MEDICA®

Personalize. Empower. Improve.

How To Get The Care You Need

A member guide to Medica.

HOW TO GET THE HELP YOU NEED
A member guide to Medica

WELCOME!
MEDICA IS HERE FOR YOU.

Welcome to Medica. We are happy to have you as a member. 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.

This guide has been developed for Medica's fully insured members (including non-Medicare individual plans). 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 "Policy" or "Certificate of Coverage"
  - Note: This document is available on **mymedica.com** (members of Medica's Individual and Family plans will find your documents available on **medica.com**).
- Summary of Benefits and Coverage document
- Your "Explanation 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?

Visit **mymedica.com** where you can link to many helpful sites. Or call Medica Customer Service at the number on the back of your Medica ID card for help.

Medica Customer Service
Group Plan Members*
952-945-8000 or **1-800-952-3455**

Individual and Family Plan Members
952-992-1805 or **1-866-894-8051**

TTY users: **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.

**Some plans have their own dedicated Customer Service phone number.*

DO YOU NEED MEMBER DOCUMENTS?

For a copy of your coverage document or to see who's in your plan, log onto **mymedica.com**.

Please read and save this document.

Contents

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 "Certificate of Coverage" or "Policy." 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 for health services. Throughout the remainder of this guide, we use the term coverage document to refer to that book. You can access your coverage document by logging into **mymedica.com**. (Members of Medica's Individual and Family plans will find your documents available on **medica.com**.)

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 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 member ID card.

DEDUCTIBLES, COPAYMENTS OR COINSURANCE MAY BE REQUIRED

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**—a fixed dollar amount you must pay annually before your insurance starts to pay (for example, $1,000).
- **Copayment**—a fixed dollar amount you must pay for a given service when you receive services (for example, $25).
- **Coinsurance**—the percentage of the covered amount you must pay for a given service (for example, 25% coinsurance).

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

*Amounts are not listed on Individual and Family plan ID cards.

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 member 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 customer service, or go to **mymedica.com** to obtain one.

Please note that claims for non-network providers must be submitted within 365 days 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. Also, if you are out of Medica's service area (Minnesota, North Dakota, South Dakota, western Wisconsin) 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 customer service for more information regarding your benefit levels and to make sure that the hospital you plan to use is in your plan'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 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 PHYSICIAN OR FACILITY

There 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 on **medica.com**.

Select the type of member you are from the list and click on *Find a physician or facility.* Then, follow the instructions and use icons to search for providers that are conveniently located and meet your needs.

Please confirm with the provider's office that they are part of your health plan's network before your first visit. If you have questions regarding whether your provider or clinic participates in your plan's network, 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 a Medica network, a special committee reviews that provider's education, experience and past performance. The work of this committee is reviewed and overseen by the Medical Committee of the Medica Board of Directors, which reports to the full Medica Board of Directors.

If you are interested in your own provider's background, including professional qualifications such as medical school attended, residency completed and board certification status, contact the State Board of Medical Practice or State Board of Medical Examiners. Check your state's official government website.

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 female reproductive system. They are also trained in routine preventive services or reproductive services.

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.

Important! If you choose to see a provider who's not in the Medica network, you usually file your own itemized claim and **your costs may be significantly higher**. For more detailed information about out-of-network care, costs and how they're calculated, refer to your coverage document or see the *Out-of-Network Costs Member Tip Sheet* at **medica.com**, or call Medica Customer Service for help.

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 network.

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 access your coverage document any time on **mymedica.com** (members of Medica's Individual and Family plans will find your documents available at **medica.com**).

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 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.**

**Individual and Family plans: This is a benefit option that only applies in 2013 if the policyholder chooses to purchase this coverage during the application process. As a result of the Patient Protection and Affordable Care Act, starting on January 1, 2014 and forward, this benefit will be included in all policies.*

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 convenience care/retail health clinics in your plan's network. These are listed in the online provider search tool. For most members, help finding a location close to you is available through the Medica nurse line service. The phone numbers are listed on the back of your Medica member ID card.

Urgent care and convenience care/retail health clinics are also listed in our online provider search tool at **mymedica.com**.

CONVENIENCE CARE/RETAIL HEALTH CLINICS

Convenience care/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. These clinics are not for life-threatening emergencies. Clinics like MinuteClinic® provide after-hours care and are located in many retail stores, shopping malls and offices throughout the Twin Cities area. Find an up-to-date list of locations on our online provider search tool at **mymedica.com**.

Convenience care/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.

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 nurse line and talk with a nurse about your child's behavior. You may be directed to go to the closest urgent care facility or convenience care/retail health clinic. The Medica nurse line 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 nurse line and talk with a nurse about your symptoms. You may be directed to go to the closest urgent care facility or convenience care/retail health clinic. The Medica nurse line 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.

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, fevers, sprains, minor cuts, 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 in our online provider search tool at **medica.com**.

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. But please do not go to an emergency room for a minor problem or routine health concern. 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 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 or convenience care/retail health clinic.

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.

For medical emergencies, your copayment or coinsurance will be at Medica's in-network level, even if the provider is not in your plan's network.

CARE WHEN YOU TRAVEL OUTSIDE OF OUR SERVICE AREA

If you travel out of Medica's service area (Minnesota, North Dakota, South Dakota, western Wisconsin), you may be able to get care from any provider in UnitedHealthcare's Options PPO Network—that's more than 645,000 physicians and 5,100 hospitals nationwide—at Medica's in-network level. Just look for the UnitedHealthcare logo on the back of your Medica member ID card (employer groups only) to be sure you're eligible for this coverage*. To find a UnitedHealthcare network provider, go to **mymedica.com** and under *Find a physician or facility,* find the *Travel Program.*

**Does not apply to Individual and Family plan members on a short-term policy.*

If you plan to travel 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 Medica health care plan provides coverage for emergency medical treatment. Please see your coverage document for specific benefit levels.

You should carry your Medica member ID card with you when you travel. It has many important telephone numbers to help you access advice about your health care and coverage. Most Medica members who are ill can call the Medica nurse line for health care advice. The phone number is listed on the back of your Medica member ID card.

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 member ID card.

MEDICA 24-HOUR NURSE LINE

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

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 nurse line is staffed 24 hours every day. The toll-free phone numbers are listed on the back of your Medica member ID card.

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

HEALTH COACHING: SUPPORT FOR MANAGING YOUR HEALTH

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

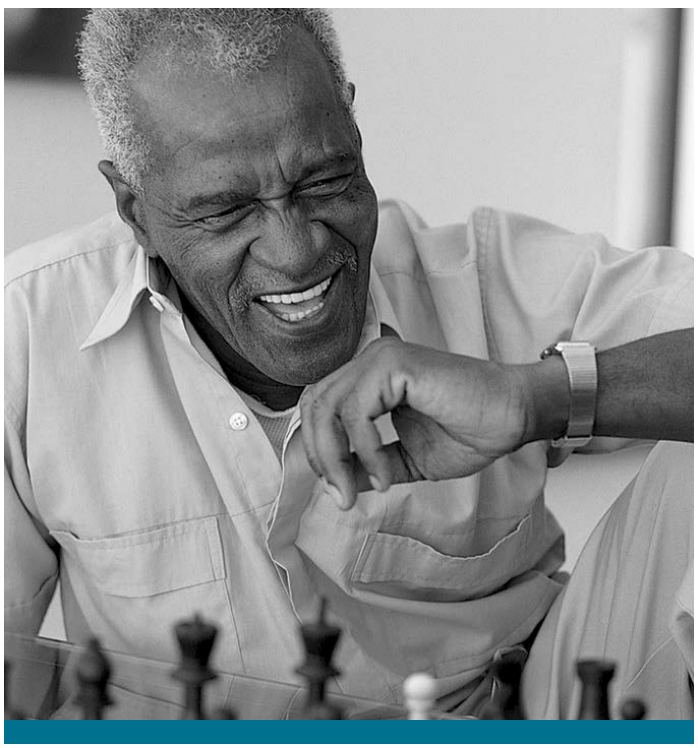
The program is based on a holistic mind/body approach to medicine that provides a way for participants to find the strength within themselves to make desired life changes. Through coaching conversations, participants learn to build upon their strengths and increase their motivation and confidence to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

You may be invited to participate in this program. Your doctor may refer you to the Health Coaching 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**.

**Does not apply to Individual and Family plan members.*



Meeting your individual health care needs.

No two Medica members are alike or have exactly the same needs. That is why Medica offers extra services. 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 works with a language interpreter service, which provides a pool of more than 100 interpreters who assist us in communicating with Medica members (In some circumstances, you may have the right to receive certain written notices in a language other than English.).

**These services may not be available to all plans.*

SERVICES FOR TTY USERS

Call the National Relay Center to reach a Customer Service representative who can answer your questions.

TTY users call the National Relay Center at **1-800-855-2880**

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

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

PHARMACY SERVICES: HOW DO MY PRESCRIPTION DRUG BENEFITS WORK FOR ME?

The Medica Preferred Drug List (PDL) is comprised of drugs that provide the most value and have proven safety and effectiveness. This list is grouped into tiers and Tier 1 is your lowest copayment or coinsurance option. The PDL contains a wide variety of generic and brand-name drugs and is reviewed and updated on a regular basis by an independent committee of physicians and pharmacists. If a drug is on the PDL, it does not guarantee coverage because certain limitations may apply. Please refer to your coverage document on **mymedica.com** for more information, or call the Customer Service number on the back of your Medica ID card. You also can look up drugs on the PDL on **mymedica.com**.

Exception Process.

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

The physicians and pharmacists who help develop and maintain the PDL work to include medications for all therapeutic needs. Still, there are times when a member may require a medication that is not covered and their doctor may request an exception. Criteria are established to determine when an exception will be granted. The prescriber will be notified of an approval or denial of their exception request.

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 your plan's network? It can happen if Medica terminates its contract with your provider without cause.* It can also happen if you are a new Medica member because your employer changed health plans and your current provider is not in a Medica network.

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

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

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

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

   - An acute condition.
   - A life-threatening mental or physical illness.
   - Pregnancy 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.

2. **If you have a short life expectancy.**

   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.

3. **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.

4. If you are a member in a Wisconsin plan and your provider was a Medica network 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. You may be able to continue receiving care from your primary care physician through the end of the current contract period. You may be able to continue receiving care from any other type of provider for up to 90 days. If you are in the second or third trimester of pregnancy, you may be able to continue care with your provider through post-partum care.

Your provider must agree to certain 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. Coverage will not be provided for services or treatment that are not otherwise covered.

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

Please see your coverage document for more information.

ADVANCE DIRECTIVES: MAKING YOUR WISHES KNOWN

In 1990, the Federal Government passed a law requiring Medica to tell our members about advance directive laws—the laws about the instructions you can write to tell your doctors and family what kind of care you want if you're too sick to make health care decisions yourself.

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

An advance directive is a written instruction, such as a living will or health care power of attorney. The law recognizes advance directives as they relate to health care that's provided to a patient who is unable to make decisions because of illness or injury. The instructions are written and witnessed in advance of the possible need for them. Advance directives can provide peace of mind now and will protect your right to care the way you want it.

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

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

Keeping yourself and your family healthy.

One of the easiest ways to prevent illness 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, preventive services and immunizations for healthy children and adults. These guidelines were adapted from the Institute for Clinical Systems Improvement (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.

ROUTINE PRENATAL CARE

Event	Screening Maneuvers	Counseling, Education, Intervention	Immunization & Chemoprophylaxis
Preconception Visit	Risk profiles Height and weight/BMI Blood pressure History and physical Cervical cancer screening Rubella/rubeola Varicella Domestic violence Depression	Preterm labor Substance use Nutrition and weight Domestic violence List of medications, herbal supplements, vitamins Accurate recording of menstrual dates	Tetanus booster Rubella/MMR [Varicella/VZIG] Hepatitis B vaccine Folic acid supplement
Visit 1 6–8 weeks**	Risk profiles GC/Chlamydia Height and weight/BMI Blood pressure History and physical* Rubella Varicella Domestic violence Depression CBC ABO/Rh/Ab Syphilis Urine culture HIV [Blood lead screening] Viral hepatitis	Preterm labor [VBAC] Prenatal and lifestyle education • Physical activity • Nutrition • Follow-up of modifiable risk factors • Nausea and vomiting • Warning signs • Course of care • Physiology of pregnancy Discuss fetal aneuploidy screening	Tetanus booster Nutritional supplements Influenza [Varicella/VZIG] Pertussis
Visit 2 10–12 weeks	Weight Blood pressure Fetal aneuploidy screening Fetal heart tones	Preterm labor education Prenatal and lifestyle education • Fetal growth • Review labs from visit • Breastfeeding • Nausea and vomiting • Physiology of pregnancy • Follow-up of modifiable risk factors	
Visit 3 16–18 weeks	Weight Blood pressure Depression Fetal aneuploidy screening Fetal heart tones OB Ultrasound (optional) Fundal height Cervical assessment	Preterm labor education Prenatal and lifestyle education • Follow-up of modifiable risk factors • Physiology of pregnancy • Second-trimester growth • Quickening Preterm labor prevention	[Progesterone]
Visit 4 22 weeks	Weight Blood pressure Fetal heart tones Fundal height Cervical assessment	Preterm labor education Prenatal and lifestyle education • Follow-up of modifiable risk factors • Classes • Family issues • Length of stay • Gestational diabetes mellitus (GDM) Preterm labor prevention	[RhoGam 17]

[Bracketed] items refer to high-risk groups only.

* It is acceptable for the history and physical and laboratory tests listed under Visit 1 to be deferred to Visit 2 with the agreement of both the patient and the clinician.

** Should also include all subjects listed for the preconception visit if none occurred.

Reference: Institute for Clinical Systems Improvement (July 2012)

ROUTINE PRENATAL CARE (CONTINUED)

Event	Screening Maneuvers	Counseling, Education, Intervention	Immunization & Chemoprophylaxis
Visit 5 28 weeks	Preterm labor risk Weight Blood pressure Depression Fetal heart tones Fundal height Gestational diabetes mellitus (GDM) Domestic violence [Rh antibody status] [Hepatitis B Ag] [GC/Chlamydia]	Psychosocial risk factors Preterm labor education Prenatal and lifestyle education • Follow-up modifiable risk factors • Work • Physiology of pregnancy • Preregistration • Fetal growth Preterm labor prevention Awareness of fetal movement	[ABO/Rh/Ab] [RhoGAM] [Hepatitis B Ag]
Visit 6 32 weeks	Weight Blood pressure Fetal heart tones Fundal height	Preterm labor education Prenatal and lifestyle education • Follow-up of modifiable risk factors • Travel • Contraception • Sexuality • Pediatric care • Episiotomy Labor and delivery issues Warning signs/pregnancy–induced hypertension [VBAC] Preterm labor prevention	
Visit 7 36 weeks	Weight Blood pressure Fetal heart tones Fundal height Cervix exam as indicated Confirm fetal position Culture for group B streptococcus	Prenatal and lifestyle education • Follow-up of modifiable risk factors • Postpartum care • Management of late pregnancy symptoms • Contraception • When to call provider • Discussion of postpartum depression	
Visit 8–11 38–41 weeks	Weight Blood pressure Fetal heart tones Fundal height Cervix exam as indicated	Prenatal and lifestyle education • Follow-up of modifiable risk factors • Postpartum vaccinations • Infant CPR • Post-term management Labor and delivery update Breastfeeding	
Visit Post-Partum 4–6 weeks	Cervical cancer screening [GC/Chlamydia] Height and weight/BMI Blood pressure History and physical Domestic violence Depression Gestational diabetes mellitus (GDM)	Contraception Discussion of postpartum depression Breastfeeding concerns and support	Tetanus/pertussis

[Bracketed] items refer to high-risk groups only.

Reference: Institute for Clinical Systems Improvement (July 2012)

PREVENTIVE SERVICES FOR CHILDREN AND ADOLESCENTS

Service	0–2 Years	2–6 Years	7–12 Years	13–18 Years
Breastfeeding Counseling	Promote and support breastfeeding.			
Depression Screening			Screen adolescents ages 12–18 for major depressive disorder when systems are in place for accurate diagnosis, treatment and follow-up.	
Folic Acid Chemoprophylaxis Counseling				Counsel women to consume 400–800 micrograms of folic acid per day from food sources or supplements.
Hearing Screening	Screen for congenital hearing loss before age one month.			
Infant Sleep Positioning and SIDS Counseling	Ask about the child's sleep environment. Inform parents to place infants on their back to sleep.			
Motor Vehicle Safety Screening and Counseling	Ask about the use of car seats, booster seats and seat belts in the family. Ask about helmet use in recreational activities.			
Obesity Screening		Record height, weight and calculate body mass index annually.		
Oral Health Counseling and Treatment	Fluoride should be provided to prevent caries and cavities. Risk assessment including oral screening and referral for dental care should be provided for those at high risk. Counseling on oral health preventive measures should be provided.			
Tobacco Use Screening, Prevention and Intervention in Adolescents	Establish tobacco use and secondhand exposure; offer tobacco cessation on a regular basis. Provide brief intervention.			
Vision Impairment Screening (age five years and younger)		Recommended for all children 3–5 years of age. Vision screening should be recommended for children under the age of three.		

Reference: Institute for Clinical Systems Improvement (September 2012)

RECOMMENDED IMMUNIZATION SCHEDULE FOR PERSONS AGED 0 THROUGH 6 YEARS

Range of recommended ages for all children | Range of recommended ages for certain high-risk groups | Range of recommended ages for all children and certain high risk groups

Vaccine	Birth	1 mo.	2 mos.	4 mos.	6 mos.	9 mos.	12 mos.	15 mos.	18 mos.	19–23 mos.	2–3 yrs.	4–6 yrs.
Hepatitis B[1]	Hep B	Hep B			Hep B							
Rotavirus[2]			RV	RV	RV[2]							
Diphtheria, tetanus, pertussis[3]			DTaP	DTaP	DTaP		*see footnote 3*	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	Hib[4]		Hib					
Pneumococcal[5]			PCV	PCV	PCV		PCV				PPSV	
Inactivated poliovirus[6]			IPV	IPV	IPV							IPV
Influenza[7]					Influenza (Yearly)							
Measles, mumps, rubella[8]							MMR		*see footnote 8*			MMR
Varicella[9]							Varicella		*see footnote 9*			Varicella
Hepatitis A[10]							Dose 1[10]				HepA Series	
Meningococcal[11]						MCV4 — *see footnote*[11]						

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. **Hepatitis B (HepB) vaccine.** (Minimum age: birth)

   At birth:

   - Administer monovalent HepB vaccine to all newborns before hospital discharge.
   - For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after receiving the last dose of the series.
   - If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing ≥2,000 grams, and HepB vaccine plus HBIG for infants weighing <2,000 grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).

   Doses after the birth dose:

   - The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
   - Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
   - Infants who did not receive a birth dose should receive 3 doses of a HepB containing vaccine starting as soon as feasible (Figure 3).
   - The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.

2. **Rotavirus (RV) vaccines.** (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])
   - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** (Minimum age: 6 weeks)
   - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. **Haemophilus influenzae type b (Hib) conjugate vaccine.** (Minimum age: 6 weeks)
   - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
   - Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.

5. **Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
     - – All children aged 14 through 59 months
     - – Children aged 60 through 71 months with underlying medical conditions.
   - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.

6. **Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
   - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

7. **Influenza vaccines.** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
   - For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - For children aged 6 months through 8 years:
     - – For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
     - – For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.

8. **Measles, mumps, and rubella (MMR) vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.

9. **Varicella (VAR) vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
   - For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. **Hepatitis A (HepA) vaccine.** (Minimum age: 12 months)
    - Administer the second (final) dose 6 to18 months after the first.
    - Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
    - A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.

11. **Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM])
    - For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
    - For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
    - For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.
    - See *MMWR* 2011;60:72–6, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003. pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www. cdc. gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf, and *MMWR* 2011;60:1391–2, available at http://www.cdc.gov/mmwr/pdf/wk/mm6040. pdf, for further guidance, including revaccination guidelines.

Reference: Institute for Clinical Systems Improvement (September 2012)

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

Department of Health and Human Services • Centers for Disease Control and Prevention

RECOMMENDED IMMUNIZATION SCHEDULE FOR PERSONS AGED 7 THROUGH 18 YEARS

Range of recommended ages for all children | Range of recommended ages for catch-up immunization | Range of recommended ages for certain high-risk groups

Vaccine	7–10 Years	11–12 Years	13–18 Years
Tetanus, diphtheria, pertussis[1]	1 dose (if indicated)	1 dose	1 dose (if indicated)
Human papillomavirus[2]	*see footnote 2*	3 doses	Complete 3-dose series
Meningococcal[3]	*see footnote 3*	Dose 1	Booster at 16 years old
Influenza[4]	Influenza (yearly)		
Pneumococcal[5]	*see footnote 5*		
Hepatitis A[6]	Complete 2-dose series		
Hepatitis B[7]	Complete 3-dose series		
Inactivated poliovirus[8]	Complete 3-dose series		
Measles, mumps, rubella	Complete 2-dose series		
Varicella[10]	Complete 2-dose series		

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. **Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
   - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
   - Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid–containing vaccine are needed.
   - Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid–containing vaccine.
2. **Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).** (Minimum age: 9 years)
   - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
   - The vaccine series can be started beginning at age 9 years.
   - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
   - See *MMWR* 2010;59:626–32, available at http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf.
3. **Meningococcal conjugate vaccines, quadrivalent (MCV4).**
   - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
   - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
   - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
   - If the first dose is administered at age 16 years or older, a booster dose is not needed.
   - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
   - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
   - See *MMWR* 2011;60:72–76, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf, for further guidelines.
4. **Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).**
   - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No.RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - Administer 1 dose to persons aged 9 years and older.
   - For children aged 6 months through 8 years:
     - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
     - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
5. **Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).**
   - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
   - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.
6. **Hepatitis A (HepA) vaccine.**
   - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
   - Administer 2 doses at least 6 months apart to unvaccinated persons.
7. **Hepatitis B (HepB) vaccine.**
   - Administer the 3-dose series to those not previously vaccinated.
   - For those with incomplete vaccination, follow the catch-up recommendations.
   - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered at least 6 months after the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
   - IPV is not routinely recommended for U.S. residents aged 18 years or older.
9. **Measles, mumps, and rubella (MMR) vaccine.**
   - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.
10. **Varicella (VAR) vaccine.**
    - For persons without evidence of immunity (see *MMWR* 2007;56[No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

Reference: Institute for Clinical Systems Improvement (September 2012)

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

Department of Health and Human Services • Centers for Disease Control and Prevention

Level One Services by Age

Service	19–39 Years	40–64 Years	65 Years and Older
Alcohol abuse, hazardous and harmful drinking screening and brief counseling	Identify those with risky or hazardous drinking, as well as those who have carried that behavior to the point of meeting criteria for dependence, and then provide brief intervention.		
Aspirin chemoprophylaxis counseling		Encourage for men age 45–79 years when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. Encourage for women age 55–79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	
Breast cancer screening		Mammogram every one to two years for women ages 50–75 years.	
Cervical cancer screening	No screening before age 21 regardless of age of onset of sexual activity. Screening every three years between ages of 21–65.		Stop screening at age 65–70 if adequate screening was carried out in the preceding 10 years.
Chlamydia screening	All sexually active women age 25 years and younger.		
Colorectal cancer screening		Age 50 years and older or age 45 years of age and older for African Americans and American Indians/Alaska Natives. No screening recommended for ages 76–85 unless there are significant considerations that support screening in an individual patient. No screening recommended for ages 86 or older.	
Hypertension screening	Blood pressure every two years if less than 120/80; every year if 120–139/80–89 Hg.		
Influenza immunization	Annually during flu season for all individuals.		
Lipid screening	Fasting fractionated lipid screening for men over age 34 every five years.	Fasting fractionated lipid screening for men over age 44 every five years.	
Pneumococcal immunization	Immunize high-risk groups once. Reimmunize those at risk of losing immunity once after five years.		Immunize at age 65 if not done previously. Reimmunize once if first received more than five years ago and before age 65, or an immunocompromising condition is present.
Tobacco use screening and brief intervention	Establish tobacco use status for all patients and reassess at every opportunity. Provide brief intervention.		

Reference: Institute for Clinical Systems Improvement (September 2012)

Level Two Services by Age

Service	19–39 Years	40–64 Years	65 Years and Older
Abdominal aortic aneurysm screening			Men ages 65–75 who have ever smoked.
Depression screening	Routine screening if there are systems in place to ensure accurate diagnosis, effective treatment and careful follow-up.		
Folic acid chemoprophylaxis counseling	Counsel women of reproductive age to consume 400 to 800 micrograms of folic acid per day from food sources or supplements.		
Hearing screening		Hearing screening followed by counseling on the availability of hearing aid devices and making referrals as appropriate for older adults.	
Hepatitis B immunization	Universal routine immunization for young adults less than 40 years of age.		
Herpes zoster/shingles immunization		Immunize at age 60 and older in patients who have no contraindications.	
Human papillomavirus (HPV) immunization	Recommended for all 11- to 12-year-old females and catch-up for females age 12–26. Routine vaccination of males ages 11–12 years with three doses of HPV4. The vaccination series can be started beginning at age 9. Males ages 13 to 21 years who had not already received the HPV4 vaccine should also be vaccinated. Males ages 22 through 26 years of age may be vaccinated.		
Inactivated polio vaccine (IPV) immunization	Vaccination should occur for adults not previously immunized against polio.		
Measles, mumps, rubella (MMR) immunization	Persons born during or after 1957 should have one dose of measles vaccine; a second dose may be required in special circumstances.		
Obesity screening	Record height, weight and calculate body mass index at least annually.		
Osteoporosis screening	Women younger than age 65, who are post menopausal and determined to have a significantly increased fracture risk should be screened.		Women age 65 and older should be screened for osteoporosis.
Tetanus-diphtheria immunization	Administer a one-time dose of Tdap to adults who have not received Tdap previously or for whom vaccine status is unknown.		
Varicella immunization	For all adults without evidence of immunity, a dose of varicella vaccine should be given followed by a second dose at an interval of at least 28 days. A catch-up second dose of varicella vaccine should be given to all children, adolescents and adults who received only one dose previously.		
Vision screening			Objective vision testing for adults age 65 and older.

Medica's role in your health care.

KEEPING HEALTH CARE AFFORDABLE

Note: The following two paragraphs apply only to members who have coverage under a Health Maintenance Organization (HMO) plan. Please see your coverage document to determine whether it applies to you.

As a non-profit organization, Medica partners with you and your doctor to help keep health care affordable and accessible. In 1973, the Minnesota State Legislature passed a law that requires all Minnesota health maintenance organizations (HMOs) to be not-for-profit organizations.

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

QUALITY IMPROVEMENT

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 substance abuse 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?

**Individual and Family plans: This is a benefit option that applies only in 2013 if the policyholder chooses to purchase this coverage during the application process. As a result of the Patient Protection and Affordable Care Act, starting on January 1, 2014 and forward, this benefit will be included in all policies.*

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 Health 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 ensure 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.

If coverage is denied, you can appeal. See the *Complaints or Grievances/Appeals* section in your coverage document. 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 website at **mymedica.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/members**. They can also be requested by calling Medica Customer Service at **952-945-8000** or **1-800-952-3455**.

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 Preferred Drug List based on their safety, effectiveness and value. For more information about the Medica Preferred Drug List, see the *Pharmacy services* section of this guide.

Complaints or Grievances/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. We have formal complaint or grievance/appeal processes, which are outlined in your coverage document. 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 your complaint is in regard to quality of care, it will be investigated, but details of the outcome cannot be provided. In some states, quality of care cases involving Medica are reviewed by a state regulator.

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, or subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking, 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. **Individual and Family plan policyholders, refer to your plan document.**

Plan Type	Complaints and Appeals Process
Minnesota fully insured plans (Medica Health Plans or Medica Insurance Company)	You may contact your state regulator at any time to file a complaint about Medica or about a doctor or health care provider. • Call the Minnesota Department of Health at 651-201-5100 or 1-800-657-3916 regarding HMO benefits. Or • Call the Minnesota Department of Commerce at 651-539-1600 or 1-800-657-3602 (outside metro only) regarding insurance benefits. **First Level of Review** If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a review. You may choose to designate a representative to act on your behalf at any time during the review process or external review process. If you choose to do so, contact Medica to obtain 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. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or for employer group plans not governed by ERISA, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. 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 assistance, please contact Medica at the following address and telephone numbers: **Mail:** Medica Customer Service, Route 0501, PO Box 9310, Minneapolis MN 55440-9310 **Telephone:** Minneapolis/St Paul area: 952-945-8000 Outside Minneapolis/St Paul area: 1-800-952-3455 TTY users, call the National Relay Center: 1-800-855-2880 **Procedures for complaints that do not involve a medical determination:** 1. If you contact Medica to express a complaint verbally, Medica will communicate a decision to you within 10 calendar days from receipt of the complaint. If you remain dissatisfied with Medica's decision, Medica will provide you with a complaint form to submit your complaint in writing. If you need assistance with completing the complaint form Medica will help you. The complaint form can be mailed to the address listed above. 2. If you submit your complaint in writing, Medica will communicate a decision to you within 30 calendar days. If you remain dissatisfied with Medica's decision, you may pursue an appeal as described below under the section "Second Level of Review". Medica's second level of review must be completed before you have the right to submit a request for external review. **Procedures for complaints that require a medical determination:** 1. If this decision was based on medical necessity, you have one year from the date of the decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level review. Your appeal will be completed no later than 30 calendar days from receipt of your request. If waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your first level review is being conducted. **Second Level of Review** If you remain dissatisfied with Medica's decision after your first level review, you may pursue a second level of review. Your request must be submitted to Medica within one year following the date of Medica's first level review decision. Generally, the second level review is optional if the complaint requires a medical determination and you may file a request for external review. Medica will inform you whether the second level of review is optional or required. 1. Medica's Second Level of Review Options • Hearing. Under this process, you present your case to a committee, either in person or in writing. If this second level of review is required, Medica will notify you of the decision within 30 calendar days of your appeal request. If the second level of review is optional, Medica will notify you of the decision within 45 calendar days of your appeal request. • Written reconsideration. Under this process, the committee will review your appeal. Medica will notify you of the decision within 30 calendar days of your appeal request. **External Review Option** You may choose to have your case reviewed by an external review organization. This process is coordinated by the appropriate state regulator at the numbers listed above. You may submit additional information to be reviewed by the external review organization. You must submit your written request for external review within six months from the date of Medica's decision. You will be notified of the review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided within 72 hours. The external review organization's decision is not binding on you, but it is binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. To make a request for external review, contact the appropriate state regulator at the numbers listed above. You must include a $25.00 filing fee at the time of the request for external review, unless waived by the regulator. The fee will be refunded if Medica's decision is completely overturned. **Right to Civil Action** If you remain dissatisfied with Medica's determination after completing the required appeals process, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.

Plan Type	Complaints and Appeals Process
Your Appeals Rights in Minnesota Individual and Family Plans (Medica Health Plans or Medica Insurance Company)	You may contact your state regulator at any time to file a complaint about Medica or about a doctor or health care provider. • Call the Minnesota Department of Health at 651-201-5100 or 1-800-657-3916 regarding HMO benefits. Or • Call the Minnesota Department of Commerce at 651-539-1600 or 1-800-657-3602 (outside metro only) regarding insurance benefits.
	First Level of Review If you are dissatisfied with Medica's decision, call or write us to request a review at the phone numbers and address listed below. You may designate a representative to act on your behalf at any time during the 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 and at no cost to you, you may request from Medica a written copy 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 review, additional information or assistance, please contact Medica at the following address and telephone numbers: **Mail:** Medica Customer Service, Route CW295IFB, PO Box 9310, Minneapolis MN 55440-9310 **Telephone:** 1-888-592-8211 TTY users, call the National Relay Center: 1-800-855-2880 and then ask them to dial 1-888-592-8211. **Procedures for complaints that do not involve a medical determination:** 1. If you contact Medica to express a complaint verbally, Medica will tell you our decision within 10 calendar days from when we receive your complaint. If you are dissatisfied with Medica's decision, Medica will send you a complaint form to submit your complaint in writing. If you need assistance with completing the complaint form, Medica will help you. Mail the complaint form to the address listed above. 2. If you submit your complaint in writing, Medica will send you our decision within 30 calendar days. If you are dissatisfied with Medica's decision, you may pursue an External Review as described below. **Procedures for complaints that require a medical determination:** 1. If this decision was based on medical necessity, you have one year from the date of our decision to file an appeal. You can call or write us (at the phone numbers or address above) to request a first level review. Your appeal will be completed no later than 30 calendar days from when we receive your request. Your attending provider may request an expedited, 72-hour appeal review if they believe it is warranted. You also may request an expedited review if waiting the standard 30 days might jeopardize your life, health or ability to regain maximum function, or if this time frame would subject you to severe pain that cannot be managed without the care or treatment you are requesting. In such cases, you also may have the right to request an External Review while your first level review is being conducted.
	External Review Option You may choose to have your case reviewed by an external review organization. This process is coordinated by the appropriate state regulator at the numbers listed above. You may submit additional information to be reviewed by the external review organization. You must submit your written request for external review within six months from the date of Medica's decision. You will be notified of the review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided within 72 hours. The external review organization's decision is not binding on you, but it is binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. To make a request for external review, contact the appropriate state regulator at the numbers listed above. You must include a $25.00 filing fee at the time of the request for external review, unless waived by the regulator. The fee will be refunded if Medica's decision is completely overturned.

Plan Type	Complaints and Appeals Process
North Dakota fully insured plans (Medica Health Plans or Medica Insurance Company)	**Information Related to a Decision** If you have any questions related to a claim, please refer to your Certificate of Coverage, or contact Medica Customer Service at the phone numbers or address listed below. **Right to Appeal a Decision** If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a first level appeal. You have one year from the date of the decision to file an appeal. Your appeal will be completed no later than 30 calendar days from receipt of your request. If waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your first level appeal review is being conducted. You may choose to designate a representative to act on your behalf at any time during the appeal or external review process. If you choose to do so, contact Medica to obtain 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. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or for employer group plans not governed by ERISA, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You may also file a complaint with your state regulator at any time. You may contact the North Dakota Insurance Commissioner at 1-800-247-0560 to file a complaint. At any time and at no cost to you, you may request a written copy from Medica of: • The rule or guideline used to make our decision, • The clinical judgment used to apply the terms of your plan to your medical circumstances, and • Any other document or information related to this review. To request an appeal, additional information or assistance, please contact Medica at the following address and telephone numbers: **Mail:** Medica Customer Service, Route 0501, PO Box 9310, Minneapolis MN 55440-9310 **Telephone:** Minneapolis/St Paul area: 952-945-8000 Outside Minneapolis/St Paul area: 1-800-952-3455 TTY users, call the National Relay Center: 1-800-855-2880 **Additional Levels of Review** If you remain dissatisfied with Medica's decision after your first level appeal, you may pursue additional levels of review. You have the option of requesting a voluntary second level appeal. The Medica second level of review is optional. You may also request an independent review of Medica's decision by an external review organization upon completion of either your first level or second level appeal if your case involves medical necessity, investigative/experimental procedures or a rescission of a policy determination. Below is a description of Medica's Voluntary Second Level of Review and External Review Procedures: 1. Medica's Voluntary Second Level of Review Options • Hearing or file review. If you would like to request a voluntary second level appeal, your request must be submitted in writing to Medica within one year following the date of Medica's first level review decision. To file a request for a second level appeal, additional information or assistance, please contact Medica at the address and telephone numbers listed above. Under this process, you present your case to a committee, either in person or in writing. Medica will notify you of its decision within 45 calendar days of your appeal request. 2. External Review Option For decisions that involve a medical necessity or experimental/investigative determination, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an external review organization. Your request must be submitted in writing to Medica within four (4) months following the date of Medica's review decision. An independent entity designated by the North Dakota Commissioner of Insurance will conduct the external review. You may submit additional information to be reviewed by the external review organization. You will be notified of the external review organization's decision within 45 days from 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. This process is coordinated through Medica. To submit a request for external review contact Customer Service at the address listed above. **Right to Civil Action** If you remain dissatisfied with Medica's determination after completing the required appeals process, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.

Plan Type	Complaints and Appeals Process
South Dakota fully insured plans (Medica Insurance Company)	**Information Related to a Decision** If you have any questions related to a claim, please refer to your Certificate of Coverage, or contact Medica Customer Service at the telephone numbers or address listed below. **Right to Appeal a Decision** If you are dissatisfied with Medica's decision, you can call or write us at the telephone numbers and address listed below to request a first level appeal. You have one year from the date of the decision to file an appeal. Medica will provide written notice of its first level review decision to you within 30 calendar days from receipt of your request. For pre-service appeals, if Medica does not issue a decision within 30 days, you have the right to request an external review, as described below. If waiting the standard 30-day turnaround time might jeopardize your health or your ability to retain maximum function, or your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your first level appeal review is being conducted. You may choose to designate a representative to act on your behalf at any time during the appeal or external review process. If you choose to do so, contact Medica to obtain 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. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or for employer group plans not governed by ERISA, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You may also file a complaint with your state regulator at any time. You also have the right at any time during this process to file a complaint with the South Dakota Division of Insurance. They can be reached at: South Dakota Division of Insurance, Department of Revenue and Regulations, 445 E. Capitol, Pierre, SD 57501. Telephone 605-773-3563 and Fax 605-773-5369. At any time and at no cost to you, you may request a written copy from Medica of: • The rule or guideline used to make our decision, • The clinical judgment used to apply the terms of your plan to your medical circumstances, and • Any other document or information related to this review. To request an appeal, additional information or assistance, please contact Medica at the following address and telephone numbers: **Mail:** Medica Customer Service, Route 0501, PO Box 9310, Minneapolis MN 55440-9310 **Telephone:** Minneapolis/St Paul area: 952-945-8000 Outside Minneapolis/St Paul area: 1-800-952-3455 TTY users, call the National Relay Center: 1-800-855-2880 **Additional Levels of Review** If you remain dissatisfied with Medica's decision after your first level appeal, you may pursue additional levels of review. You have the option of requesting a voluntary second level appeal. The Medica second level of review is optional. You may also request an independent review of Medica's decision by an external review organization upon completion of either your first level or second level appeal if your case involves medical necessity, investigative/experimental procedures or a rescission of a policy determination. <u>Below is a description of Medica's Voluntary Second Level of Review and External Review Procedures</u>: 1. Medica's Voluntary Second Level of Review Options • Hearing or file review. If you would like to request a voluntary second level appeal, your request must be submitted in writing to Medica within 4 months following the date of Medica's first level review decision. To file a request for a second level appeal, additional information or assistance, please contact Medica at the address and telephone numbers listed above. Under this process, you present your case to a committee, either in person or in writing. Medica will notify you of its decision within 45 calendar days of your appeal request. 2. External Review Option For decisions that involve a medical necessity or experimental/investigative determination, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an independent health care professional at an external review organization. This process is coordinated by the South Dakota Division of Insurance. Your request must be submitted in writing to the South Dakota Division of Insurance within four (4) months following the date of Medica's review decision. You may submit additional information to the external review organization. You will be notified of the external review organization's decision within 45 days from receipt of your request. However, (a) if waiting the standard 45-day turnaround time might jeopardize your health or your ability to retain maximum function; (b) if you received emergency services and you have not been discharged from the facility; or (c) for investigative/experimental procedures where your physician certifies in writing that treatment would be less effective if not promptly initiated, you or your attending provider may request an expedited, 72-hour external review. In the case of a request for an expedited external review, you may make your request orally directly to South Dakota Division of Insurance at the numbers listed above. The external review organization's decision is binding on you and on Medica. Only one external review request is permitted for each adverse determination. To make a request for external review, contact Medica Customer Service or the South Dakota Division of Insurance at the numbers listed above to obtain an "External Review Request" form. You must submit the form to the South Dakota Division of Insurance to request an external review. You must include a $25.00 filing fee made payable to South Dakota Division of Insurance at the time of the request for external review. **Right to Civil Action** If you remain dissatisfied with Medica's determination after completing the required appeals process, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.

Plan Type	Complaints and Appeals Process
Wisconsin fully insured plans (Medica Health Plans of Wisconsin and Medica Insurance Company)	**Information Related to a Decision** If you have any questions related to a claim, please refer to your Certificate of Coverage, or contact Medica Customer Service 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 Customer Service 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. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or for employer group plans not governed by ERISA, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. **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) along with copies of any supporting documents to Medica at the address listed below. 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-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 or assistance, please contact Medica at the following address and telephone numbers: **Mail:** Medica Customer Service, Route 0501, PO Box 9310, Minneapolis MN 55440-9310 **Telephone:** Minneapolis/St Paul area: 952-945-8000 Outside Minneapolis/St Paul area: 1-800-952-3455 TTY users, call the National Relay Center: 1-800-855-2880 **Right to External Review** If your claim involves an adverse determination, experimental treatment, pre-existing condition exclusion denial determination (as defined in your Certificate of Coverage), or a rescission of a policy or certificate, you or your authorized representative have four months from the date of 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 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 external review. The decision rendered by the external review organization is final. It 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. **Right to Civil Action** If you are dissatisfied with Medica's grievance determination, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.

Appendix

HOW MEDICA PROTECTS YOUR PRIVACY

Effective: June 11, 2003
Revised: September 23, 2013

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

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

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

Your privacy rights
The law also gives you rights to access, copy and amend your personal health information. You have the right to request restrictions on certain uses and disclosures of your personal health information. You also have the right to obtain information about how and when your personal health information has been used and disclosed.

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

MEDICA'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, healthcare services and payment for those services. HIPAA refers to this information as "protected health information" or "PHI." PHI includes information related to diagnosis and treatment plans, as well as demographic information such as name, address, telephone number, age, date of birth, and health history.

How does Medica protect your PHI?
Medica takes its responsibility of protecting your

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

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

Under what circumstances does Medica use or disclose PHI?
Medica receives, maintains, uses and shares PHI only as needed to conduct or support: (i) treatment-related activities, such as referring you to a doctor; (ii) payment-related activities, such as paying a claim for medical services; and (iii) 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.

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

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

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

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

THIS NOTICE IS INTENDED FOR MEDICA MEMBERS.

How does Medica protect your information?
Medica takes its responsibility of protecting your information seriously. Medica maintains measures to protect your information from unauthorized use or disclosure. These measures include the use of policies and procedures, physical, electronic and procedural safeguards, secured files and buildings and restrictions on who and how your information may be accessed.

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

How does Medica collect your information?
Medica collects information about you in a variety of ways. Medica obtains such information about you from:

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

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

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

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

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

AUTHORIZATION FOR ROUTINE BUSINESS PURPOSES

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

FULLY INSURED MEMBER RIGHTS AND RESPONSIBILITIES

As a fully insured member of Medica, you have the right to:

1. Available and accessible services, including emergency services (defined in your coverage document) 24 hours a day, seven days a week;

2. 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;

3. 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. Be treated with respect and recognition of your dignity, and privacy of your medical and financial records maintained by Medica or any network provider in accordance with existing law;

5. If you have coverage under Medica Health Plans, complaints related to in-network benefits are reviewed by the Minnesota Department of Health and complaints related to out-of-network benefits are reviewed by the Minnesota Department of Commerce. If you have coverage under Medica Insurance Company, contact Minnesota's Commissioner of Commerce to file a complaint about issues related to benefits.

See your Coverage Document for additional information. If you live in North Dakota, South Dakota or Wisconsin, please refer to pages 24–26 for information about filing a complaint with the State or contact Medica Customer Service for more information about filing a complaint or how to begin legal proceedings. You may begin a legal proceeding if you have a problem with Medica or any provider; and

6. Receive information about Medica, its services, its practitioners and providers, and members' rights and responsibilities.

Member responsibilities:

To increase the likelihood of maintaining good health and to ensure that the best quality care is received, it is important that you take an active role in your health care by:

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

2. Providing the necessary information to health care professionals needed to determine the appropriate care. This objective is best obtained when you share:
   a. Information about lifestyle practices; and
   b. Personal health history;

3. Following the instructions given by those providing health care;

4. Practicing self-care by knowing:
   a. How to recognize common health problems and what to do when they occur;
   b. When and where to seek appropriate help; and
   c. How to prevent health problems from recurring;

5. Practicing preventive health care by:
   a. Having the appropriate tests, exams and immunizations recommended for your gender and age as described in your Coverage Document; and
   b. Engaging in healthy lifestyle choices (such as exercise, proper diet and rest).

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

1. Right to privacy.

2. Right to file a complaint or an appeal about Medica, the care you received or a decision regarding your health care. You may do so by contacting Medica Customer Service at **952-945-8000** or **1-800-952-3455**. Please refer to your coverage document for more information on your complaint and appeal rights.

3. Right to make recommendations regarding Medica's members' rights and responsibilities statement.

4. Responsibility to participate in understanding your health problems, participate in developing mutually agreed-upon treatment goals to the degree possible and to follow the plans that you have agreed on with your health care professional.

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

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

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

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

Non-network providers.

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

Medica Financial Update

The chart on the next page has important information for all Medica members. We hope you will take a moment to read it. On the right is a list of Medica's assets, liabilities, revenue and expenses for the 2011 fiscal year. Beside that are the results for 2012. By comparing the 2012 results to 2011, you can see how Medica has performed in each category.

HERE ARE SOME KEY TERMS:

Assets:
Items of value that are owned by Medica.

Expenses:
Costs of providing health care benefits to members.

Liabilities:
Amounts owed on the assets.

Net Assets:
The net worth of the company.

Net Income:
Income after taxes.

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

2012 FINANCIAL STATEMENT

Combined Balance Sheet (in thousands):	December 31, 2012	December 31, 2011
Assets:		
Cash, cash equivalents, and investments, at fair value	1,027,262	1,065,016
Other assets	289,264	207,259
Total Assets	**$1,316,526**	**$1,272,275**
Liabilities and Net Assets:		
Claims Payable	283,382	280,307
Other Liabilities	234,605	247,502
Total Liabilities	**517,987**	**527,809**
Net Assets	**798,539**	**744,466**
Total Liabilities and Net Assets	**$1,316,526**	**$1,272,275**

Combined Statement of Operation and Changes in Net Assets (in thousands):	December 31, 2012	December 31, 2011
Revenue:		
Premiums, net of reinsurance	2,986,948	2,829,410
Administrative services contract fees	72,121	69,689
Total Revenue	$3,059,069	$2,899,099
Expenses:		
Medical and other benefits, net of reinsurance	2,595,402	2,414,386
Other operating expenses	428,038	403,453
Total Expenses	$3,023,440	$2,817,839
Operating Income	$35,629	$81,260
Investment income, income taxes, and other non-operating expenses	14,485	(10,078)
Net unrealized gains (losses) on investment, net of tax	3,959	7,621
Change in Net Assets	$54,073	$78,803

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

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 8 a.m. to 6 p.m., Monday through Friday (9 a.m. to 6 p.m. Wednesday).

Please have your Medica ID card available when you call.

- Group Plan Members*
  In Twin Cities metro area: **952-945-8000**. Outside metro area: **1-800-952-3455**

  If you do not have an ID card and don't know your group number, simply stay on the line until after the recorded message and a representative will help you.

  **Some plans have their own dedicated Customer Service phone number.*

- Individual Plan Members
  In Twin Cities metro area: **952-992-1805**. Outside metro area: **1-866-894-8051**

- TTY users
  National Relay Center: **1-800-855-2880** and ask for the number above.

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**

MEDICA BEHAVIORAL HEALTH**

Mental health and substance abuse services (United Behavioral Health manages the Medica Behavioral Health program.).

- Toll-free (24 hours): **1-800-848-8327** or TTY users may call the National Relay Center at **1-800-855-2880** and request that they call Medica Behavioral Health at **1-800-848-8327**.

**Individual and Family plans: This is a benefit option that only applies in 2013 if the policyholder purchased this coverage during the application process. As a result of the Patient Protection and Affordable Care Act, starting on January 1, 2014 and forward, this benefit will be included on all policies.

هذه المعلومات إتصل بالرقم الموجود على ظهر بطاقة
اذا كنت تحتاج مساعدة مجانية في ترجمة هذه المعلومات
التعريف الطبية الخاصة لك Medica

Haddii aad doonayso in Af Soomaali laguugu tarjamadda macluumaadkani, oo lacag la'aan ah, Fadlan wac Lambarka ku qoran Kaarka Caafimaadka ee Medica dhabarkiisa.

Ako zelite besplatano tumacenje ovih informacija posovite broj na pozadini vase Medica kartice.

Yog koj xav tau kev pab txhais cov ntaub ntawv no dawb, hu rau tus xov tooj nyob nram qab koj daim Medica Khaj (card).

ຖ້າທ່ານຕ້ອງໃຫ້ຊ່ວຍແປໜັງສື ຫຼືຂໍ້ມູນເຫຼົ່ານີ້ ຈົ່ງໂທຣຕາມເລກໂທຣສັບ ທີ່ໃຫ້ໄວ້ຢູ່ຂ້າງຫຼັງ ເມດິກາ ຫຼືບັດ ກວດສຸຂພາບ7ງໍ່ກາຣແ8Medica

Yoo odeeyssi kun bilashitti afaan keetitti akka sii hiikamu feete lakkoofsa caaardiii meedikaa (Medica) gama dubaarra jiru kana bilbili.

Если вам нужна помощь в переводе этой информации, позвоните по номеру, указанному на обратной стороне вашей медецинской карточки плана Medica.

ប្រសិនបើអ្នកចង់បានការជួយបកប្រែដោយឥតគិតថ្លៃព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខទូរស័ព្ទ នៅខាងក្រោយកាតមេឌីកា Medica ។

Si usted desea ayuda gratuita para traducir esta información, llame al número de teléfono situado al reverso de su tarjeta de identificación de Medica.

Nếu quý vị muốn được giúp đỡ dịch tài liệu này miễn phí, xin gọi số ghi ở mặt sau thẻ Medica cũa quý vị.

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

UNV1011

If you want free help translating this information, call the number on the back of your Medica identification card.

MEDICA®

PO Box 9310, Minneapolis, MN 55440-9310

COM1970-100613