

MEDICA®

Personalize. Empower. Improve.



health matters

City of Minneapolis Benefit Program

Your Guide to Enrollment

City of Minneapolis

Effective January 1, 2012



January 2012



Mayor R.T. Rybak

A strong commitment to health is a major reason Minneapolis is a great place to live and work. We enjoy access to high-quality medical providers and a strong public health system, great spaces for recreation and exercise, and healthy local foods. The City of Minneapolis also is committed to ensuring that opportunities for good health are available for all employees and other eligible members of our health benefits program.

This information packet describes your benefit options for the plan year that began on January 1, 2012. Before you dig in, I'd like to highlight our guiding principles in establishing your benefit program and share some exciting news about the future.

The following principles guided the design of your benefit plan:

- Provide quality health insurance
- Balance the increasing cost of care against the need to keep insurance affordable
- Limit out-of-pocket costs as much as possible
- Improve employee health and productivity with health management and wellness programs
- Provide you with tools and information to help you become more engaged in managing your health and benefit costs

The City of Minneapolis health benefits program – resulting from a productive partnership between labor and management – is headed in an exciting direction. A new wellness program introduced last year provides personalized encouragement, motivation and incentives for you to take a more active role in managing your health. When you participate in the My Health Rewards by Medica program, you'll be eligible for lower premium contributions.

I encourage you to review the information about this program on page 12 of this enrollment information packet. The City is 100 percent committed to supporting your health and wellness.

A handwritten signature in black ink, appearing to be "R.T. Rybak".

R.T. Rybak
Mayor

Welcome!

This information packet describes your options for the plan year that began on January 1, 2012. The City offers one medical plan design with a choice of three provider networks and wellness initiatives that are integrated into the plan to improve your health and reduce plan costs. The City of Minneapolis Medical Plan is provided by Medica.

Participating in Wellness Activities Can Lower Your Premium Payments

When you complete the following wellness activities, you will pay a lower health insurance premium contribution for 2012 and 2013, and receive gift cards from Medica. (Your adult dependents may also participate in the program to earn gift cards, but they cannot earn the lower premium.)

Details can be found in the table below. Pay close attention to each required activity and the deadline associated with it. If you complete the Personal Health Profile, complete eight Health Topics and set eight Goals any time within the first two months of your 2012 benefits eligibility, a lower premium will take effect beginning the third month you are enrolled.

Activity	Premium Deadline	Gift Card Amount	Gift Card Deadline
Personal Health Profile	Two months after 2012 benefits eligibility	\$20	December 31, 2012
Health Topics (8 required)	Two months after 2012 benefits eligibility	\$40 for completion of health topics and goals	December 31, 2012
Health Goals (8 required)	Two months after 2012 benefits eligibility		December 31, 2012
Complete Two Calls with Health Coach*	August 31, 2012 for 2013 premium	None	N/A
Complete Health Coaching Program**	Does not impact premium	\$75	December 31, 2012

* Applies only to those who are invited to participate by a Medica health coach by June 30, 2012.

** All employees and adults dependents can participate regardless of whether they were contacted by a Medica health coach.

Two Options for Participating

1. Online

- Visit www.mymedica.com and click on the Register Now button at the bottom of the Site Login box.
- Complete the registration. You will need your Medica ID card for this step.
- Once you are logged in to mymedica.com, click the Health & Wellness tab at the top of the page.
- Complete the Account Set Up for the Health & Wellness page.
- Once you are set up, the Personal Health Profile will load automatically. Click “Start Now” to take the health assessment.

2. Paper

If you do not have access to a computer, you can still participate by completing a paper version of the Personal Health Profile, Health Topics and Goals. To request a paper copy, call Medica Customer Service at 952-945-8000.

Who’s an eligible dependent?

Eligible dependents include:

- Your spouse - the person of the opposite sex to whom you are legally married
- Your children under age 26
- Your disabled children of any age who are chiefly dependent upon you for support

The term “children” includes:

- Biological children, step children, adopted children, and legal wards
- Grandchildren who reside with you from birth and are financially dependent upon you

Questions?

Please call City of Minneapolis Human Resources at 612-673-2031 or email benefits@minneapolismn.gov. You may also call Medica Customer Service at 952-945-8000 or 1-800-952-3455 or 1-800-855-2880 for the hearing impaired.

What is a Provider Network?

A provider network comprises physicians, hospitals and other health care providers that have agreed to deliver care to Medica members.

- Medica selects providers to be in its networks based on the quality of care they provide and their proximity to places where Medica members live, work or travel.
- Network providers have a contract with Medica to care for you at discounted prices negotiated on your behalf.
- Network providers can't bill you for more than the discounted amounts allowed by Medica's contract.

Selecting a Provider Network

When you enroll in the City of Minneapolis Medical Plan, you must select one of these networks: Medica Elect[®], Medica EssentialSM or Medica Choice[®] Passport. You can't change your network once the plan year starts, so it's important to choose the best network for your needs at enrollment time.

As you weigh your options, think about:

- **Whether your current providers participate in Medica Elect or Medica Essential.** If they do, you could save on employee contributions while keeping your current providers.
- **Whether it's important to keep your current doctor.** Would you be willing to change doctors to move into a lower-cost provider network?
- **Whether it's important to have access to specialists without a referral.** The Medica Choice Passport network does not require referrals within the network. The Medica Elect and Medica Essential networks do not require referrals for care received within your selected care system.
- **Whether you live or work within a reasonable travel distance to network providers,** especially if you choose a network that requires you to designate a primary care clinic, like Medica Elect or Medica Essential.

Please review the network summaries on the next page for more information on your provider network options.

Why Is it Important to See Network Providers?

If you see a provider who is not in your Medica network, your costs will be **significantly higher** because you will receive a lower coverage amount under your benefit plan *and* your share of the costs will be based on the provider's full charges rather than the discounted rate Medica negotiates with network providers.

Is your doctor in the network you're considering?

There are two easy ways to find out:

1. Visit mymedica.com and choose Find Physician or Facility, then Member Through Work.
2. Call Medica Customer Service at 952-945-8000 or 1-800-952-3455.



Medica Elect® and Medica EssentialSM Networks

Consider selecting Medica Elect or Medica Essential if you live or work near the participating care systems and you want to save on monthly premium costs.

Medica Elect and Medica Essential are two different provider networks, but both have these features:

- **Providers in the Medica Elect and Medica Essential networks are grouped into care systems.** A care system is a group of primary care clinics, specialists and hospitals that have agreed to work together. Care systems included in each network are shown to the right.
- **You need to choose a primary care clinic affiliated with your selected care system.** At the time of enrollment, each covered family member must designate a primary care clinic within the network you've chosen (Medica Elect or Medica Essential). This is the clinic where you will go for regular care visits, including preventive care. Your primary care clinic will also coordinate your care. You may change your primary care clinic by calling Medica Customer Service. All clinic changes become effective on the first of the month, provided your request is received at least 10 days prior. If the request is received any later than that, the change will become effective on the first of the following month.
- **Each covered family member may choose their own primary care clinic within your selected network.** For example, the primary care clinic for your child may be a pediatric clinic and yours may be a family practice clinic. These clinics can be in different care systems, but must be within the same network (Medica Elect or Medica Essential).
- **You may see any provider at your primary clinic.**
- **You do not need referrals for services received within your care system.** You may see any physician or specialist within your selected care system without obtaining a referral. If you need to see a network provider outside of your care system, you will need a referral from your primary care clinic to receive the highest level of benefits.
- **To get the highest level of benefits, see network providers.** Sometimes even network doctors are not aware that they should send you to a network hospital or specialist for care. If you receive care from a provider or hospital outside your selected network, your costs will be much higher and you may be responsible for paying the entire cost of the services you receive.
- **If you travel out of Medica's service area,** you can get care from more than 659,000 physicians and care professionals and 5,100 hospitals in our nationwide network.
- **The Medica Elect and Medica Essential networks are always being updated.** Because providers are added to or drop out of the networks throughout the year, please check the online directory on mymedica.com, or call Customer Service before receiving services to verify that your provider is still in your selected network.

Is your doctor in the network?

There are two easy ways to find out:

1. Visit mymedica.com and choose Find Physician or Facility, then Member Through Work, then Medica Elect or Medica Essential.
2. Call Medica Customer Service at 952-945-8000 or 1-800-952-3455.

Medica Elect Care Systems

- Allina Medical Clinics (Twin Cities area)
- Aspen Medical Group (Twin Cities area)
- Children's Physician Network (Twin Cities area)
- Hennepin Faculty Associates (Twin Cities area)
- Integrity Health Network (Duluth area)
- Lakeview Medical Group (Stillwater area)
- Minnesota HealthCare Network (Twin Cities and Central Minnesota areas)
- Park Nicollet Health Services/Methodist Hospital (Twin Cities area)
- RiverWay/North Suburban (Twin Cities area)
- St. Luke's Care System (Duluth area)

Medica Essential Care Systems

- Altru Health System (Grand Forks area)
- Essentia Health West (Fargo-Moorhead area)
- Fairview Physician Associates (Twin Cities area)
- HealthEast Care System (Twin Cities area)
- Integrity Health Network (Duluth area)
- St. Luke's Care System (Duluth area)

Medica Choice® Passport Network

Consider selecting Medica Choice Passport if it's important to you to be able to see a wide range of providers without a referral. Greater flexibility makes Medica Choice Passport a more expensive network option.

Here are the key features of the Medica Choice Passport network:

- Medica's largest regional provider network, with more than 95% of Minnesota hospitals and physicians, including Mayo Clinic.
- You do not need a referral to see specialists in the network.
- You do not need to designate a primary care clinic to enroll.
- You have access to a UnitedHealthcare Options PPO national network that covers you outside the Medica service area (Minnesota, North Dakota, eastern South Dakota and western Wisconsin).

Is your doctor in the network?

There are two easy ways to find out:

1. Visit mymedica.com and choose Find Physician or Facility, then Member Through Work, then Medica Choice with UnitedHealthcare Options PPO.
2. Call Medica Customer Service at 952-945-8000 or 1-800-952-3455.



Summary of Benefits Overview

You will share in the cost of your health care through “up-front” costs (monthly premiums) and “pay-as-you-go” (out-of-pocket) costs.

Premiums are the total amount paid each month for coverage. You share the cost of your premiums by making employee contributions via payroll deduction and the City of Minneapolis pays the rest.

Out-of-pocket costs include the following:

- **Copayment** – the fixed dollar amount you pay when you pick up a prescription.
- **Coinsurance** – a percentage of the amount owed for covered services that you pay.
- **Deductible** – a fixed dollar amount you owe prior to your health plan paying anything. There are separate deductibles for individuals and families, and for in- and out-of-network services. Some services may be excluded from the deductible. For example, preventive care is covered at 100%, even if you have not satisfied your deductible.
- **Out-of-pocket maximum** – the total amount of charges for covered services that you have to pay in deductibles, copayments and coinsurance during the contract year of your health plan. There are separate out-of-pocket maximums for individuals and families, and for in- and out-of-network services.
- **Exclusions** – health services that are not covered under your plan. You are responsible for the full cost of services that are excluded by your plan. Charges for non-covered services do not count toward your out-of-pocket maximum.

Stretch Your Health Care Dollar

Main Street Medica is a website that shows actual cost ranges for dozens of common procedures and services provided in hospitals, clinics, surgery centers, pharmacies and other settings. Link to Main Street Medica from the home page of mymedica.com.

Costs can vary significantly between different providers. Knowing the difference can help you save money, especially because the City of Minneapolis Medical Plan has coinsurance. For example, after you meet your deductible, the plan pays for 80% of X-ray and imaging services, and you pay 20% coinsurance. That means if you need an MRI and use Main Street Medica to select a lower-cost provider, your out-of-pocket costs will be less.

A word about out-of-network costs

Notice that the Summary of Benefits on page 8 shows your benefits under the City of Minneapolis Medical Plan when you see providers in the network and how that coverage is reduced if you go to providers outside the network.

Remember that when you see providers outside the network, you also lose the savings of the discount Medica negotiates with network providers on your behalf. If you see providers outside your network, your costs will be **significantly higher**. Out-of-network services also don't count toward the in-network deductible or the in-network out-of-pocket maximum.



Employee Premium Contributions

Premium contribution rates are design to reward employees who take steps to manage their health. For the first two months you are enrolled in the medical plan, you will pay the higher “Standard Rate.” If you complete the Personal Health Profile, complete eight Health Topics and set eight Health Goals (as described on page 2) by the end of the two-month period, your monthly premium contributions will be reduced to the lower “Wellness Rate.”

Your monthly costs also will vary depending on the network you choose and whether you choose single or family coverage. The amounts shown below apply to full-time City of Minneapolis employees:

Medica Network	Coverage Level	Wellness Rate	Standard Rate
Medica Elect®	Single	\$40.70	\$69.27
Medica Elect®	Family	\$141.24	\$232.66
Medica Essential SM	Single	\$40.70	\$69.27
Medica Essential SM	Family	\$141.24	\$232.66
Medica Choice® Passport	Single	\$58.65	\$88.65
Medica Choice® Passport	Family	\$214.44	\$311.70

The City of Minneapolis pays the majority of the cost of your medical insurance premiums. Your contribution toward those premiums (as shown above) will be withdrawn automatically from the second paycheck of each month.

HRA/VEBA

In addition to the contribution the City of Minneapolis makes toward your medical premiums, the City also makes monthly contributions to your HRA/VEBA account. The HRA/VEBA plan is designed to help you cover out-of-pocket health care expenses. The City of Minneapolis will contribute \$90 (single) or \$190 (family) to your HRA/VEBA account each month.

City of Minneapolis Medical Plan Summary of Benefits

Partial Listing of Covered Services	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	\$1,000 per member \$2,000 per family	\$1,500 per member \$3,000 per family
Annual Out-of-Pocket Maximum	\$2,000 per member \$4,000 per family	\$3,000 per member \$6,000 per family
Lifetime Maximum	Unlimited	\$2,000,000
	When you receive covered services after the deductible has been met, the plan pays:	When you receive covered services after the deductible has been met, the plan pays:
Preventive Care <ul style="list-style-type: none"> • Routine Physical & Eye Exams • Immunizations, Well Child Care and Cancer Screenings 	<i>The deductible does not apply to these services.</i> 100% 100%	<i>The deductible does not apply to these services.</i> 100% 100%
Office Visits <ul style="list-style-type: none"> • Illness or Injury • Chiropractic Care • Physical, Occupational & Speech Therapy • Mental Health and Substance Abuse 	80% 80% 80% 80% for individual therapy or 90% for group therapy	60% 60% Limited to 15 visits per member, per year. 60% 60% Physical and occupational therapy is limited to a combined limit of 20 visits per member per year. Speech therapy is limited to 20 visits per member per year.
Prescription Drugs <i>See page 10 for more information about drug tiers.</i>	<i>The deductible does not apply to these services.</i> Retail: (34-day supply) Tier 1: 100% after \$10 copayment Tier 2: 100% after \$25 copayment Tier 3: 100% after \$50 copayment Mail: (93-day supply) Tier 1: 100% after \$20 copayment Tier 2: 100% after \$50 copayment Tier 3: 100% after \$100 copayment	60%. Member pays the greater of 40% or a \$50 copayment per prescription unit. Mail order: No coverage
Specialty Prescription Drugs <i>Up to a 34-day supply per prescription for specialty prescription drugs received from a designated specialty pharmacy.</i> <i>See page 10 for more information about specialty drugs.</i>	<i>The deductible does not apply to these services.</i> Retail: (34-day supply) Tier 1: 100% after \$25 copayment Tier 2: 100% after \$50 copayment Mail: (93-day supply) Tier 1: 100% after \$50 copayment Tier 2: 100% after \$100 copayment	No coverage
Inpatient Hospital Services <ul style="list-style-type: none"> • Facility • Physician • Mental Health and Substance Abuse 	80% 80% 80%	60% 60% 60%
Outpatient Hospital Services <ul style="list-style-type: none"> • Facility • Physician 	80% 80%	60% 60%
Lab and Pathology	80%	60%
X-Ray and Other Imaging	80%	60%
Urgent or Emergency Care <ul style="list-style-type: none"> • Urgent Care Center • Hospital Emergency Room • Emergency Ambulance 	80% 80% 80%	Covered as in-network benefit Covered as in-network benefit Covered as in-network benefit
Durable Medical Equipment and Prosthetics	80%	60%
Home Health Care <i>Limited to a combined maximum of 120 visits per member per year for in-network and 60 visits out-of-network.</i>	80%	60%

Out-of-Network Coverage

- Coverage is limited to the non-network provider reimbursement amount (as defined in your Certificate of Coverage) after deductible is met.
- If you decide to utilize your out-of-network benefits, you may pay more than you would for in-network benefits. The amount you pay could include a percentage coinsurance, a fixed dollar copayment and/or deductible amount. In addition, if the amount that your non-network provider bills you is more than the non-network provider reimbursement amount (as defined in your Certificate of Coverage) **you are responsible for paying the difference**, and such difference will not be applied toward the out-of-pocket maximum.

Exclusions and Limitation to Coverage

The following is a list of some of the services and supplies that are excluded from coverage. When you enroll, the Certificate of Coverage you receive will provide a more complete and detailed list of exclusions. Please refer to your Certificate of Coverage for specific information about excluded services or supplies.

- Cosmetic Surgery
- Refractive Eye Surgery
- Exams for employment, insurance, administrative proceedings, research or licensure
- Personal convenience items and some nondurable supplies
- A drug, device, or medical treatment or procedure that is investigative or not a covered health service
- Custodial supportive care and self-care or self-help training
- Educational classes, programs or seminars
- Services prohibited by law or regulation
- Services for which coverage is available under worker's compensation, employer liability or any similar law

This health care plan is administered by Medica Health Plans (MHP). It may not cover all your health care expenses; read your Certificate of Coverage carefully to determine which expenses are covered. This is a Summary of Benefits only and does not outline all of your benefits. If there is a discrepancy between information in this summary and your Certificate of Coverage, the Certificate of Coverage will take precedence in determining your benefits.

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Contact Medica Customer Service at **952-945-8000** (Minneapolis/St. Paul metro area), **800-952-3455** (outside of Minneapolis/St. Paul metro area), or **800-855-2880** (individuals with hearing impairments) for more information or answers to specific questions.

Online Member Service Center

Manage your benefits — any time, from any computer — on our secure, members-only website, mymedica.com. Once you register, you can refer to your policy, search for a network provider, check your deductibles and copays, view your claims and even chat live with a nurse.

About Prescription Drug Coverage

Medica uses an independent team of doctors and pharmacists to review all the drugs that are currently available and determine which are safe, effective, offer a reasonable price value and are most useful for the needs of Medica members. Drugs that meet these criteria are placed on Medica's Preferred Drug List. There are thousands of medications on this list, and it's likely that yours will be, too.

Your Summary of Benefits lists your share of your prescription costs, plus any restrictions. Medica has more than 60,000 network retail pharmacies from which to choose.

Prescription Categories

Medica organizes its prescription drugs into three categories or "tiers" with different copayment amounts for each:

- **Tier 1 is your lowest copayment option.** Most generic drugs will be included in this tier. In the future, it's possible that selected brand-name drugs will be included as well. Ask your doctor to prescribe a Tier 1 medication if it would be as good an option for you as another medication in the more expensive tiers.
- **Tier 2 is a higher copayment option.** Many brand-name drugs are covered in this tier. Choose a drug from this category if an appropriate alternative for your condition is not available in Tier 1.
- **Tier 3 is the highest copayment option.** The covered medications in this category are usually brand-name medications that are typically more costly. You'll save money if your doctor can find an appropriate alternative to a Tier 3 medication for you in Tier 1 or Tier 2.
- **Specialty drugs** are in a separate category with two tiers. These are typically higher-cost, high-tech, self-injectable or oral medications that often require special handling and are taken by people who have complex or chronic conditions. Medica's Customer Service team can help you find out if your medication is included in the specialty pharmacy program and which specialty tier it is in. If you require a specialty medication, you must have it filled through Walgreens Specialty Pharmacy or Fairview Specialty Pharmacy in order to receive coverage.

Mail Order

You may arrange to receive your prescriptions via mail order, which offers both convenience and cost savings. In most cases, you will pay two copays for a three-month supply. Details and order forms are available in the Pharmacy section on mymedica.com.

Are your prescriptions covered?

Coverage is provided for drugs on Medica's Preferred Drug List. There are two easy ways to find out if your medications are on the list:

1. Visit mymedica.com.
 - Select **Pharmacy Information**.
 - You can search for medications by name or by the condition they treat, or view Medica's list of preferred drugs and specialty medications.
2. Call Medica Customer Service at 952-945-8000 or toll free 1-800-952-3455 or 1-800-855-2880 TTY for hearing impaired.



Put Medica to Work for You

More than any other health plan, Medica responds to your needs with tailor-made services and resources that support you in improving your health and making the most of your benefits. Best of all, these are all part of your benefit plan once you become a member. We're ready when you are. Call Medica Customer Service for details on any of the resources below:

Health Rewards Program | *Can Medica help me get motivated to make positive changes?*

Here's a program that rewards you for making better health decisions. Earn gift cards from Medica when you take an online health assessment called a Personal Health Profile, complete Health Topics and Goals tailored to your needs and learning style, or work one-on-one with a health coach to achieve your wellness goals. Access all these features on mymedica.com under Health & Wellness. Plus, when you complete the program activities, you'll be eligible for the lowest health plan contribution rates. Find more information about this exciting program on the next page.

Health Club Reimbursement Program | *Does it really pay to exercise?*

We'll give you a \$20 credit toward your monthly dues when you meet your monthly workout requirement at any participating fitness club. That's just a few workouts a week, for money in your pocket. View the complete list of Fit ChoicesSM by Medica network fitness centers at mymedica.com under Health & Wellness. In 2012, City of Minneapolis employees will continue to enjoy a \$20 credit for a minimum of eight health club visits per month.

Employee Assistance Program | *Where can I get help with life's challenges?*

Medica offers a toll-free hotline 24 hours a day, 365 days a year with counselors who can help resolve personal and work concerns, family problems and financial difficulties. Our counselors help you identify, understand, and cope with problems. Call the Employee Assistance Program hotline – any time – at 1-800-626-7944.

24-Hour Nurse Line | *How can I get fast answers to health care questions?*

Call Medica CallLink[®] at 1-800-962-9497 to speak to an experienced nurse for information and advice about general health issues, self-care for minor injuries and illnesses, or help finding a network provider. The nurse line is open all day, every day, all year.

Tobacco Cessation Program | *Can Medica help me quit tobacco?*

Quitting tobacco is one of the most beneficial things you can do for your health. Medica supports you with over-the-counter nicotine replacement therapy at no additional cost (if medically appropriate), help from health care providers and one-on-one telephone counseling. Call the Tobacco Cessation Program hotline at 1-800-934-4824 to learn how Medica can help you leave tobacco behind.

Main Street Medica | *Which providers deliver the best quality at a cost that's right for me?*

Cost and quality can vary significantly among providers, and knowing the difference can help you save money and have a better outcome. Look up cost ranges for common procedures at dozens of facilities using Main Street Medica. Link to Main Street Medica from mymedica.com.

Online Member Service Center |

How can I stay on top of my benefit plan?

Manage your benefits – any time, from any computer – on our secure, members-only website, mymedica.com.

Once you register, you can refer to your policy, search for a network provider, view your claims information and even chat live with a nurse.



Tailor-Made Support for Improving Your Health

When it comes to your health, no one is quite like you. That's why Medica's My Health Rewards program is designed to meet your needs, even as they change over time. And it's all available at no extra charge to Medica members.

It's all about you!

Visit mymedica.com, your member website, and click on the Health & Wellness tab. The first time you visit the site, you'll be asked to complete a short health assessment questionnaire called the Personal Health Profile.

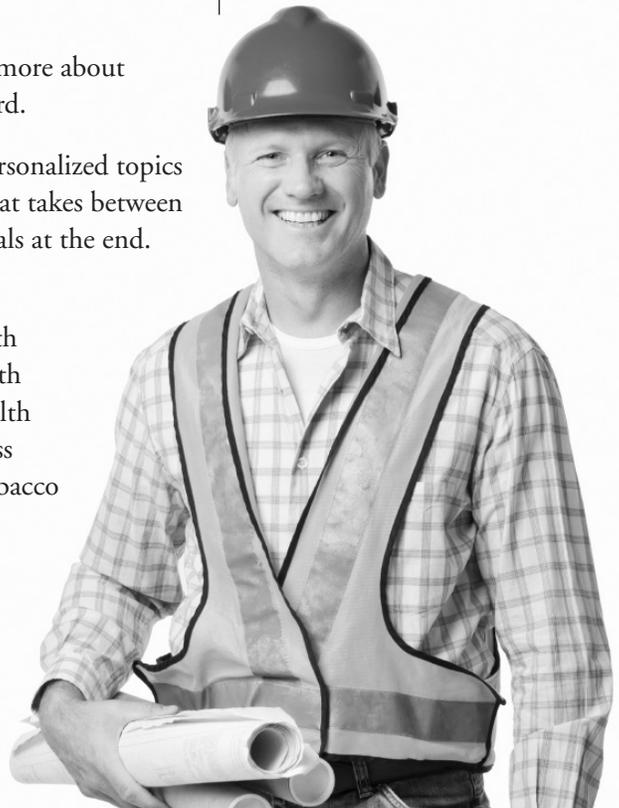
In addition to determining your health status, the Personal Health Profile measures how ready, willing and able you are to take health-related action. Why is that important? Research shows that when health support is geared toward your own knowledge, skills and confidence level, it does a better job of helping you succeed at managing your own health and health care. Your answers to the Personal Health Profile questions will help Medica customize the entire program to meet your unique needs.

For example, after you complete the Personal Health Profile, you'll receive your Personal Health Scorecard. This user-friendly tool gives you an at-a-glance view of health actions recommended just for you. These include preventive cancer screenings and care suggestions for specific conditions or diseases you may have, such as diabetes, asthma or heart disease.

Earn rewards for program activities

The best reward for participating is improved health, but to encourage you along the way, Medica offers valuable gift cards when you (or your family members) complete specific program activities:

- **Personal Health Profile.** Complete this first step toward knowing more about your current health status and you'll be rewarded with a \$20 gift card.
- **Online Health Topics and Goals.** Choose from more than 200 personalized topics that cover a variety of conditions. Each topic includes an activity that takes between 10 and 25 minutes to complete, and enables you to set a goal or goals at the end. Complete eight topics and set eight goals to earn a \$40 gift card.
- **Health coaching.** When you work one-on-one with a Medica health coach, you'll take big steps toward achieving your best possible health and earn a \$75 gift card. Medica may invite you to work with a health coach or you can request one by calling Medica Health and Wellness Coaching at 1-866-905-7430. You can also receive help quitting tobacco through a separate Medica program – learn more on page 11.



PRIVACY NOTICE

Effective: June 11, 2003
Revised: September 1, 2011

HOW MEDICA PROTECTS YOUR PRIVACY

Summary

There are several state and federal laws requiring Medica to protect our members' personal information. The most comprehensive regulations were issued under the Health Insurance Portability and Accountability Act (HIPAA). These regulations have been updated from time to time. Essentially, HIPAA regulations require health plans 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 provide a revised privacy notice within 60 days of the date it is amended.

When the law permits use and disclosure

The law permits Medica to use and disclose your personal 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 information without your authorization, such as public health, regulatory and law enforcement activities. Whether personal information is used or disclosed with or without authorization, Medica uses or discloses personal 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 information. You have the right to request restrictions on certain uses and disclosures of your personal information. You also have the right to obtain information about how and when your personal information has been used and disclosed.

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

MEDICA'S PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, UNDER STATE AND FEDERAL LAW, INCLUDING THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA INSURANCE COMPANY, MEDICA HEALTH PLANS, AND MEDICA HEALTH PLANS OF WISCONSIN MEMBERS (REFERRED TO AS "MEDICA").

Medica is committed to protecting and maintaining the privacy and confidentiality of your information. We refer to this information as "protected health information" or "PHI." This notice describes our privacy practices and our related legal duties. It also describes your rights regarding your PHI.

What is PHI?

As a health plan, Medica has information about our members such as name, address, telephone number, member number, age, date of birth, and health history. In addition, Medica receives information about our members' health care services. This and any other information that identifies you is called "PHI."

How does Medica protect your PHI?

Medica takes its responsibility of protecting your PHI seriously. Where possible, Medica de-identifies PHI. We use and disclose 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 technology safeguards, Medica has policies and procedures that require Medica's employees to protect your PHI. Medica provides training on privacy and security to its employees.

We protect the PHI of applicants and former members just as we protect the PHI of current Medica members.

Under what circumstances does Medica use or disclose PHI?

Medica receives, maintains, uses and shares PHI to carry out certain health plan activities. Routine activities include: (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. Other examples of routine 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
- Credentialing and quality assessment
- 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 us in our operations. These businesses are called "business associates" in the HIPAA regulations. We require 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 Medica to use or disclose your PHI without your authorization. Examples of these are:

- 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); and
- assisting in the avoidance of a serious and imminent threat to health or safety.

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 us 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 us as described below. If we use any identifiers, we will request your permission first.

Family Members. Under some circumstances we can disclose information about you to a family member. We cannot disclose information about one spouse to another spouse, without permission. We can disclose some information about minor children to their parents. You should know, however, that state laws do not allow us 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 us to get your permission. Medica will not be able to release the PHI until we have obtained your authorization. In this situation, you do not have to allow Medica to use or disclose your protected health information. Medica will not take any action against you if you decide not to give us 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.

Marketing. Medica is not permitted to sell your PHI without your permission. There are some limited exceptions to this rule—such as for research or public health activities. We are only allowed to contact you, without first getting your permission, to encourage you to use or purchase a particular item or service in a few situations. For example, we can contact you about new or additional benefits under your health plan, but we cannot contact you to tell you about other types of products.

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. If Medica is able to provide you with health plan services without using or disclosing your PHI as you request, we will agree.

Request confidential communications. You may ask us to send you PHI to a different address or by fax instead of mail. Medica will agree to do this if we are able, but the request must be in writing.

Inspect or obtain a copy of your PHI. Medica keeps members' PHI in a designated record set. You have the right to see or get a copy of your PHI. Your request must be in writing on Medica's form. Usually we will get this to you within thirty (30) days. Medica may charge you a reasonable amount for providing copies. You should know that not all the information we have is available to you and there are certain times when others, such as your doctor, ask us 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 us a written request to make a correction or addition. Medica may not be able to agree to make the change. For example, if we received the information from a clinic, we cannot change the clinic information—only the clinic can. If we cannot make the change, we will let you know within thirty (30) days. You may send a statement explaining why you disagree with us. Medica will respond to you. Your request, our disagreement and your statement disagreeing with us 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 we do not have to track. For example, we do not have to list the times we disclosed your PHI when you gave us permission to disclose it. Your request cannot go back more than six 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." Every violation of the HIPAA Privacy Rules, therefore, will not 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 US AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

Right to file a complaint or grievance about Medica's privacy practices

If you feel your privacy rights have been violated, 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. We may change this notice and our privacy practices, as long as our change is consistent with state and federal law. If we make a change, we will send you a revised notice by mail or electronically.

Medicare Part D Creditable Coverage Notice

Important Notice from Medica* on behalf of Your Plan Sponsor** About Your Prescription Drug Coverage and Medicare (“Medicare Part D”)

You may disregard this notice if you are not eligible for Medicare Part D, or will not become eligible within 12 months.

This notice pertains only to those members, and their covered dependents, who are eligible for Medicare Part D, or who will be eligible within the next 12 months. In general, an individual who is entitled to Part A and/or enrolled in Part B is eligible for Medicare Part D. In most instances, a person has Part A coverage if he or she has attained age 65 and receives monthly Social Security benefits or is a qualified railroad retirement beneficiary. Individuals under age 65 may also become entitled to Medicare Part A benefits if they receive at least 24 months of social security or railroad retirement benefits based on disability.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Plan Sponsor and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. Medica, in conjunction with your Plan Sponsor, has determined that the prescription drug coverage offered by your benefit plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you do decide to join a Medicare drug plan and drop your coverage with Medica, *WHICH*

* “Medica” refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company and Medica Self-Insured.

** Your Plan Sponsor is the entity that established your benefit plan, and is typically your employer (or former employer).

Medicare Part D Creditable Coverage Notice

INCLUDES BOTH YOUR MEDICAL AND PRESCRIPTION DRUG COVERAGE, be aware that you may not be able to get this coverage back.

Please contact your Plan Sponsor for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your Plan Sponsor and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...

Contact our office for further information by calling the number listed on the back of your member ID card. If, however, you have a question about your eligibility for Medicare Part D, you should call 1-800-MEDICARE. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy from Medica at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048,
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Visit www.medicare.gov.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 1, 2011 forward

Name of Entity/Sender: Medica*

Contact--Position/Office: Customer Service

Address: Route CP 555, P.O. Box 9310, Minneapolis, MN 55440-310

Phone Number: 1-800-952-3455 or 952-945-8000 (Or refer to number on back of ID card)

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