

MCHA SUMMARY OF BENEFITS
Administered by Medica

The HDHP is a Federally qualified plan for a health savings account (HSA)

Partial Listing of Covered Services

In-Network Benefits

These benefits apply when services are provided by network providers or are authorized in advance by MCHA.

Out-Of-Network Benefits*

These benefits apply when services are provided by non-network providers.

Lifetime Maximum Benefit

\$5,000,000

Out-of-Pocket Maximum

Individual

\$3,000, per calendar year for 2008

Family

\$6,000, per calendar year for 2008

Deductible

Individual

\$3,000, per calendar year for 2008

Family

\$6,000, per calendar year for 2008

	When you receive covered services after deductible has been met, MCHA pays:	When you receive covered services after deductible has been met, MCHA pays:
Preventive Care Received in the Physician's Office or Hospital		
• Routine Physical & Eye Exams	100%	100%
• Routine Cancer Screenings	100%	100%
• Immunizations	100%	100%
• Well Child Care, Physical Exams & Immunizations, Birth to Age 18	100% The deductible does not apply.	100% The deductible does not apply.
• Allergy Shots	100%	100%
Services Received in the Physician's Office		
• Office visits for illness or injury	100%	100%
• Lab and X-ray	100%	100%
• Surgical Services	100%	100%
Chiropractic Care	100%	100%
Services Received in a Hospital or Surgicenter		
• Inpatient Hospital Facility	100%	100%
• Inpatient Hospital Physician	100%	100%
• Outpatient Hospital Facility	100%	100%
• Outpatient Hospital Physician	100%	100%
• Outpatient Lab and X-ray Facility	100%	100%
• Outpatient Lab and X-ray Physician	100%	100%
Urgent or Emergency Care		
• Urgent Care Center	100%	100%
• Hospital Emergency Room	100%	100%
• Emergency Ambulance	100%	100%
Emergency Services from Non-Preferred Providers	100%	
Maternity Care Received in the Physician's Office or Hospital		
• Prenatal Services	100% The deductible does not apply.	100% The deductible does not apply.
• Delivery Services Physician	100%	100%
• Delivery Services Hospital	100%	100%
• Postnatal Services	100%	100%
Prescription Medications Received at a Pharmacy <i>Up to a 34-day supply per prescription.</i>	Formulary: 100% per prescription unit or refill.	Formulary: 100% per prescription unit or refill.

Partial Listing of Covered Services

In-Network Benefits

These benefits apply when services are provided by network providers or are authorized in advance by MCHA.

Out-Of-Network Benefits*

These benefits apply when services are provided by non-network providers.

	When you receive covered services after deductible has been met, MCHA pays:	When you receive covered services after deductible has been met, MCHA pays:
Specialty Prescription Drugs Received at a Pharmacy <i>Up to a 34-day supply per prescription for specialty prescription drugs received from a designated specialty pharmacy.</i>	Formulary: 100% per prescription unit or refill for specialty prescription drugs.	No Coverage.
Mental Health Care	Care must be provided by a MCHA-designated mental health provider. You must receive authorization from MCHA's designated mental health provider prior to receiving services.	
• Outpatient Services	100%	100%
• Inpatient Services	100%	100%
Substance Abuse Care	Care must be provided by a MCHA-designated substance abuse provider. You must receive authorization from MCHA's designated substance abuse provider prior to receiving services.	
• Outpatient Services	100%	100%
• Inpatient Services	100%	100%
Rehabilitative Therapy Received in the Provider's Office or Hospital		
• Physical Therapy	100%	100%
• Occupational Therapy	100%	100%
• Speech Therapy	100%	100%
Durable Medical Equipment and Prosthetics	100%	100%
Home Health Care	100%	100%

Out of Network Coverage

* Coverage is limited to the non-network provider reimbursement amount (as defined in your Policy) 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 amounts. 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 Policy), **you are responsible for paying the difference**, and such difference will not be applied toward the Out-of-Pocket Maximum.

Exclusions and Limitations to Coverage

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

Reversal of voluntary sterilization, in vitro fertilization, sperm banking and adoption.
Exams for employment, insurance, administrative proceedings, research or licensure.
Personal convenience items and some non-durable supplies.
A drug, device or medical treatment or procedure that is investigative.
Health services that are not medically necessary.

Custodial supportive care and self-care or self-help training.
Educational classes, programs or seminars.
Services for mental disorders not listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.
Services by persons who are family or of the same legal residence.
Dental procedures, except accident-related dental.
Services prohibited by law or regulation.

Autopsies.
Injuries that occur while on military duty.
Enteral feedings except to treat PKU.
Services that are the primary responsibility of a different carrier (including but not limited to worker's compensation, auto insurance and employer's liability insurance) shall be subject to coordination of benefits.
Travel, transportation or living expenses.
Recreational therapy.
Vocational and job rehabilitation.

Contact **MCHA Customer Service at 1-866-894-8053**, 952-992-3190 (Mpls./St. Paul metro area individuals with hearing impairments), or 1-800-841-6753 (outside of Mpls./St. Paul metro area individuals with hearing impairments) for more information or answers to specific questions.

This health care plan may not cover all your health care expenses; read your Policy of Coverage carefully to determine which expenses are covered. This is a benefit summary only, and does not outline all of your benefits. When you enroll with MCHA, you will receive a Policy of Coverage. If there is a discrepancy between information in this summary and your Policy of Coverage, the Policy of Coverage will take precedence in determining your benefits.

© 2006 Medica. Medica® is a registered service mark of Medica Health Plans. "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.
12/18/08

