smoke exposure.</i>												Yes
<b>Household and Recreational Injury Prevention Discussion</b>	<p><b>Bicycle Safety:</b> Use an approved helmet when riding a bicycle that is properly fitted.</p> <p><b>Poison Prevention:</b> Have the National Poison Control Numbers readily accessible. Use child-resistant containers; dispose of expired/unused medications.</p> <p><b>Fire Safety and Burn Prevention:</b> Install smoke detectors and test bi-annually. Check water heater temperature and discuss cigarette smoking and fire safety.</p> <p><b>Choking Prevention:</b> Identify choking hazards and treatment.</p> <p><b>Fall Prevention:</b> Use gates; never leave baby unattended on changing table. Identify window and balcony hazards.</p> <p><b>Firearm Safety:</b> Store unloaded firearms in a locked place. Keep ammunition separate from firearm in a locked/safe place.</p> <p><b>Water Safety:</b> Never leave children alone near water or in a bath (through age 6). Swimming lessons are not a substitute for adult supervision for 7-12 years of age.</p> <p><b>CPR Training:</b> Recommended for all adults caring for children.</p>											
<b>Motor Vehicle Safety</b> – <i>Install and use federally approved child safety seats. Always wear a seat belt when driving or riding in a car. Do not drive or ride in a motor vehicle when the driver is under the influence of alcohol or drugs. Passengers should not ride in the cargo area of any vehicle.</i>					Infants should face the rear of the vehicle until they are both one year of age and 20 pounds. They should not be placed in any seat with an air bag. The best position in a vehicle is the middle rear seat.				All children under four years of age must ride in an appropriate car seat.	Children between the ages of 4-9 and less than 4 feet, 9 inches in height; should be in a belt-positioning booster seat.	Children under age 13 should ride in the back seat.	

## Guide to Preventive Services & Immunization Schedule for Infants, Children and Adolescents

Disease screening, counseling and education routine recommendations for average-risk individuals birth through age 18. The services below are recommendations for routine preventive care and not authorization for coverage. Check your individual plan first.

Vaccine	Protects Against	Birth	2 Mos.	4 Mos.	6 Mos.	12-15 Mos.	18-24 Mos.	4-6 Yrs.	7-12 Yrs.	13-18 Yrs.
<b>DTaP</b>	<b>Diphtheria</b> (skin lesions or breathing complications) <b>Tetanus</b> (lockjaw) <b>Pertussis</b> (whooping cough)		X	X	X	12-18 months		X	11-12 years Tdap	
<b>IPV</b>	<b>Polio:</b> A disabling condition that can lead to loss of movement from a virus that attacks the spinal cord		X	X	6-18 months			X		
<b>MMR</b>	<b>Measles:</b> (a virus that can cause diarrhea, ear infections, pneumonia, inflammation of the brain, seizures, and death) <b>Mumps:</b> (a virus that can cause inflammation of the brain and spinal cord, and permanent deafness) <b>Rubella:</b> (a virus that can cause breathing complications)	Combined Measles, Mumps, Rubella and Varicella (MMRV) is preferred for children 12 months through 12 years. <i>(If given separately follow independent schedules for MMR and Varicella)</i>				X		X		
<b>Varicella</b>	Chicken pox							X		X
<b>PCV 7</b>	Infections of the blood, brain, joints, inner ears or lungs (pneumonia)		X	X	X	X				
<b>HiB</b>	Infections of the blood, brain, joints, lungs (pneumonia)		X	X	X	X				
<b>Rotavirus</b>	Rotavirus diarrhea (and vomiting)		X	X	X					
<b>HBV</b>	Chronic inflammation of the liver, life-long complications (Hepatitis B virus)	X	X	Second dose at 4 months if first dose not received at birth	6-24 months					
<b>Hep A</b>	Inflammation of the liver (Hepatitis A virus)					X	X			
<b>Influenza Vaccine</b>	Flu and complications				Annually between October and March for ages 6 months and older					
<b>HPV</b>	A virus that can become a sexually transmitted disease, cause genital warts or develop into cancer of the cervix, vulva, vagina, anus, or penis. (Human Papillomavirus)								11-12 year olds (3 dose series)	If not previously received (3 dose series)
<b>Meningococcal</b>	An infection of the spinal cord and the fluid surrounding the brain that can cause brain damage and hearing loss. (Meningitis)								11-12 years	15 years (if not previously received)

References: Institute for Clinical Systems Improvement (October 2008)

An "X" means you should get the immunization for the age identified by the column, unless otherwise noted.

If your child misses an immunization, talk to your physician about a catch-up schedule.

## Guide to Preventive Services and Immunization Schedule for Adults

Disease screening, counseling and education for average-risk adults, without symptoms of illness or disease. These are routine recommendations; your doctor may advise you differently depending on your medical history. The services below are recommendations for routine preventive care and not authorization for coverage. Check your individual plan first.

Service	19–39 Years	40–64 Years	Over 65 Years
<p><b>Health Risk Assessment</b> <i>A physical exam and review of personal health risk factors, including counseling about how to stay healthy. This may be a separately scheduled visit or in combination with a medical appointment for other health concerns.</i></p> <p><i>Complete a personal Health Risk Assessment online and bring this to your clinic appointment (Note: not all plans have this benefit; check your individual plan.).</i></p> <p><i>Login to My Health Manager from Medica<sup>SM</sup> to learn more.</i></p>	<p>At least every 5 years</p> <p><i>Should include but is not limited to:</i></p> <ul style="list-style-type: none"> <li><i>Obesity Screening</i></li> <li><i>Tobacco Use/Exposure Screening</i></li> <li><i>Alcohol Abuse Screening</i></li> <li><i>Depression Screening</i></li> <li><i>Calcium and Osteoporosis Counseling (women only)</i></li> <li><i>Folic Acid Counseling (women of childbearing age only)</i></li> </ul>		
<p><b>Breast Cancer Screening – Mammogram</b></p> <p><i>An X-ray of your breasts.</i></p>	<p>Women: Every 1–2 years for women ages 50–75 years. Annually for women age 40–49, if at risk*.</p> <p><i>(Risk = past personal history or immediate family history of breast cancer, or previous breast biopsy with results that were of concern)</i></p>		
<p><b>Cervical Cancer Screening – Pap Smear</b></p> <p><i>A small sample of cells from the surface of the cervix is collected by your health professional. The sample is then spread on a slide (Pap smear) or mixed in a liquid fixative and sent to a lab for examination under a microscope. The cells are examined for abnormalities that may indicate abnormal cell changes, such as dysplasia or cervical cancer.</i></p>	<p>Women: Beginning at age 21 or three years after first sexual intercourse, whichever is earlier; Repeat every 3 years after three annual consecutive normal results.</p>	<p>Women: Every 3 years after three annual consecutive normal results.</p>	<p>Women: Ages 65+ with new sexual partner.</p>
<p><b>Colorectal Cancer Screening</b> <i>Four different tests are available to test for colorectal cancer; talk to your doctor about what's best for you.</i></p>	<p>Begin screening at age 50, or if African American, screening at age 45 (<i>frequency is determined by screening method chosen</i>)</p>		
<p><b>Chlamydia Screening</b> <i>A test of a sample of body fluid or urine to determine whether chlamydia bacteria are present and may be the cause of an infection. Chlamydia is the most common bacterial sexually transmitted disease in the United States.</i></p>	<p>Women: All females sexually active aged 25 years or younger, <b>and</b> those at risk* (<i>with or without symptoms</i>)</p>	<p>If at risk* (<i>risk = having new or multiple sex partners, history or a sexually transmitted infection or not using condoms consistently or correctly</i>)</p>	
<p><b>Blood Pressure Screening for Prevention of Heart Disease</b></p>	<p>Blood pressure every 2 years if less than 120/80; every year if 120–139/80–89 Hg.</p>		
<p><b>Cholesterol Testing</b> <i>A blood test that measures the total amount of fat-like substance (cholesterol) in your blood to see if you are at risk for heart disease.</i></p>	<p>Men: over age 34 every 5 years.</p>	<p>Women: over age 44 every 5 years. Men: every 5 years.</p>	
<p><b>Daily Aspirin Use for Prevention of Heart Disease</b></p>	<p>Women: discuss with practitioner after menopause Men: discuss with practitioner at age 40 and older</p> <p>If at risk* (<i>Risk = increased risk of coronary heart disease because of tobacco use, high LDL cholesterol, hypertension, or family history of premature Coronary Heart Disease</i>)</p>		
<p><b>Abdominal Aortic Aneurysm Screening</b> <i>An ultrasound to check for a stretched and bulging section in the wall of the aorta, the large artery that carries oxygen-rich blood from the heart to the rest of the body. The weakened and bulging section may burst or rupture, causing life-threatening bleeding.</i></p>	<p>Men: One lifetime screen for ages 65–74 who have ever smoked (<i>greater than 100 cigarettes in lifetime</i>)</p>		
<p><b>Vision and Hearing Screening</b></p>	<p>Adults every 2–10 years</p>		

\* "If at risk": Discuss with your doctor based on past and current medical history, family history, living situations, lifestyle and profession.

## Guide to Preventive Services and Immunization Schedule for Adults

Disease screening, counseling and education for average-risk adults, without symptoms of illness or disease. These are routine recommendations; your doctor may advise you differently depending on your medical history. The services below are recommendations for routine preventive care and not authorization for coverage. Check your individual plan first.

Vaccine	Protects Against	Ages 19–26	Ages 27–39	Ages 40–64	Ages 65 & Older	
<b>Td/Tdap</b>	<b>Tetanus:</b> (lockjaw) <b>Diphtheria:</b> (skin lesions or breathing complications) <b>Pertussis:</b> (whooping cough)	Tdap if previously not immunized, Td booster every 10 years			Td booster	
<b>IPV</b>	<b>Polio:</b> a disabling condition that can lead to loss of movement from a virus that attacks the spinal cord.	Immunize if not previously immunized				
<b>Influenza vaccine</b>	Flu and complications	Annually between October and March				
<b>PPV 23</b>	Infections of the lungs (pneumonia)	Immunize once if at risk*. Re-immunize once, if at risk of losing immunity after 5 years			Immunize at age 65 if not done previously. Re-immunize once if first dose received more than 5 years ago and before age 65 or if at risk*.	
<b>MMR</b>	<b>Measles:</b> (a virus that can cause diarrhea, ear infections, pneumonia, inflammation of the brain, seizures and death) <b>Mumps:</b> (a virus that can cause inflammation of the brain and spinal cord, and permanent deafness) <b>Rubella:</b> (a virus that can cause breathing complications)	If born during or after 1957, one dose MMR. Two doses (if at risk*)				
<b>Hep A</b>	Inflammation of the liver (Hepatitis A virus)	If at risk*				
<b>Hep B</b>	Chronic inflammation of the liver, life-long complications (Hepatitis B virus)	Immunize if not previously immunized			If at risk*	
<b>Varicella</b>	Chicken Pox	If not immune, or 2 doses not received previously.				
<b>Meningococcal</b>	An infection of the spinal cord and the fluid surrounding the brain that can cause brain damage and hearing loss. (Meningitis)	If at risk*				
<b>HPV</b>	A virus that can become a sexually transmitted disease, cause genital warts or develop into cancer of the cervix, vagina, anus or penis. (Human Papillomavirus)	If not received at age 12 (3 dose series)				
<b>Shingles</b>	A painful skin rash caused by the same virus that causes chicken pox. (Herpes Zoster)				At age 60 and older (single dose)	

\* If at risk: Discuss with your doctor based on living situations, lifestyle, past and current medical history, place of employment, history of vaccines previously administered, international travel and students attending post-secondary education institutions.

# MEDICA'S ROLE IN YOUR HEALTH CARE.

## Quality Improvement.

Medica's Quality Improvement (QI) program is made up of the projects and activities Medica performs to improve care, service, access and safety for our members. Medica chooses QI 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?
- Do our members receive quality mental health and chemical dependency care and service?
- How can we help our members be sure the care they receive is safe?
- Do our complaint or grievances and appeals processes work fairly and efficiently?
- How can we improve Medica's work processes to serve our members better?

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

Medica evaluates the QI program at the end of the year. The *Quality Improvement Program Evaluation* is a report that reviews the quality improvement activities by measuring progress toward goals and identifying trends that show how well the program performs over time. The report also tracks problems and unexpected occurrences that prevent goals from being reached.

Departments and staff throughout Medica participate in QI activities. The Chief Medical Officer and Senior Vice President of Quality and Care Management, a licensed physician, is responsible for leading the QI program. Medica's Quality Improvement Subcommittee (QIS) directs and oversees the QI program. QIS reports to the Medical Committee of the Medica Board of Directors, which reports to the full Medica Board of Directors.

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

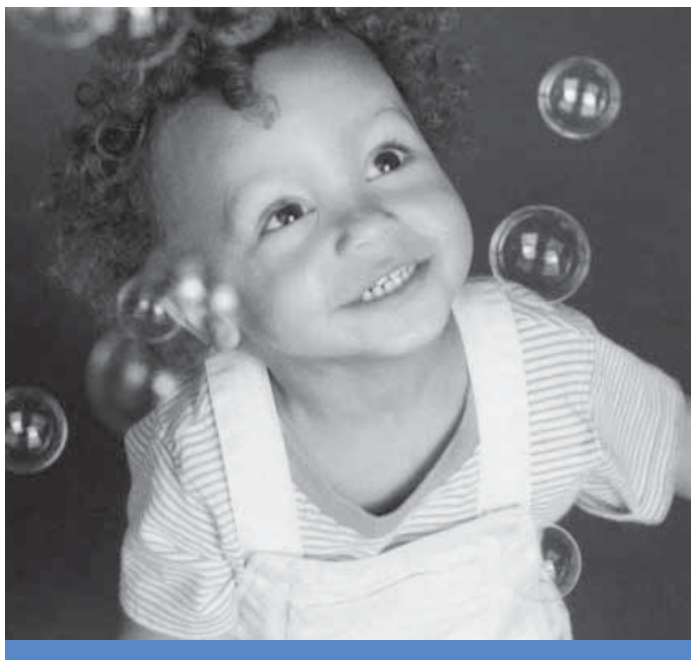
## Care coordination.

Medica's goal is to support 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 options for care before decisions are made.

One aspect of care coordination is care management. Care management focuses on identifying health problems early and ensuring delivery of timely, effective, and coordinated care.

Utilization management is another care coordination service. 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 resources. This is especially important if your plan requires prior authorization for some services. Utilization management helps assure that the care and services you are receiving are appropriate and covered by your plan. Otherwise, coverage might be denied.

If coverage for some service is denied, it is important for you to know that Medica does not reward anyone for issuing denials of 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 care management or utilization management and wish to speak to a representative of the Care Management department, please contact Medica Customer Service at the numbers listed in the *Important phone numbers* section of this guide or on the back of your Medica ID card.

If coverage is denied, you can appeal. See the *Complaints and appeals* section in this guide. Or call Medica Customer Service for more information. The number is listed in the *Important phone numbers* section of this guide. For more information about the appeal rights under your plan, see your coverage document. You may also contact us through our Web site at **medica.com**.

### 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 network. These guidelines are available to members on **medica.com > Providers > Clinical & Quality > Medical Policies > ICSI Guidelines or Medica Clinical Guidelines**. They can also be requested by calling Medica Customer Service at the numbers listed on the back of your Medica ID card or the back of this booklet.

### 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 of information to evaluate new medical technology and procedures, including behavioral health. 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 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. The Pharmacy and Therapeutics Committee, composed

of independent physicians and pharmacists from various specialties, reviews medications in all therapeutics categories to determine whether to add them to the Medica list of preferred drugs based on their safety, effectiveness and value. For more information about the Medica list of preferred drugs, see the *Pharmacy services* section of this guide.

## COMPLAINTS AND APPEALS.

Medica's goal is to help you take better care of your health. There may be a time when we deny a claim, a prior authorization request, or a request for services or care. Your plan has formal complaint and appeal processes, which are outlined in the table on the next page. Please follow these processes 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 to obtain a *Release of Information* form, which will allow Medica to discuss your appeal with your designated representative.

### How to file a complaint.

A complaint can be filed in writing or by telephone. Call Medica Customer Service at the number listed in the *Important phone numbers* section of this guide or refer to your coverage document for more information. If you make a verbal complaint that needs research, Medica will respond within 10 days. If we are not able to provide a response within that time frame, a complaint form will be provided. If you need assistance in completing the complaint form, contact Customer Service. We will respond to written complaints within 30 days.

If your complaint is in regard to quality of care, it will be investigated, but details of the outcome cannot be provided.

### How to appeal a coverage decision.

For all plan types, if your attending provider believes that Medica's decision warrants an expedited review or if Medica concludes that a delay could seriously harm your life, health or ability to regain maximum function, Medica will process your request as an expedited review. In such cases, Medica will notify you and your provider of its decision no later than 72 hours after receiving the request.

*Note: For further information on filing complaints and appeals, review your coverage document.*

Plan Type	Complaints and Appeals Process		
<p>Medica Self-Insured (MSI) groups</p>	<p><b>To file a first-level review with MSI</b></p> <p>You can call or write Medica Self-Insured (MSI) at the telephone numbers listed on the back of this guide. You must request an appeal within 180 days of receiving this decision. Your appeal will be completed no later than 30 days from receipt of your request.</p> <p>If you remain dissatisfied with MSI’s initial appeal decision, you may have the following additional levels of review available to you. Please refer to your plan document for information on the rights available to you or contact our Customer Service department. See the <i>Important phone numbers</i> section at the back of this guide or on the back of your Medica ID card.</p> <p>The options available to you are listed on your plan document. The following are examples:</p> <table border="0" data-bbox="368 609 1490 1214"> <tr> <td data-bbox="368 609 906 1214"> <p><b>Option 1</b></p> <p><b>Second Level of Review</b></p> <p>You may choose to have your case reviewed by an external review organization. This review will be coordinated by MSI. You must request external review within 180 days of receiving notification of MSI’s first-level appeal decision. You will be notified of the review organization’s decision within 60 days. The decision rendered by the external review organization is final. It is binding on both you and your employer.</p> <p><b>Civil Action</b></p> <p>If you are dissatisfied following MSI’s initial appeal decision, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.</p> </td> <td data-bbox="956 609 1490 1214"> <p><b>Option 2</b></p> <p><b>Plan Administrator Review</b></p> <p>You may submit a written request for appeal to your plan administrator. You must request an appeal within 180 days of receiving notice of MSI’s initial appeal decision. You will be notified of the plan administrator’s decision within 60 days. The decision will conclude your appeal options.</p> <p><b>Arbitration</b></p> <p>You may submit a complaint to binding arbitration, conducted pursuant to the rules of the American Arbitration Association (AAA).</p> <p><b>Civil Action</b></p> <p>You have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.</p> </td> </tr> </table>	<p><b>Option 1</b></p> <p><b>Second Level of Review</b></p> <p>You may choose to have your case reviewed by an external review organization. This review will be coordinated by MSI. You must request external review within 180 days of receiving notification of MSI’s first-level appeal decision. You will be notified of the review organization’s decision within 60 days. The decision rendered by the external review organization is final. It is binding on both you and your employer.</p> <p><b>Civil Action</b></p> <p>If you are dissatisfied following MSI’s initial appeal decision, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.</p>	<p><b>Option 2</b></p> <p><b>Plan Administrator Review</b></p> <p>You may submit a written request for appeal to your plan administrator. You must request an appeal within 180 days of receiving notice of MSI’s initial appeal decision. You will be notified of the plan administrator’s decision within 60 days. The decision will conclude your appeal options.</p> <p><b>Arbitration</b></p> <p>You may submit a complaint to binding arbitration, conducted pursuant to the rules of the American Arbitration Association (AAA).</p> <p><b>Civil Action</b></p> <p>You have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.</p>
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<p>For some MSI groups, your appeal rights may differ from those described above; please review your plan to determine your appeal rights.</p>			

# APPENDIX

## Self-insured enrollee rights and responsibilities.

### As a self-insured enrollee, you have:

1. A right to receive information about Medica, its services, its practitioners and providers, and enrollees' rights and responsibilities;
2. A right to be treated with respect and recognition of your dignity and the right to privacy;
3. A right to participate with providers in decision-making regarding your health care, including the right to refuse treatment recommended to you by Medica or any provider;
4. A right to information about your health condition, appropriate or medically necessary treatment options and risks, regardless of cost or benefit coverage, so you can make an informed choice about your health care;
5. A right to file a complaint or an appeal about Medica or the care it provides. You may do so by contacting Medica Customer Service at the number on the back of your Medica ID card. Please refer to your coverage document for more information on your complaint and appeal rights;
6. A right to make recommendations regarding Medica's enrollees' rights and responsibilities statement;
7. A responsibility to provide the necessary information to health care professionals needed to determine appropriate care. This objective is best obtained when you share:
  - a. Information about lifestyle practices, and
  - b. Personal and family health history;
8. A responsibility to follow the instructions given by those providing health care; and
9. A responsibility to participate in understanding your health problems, participate in developing mutually agreed-upon treatment goals to the degree possible and to follow the plans that you have agreed on with your health care professional.

### Protecting your privacy.

Medica respects your privacy and has policies and procedures in place to protect the privacy of your personal health information.

- Only staff members who have a need to handle your personal health information do so.
- Medica's privacy policy prohibits oral discussion of personal health information, limiting it to staff with a need to know to process claims or provide other services that you need. Staff members do not discuss your personal health information in public places, such as on an elevator, in the cafeteria or other open spaces.
- The security of all personal health information that comes to us via electronic files and transmissions is also protected.
- Our Web site has formal privacy policies and all personal data transmissions are privacy protected.
- If you would like more information about Medica's policies and procedures for disclosure of personal health information and how it is used in making coverage decisions, please contact Customer Service at the number listed on the back of your Medica ID card.

*If you have questions about the privacy practices of your self-insured plan, please contact your plan administrator.*



## How health care providers are compensated.

### **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, or a risk-sharing arrangement, such as an amount per day, per stay, per episode, per case, per period of illness, per member or per service with targeted outcome.

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

### **Fee-for-service.**

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

### **Risk-sharing.**

*Risk-sharing* payment means that the network provider is paid a specific amount for a particular unit of service, such as an amount per day, per stay, per episode, per case, per period of illness, per member, or per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a member's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a member's health services, the network provider may keep some of the excess.

### **Non-network providers.**

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider. If this happens, members may be responsible for paying the difference.

## IMPORTANT PHONE NUMBERS



### Medica Customer Service

Medica Customer Service is here to answer questions about your health plan.

Sometimes it is easiest to pick up the phone and talk with someone who can help. That is Medica Customer Service, available to answer questions about your health care plan 7 a.m. to 6 p.m., Monday through Friday.

**Please have your Medica ID card available when you call so you are able to provide your group number. If you do not have an ID card and don't know your group number, simply stay on the line after the recorded message and a representative will help you.**

### Self-Insured Members

> **952-945-8000** or **1-800-952-3455**

### Passport from Medica<sup>SM</sup>

> **1-800-228-1403**

### Definity by Medica<sup>SM</sup>

> **1-800-228-1403**

### TTY for hearing-impaired callers

> National Relay Center: **1-800-855-2880**

### Medica CallLink<sup>®</sup> Nurse Line

For many members, the Medica CallLink nurse line is available to answer questions about your health or refer you to a physician. A registered nurse is always available to answer your health questions. You can call 24 hours a day, 365 days a year.

> **To determine if this service is available to you, please refer to the back of your Medica ID card for the telephone number. TTY for hearing-impaired callers can call the National Relay Center at 1-800-855-2880 and request Medica CallLink at 1-800-962-9497.**

### Medica Behavioral Health

Mental health and chemical dependency services. (United Behavioral Health manages the Medica Behavioral Health program.)

- > Toll-free 24 hours: **1-800-848-8327**
- > TTY: **1-800-543-7162**

### Medica Tobacco Cessation Program

If you use tobacco and are thinking of quitting, call the Medica tobacco cessation program. (Note: This program may not be available to all members.)

- > Toll-free:  
**1-800-934-4824**



Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani, oo lacag la'aan ah, wac Medica: 1-800-952-3455.

1-800-952-3455: Medica **المعلومات، فاتصل بالرقم 1-800-952-3455: ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه**

Внимание: Если Вам нужна бесплатная помощь в переводе этой информации, позвоните по следующему телефону: Medica: 1-800-952-3455.

ລະວັງ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທລາ Medica: 1-800-952-3455.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a Medica: 1-800-952-3455.

ក្រំណត់សំគាល់  
បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ  
សូមទូរស័ព្ទទៅ Medica: 1-800-952-3455.

Chú Ý. Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi Medica: 1-800-952-3455.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu Medica: 1-800-952-3455.

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite Medica: 1-800-952-3455.

Hubaddhu. Yo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, bilbila kana bilbili Medica: 1-800-952-3455.

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If you want free help translating this information, call 1-800-952-3455.

**MEDICA**<sup>®</sup>

PO Box 9310, Minneapolis, MN 55440-9310

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