$500 Deductible (year 2008) Available as of July 1, 2008

MCHA SUMMARY OF BENEFITS

Administered by Medica

Partial Listing of Covered Services		MCHA 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	Individual	$3,000 per calendar year	
Medical Deductible	Individual	$400 per calendar year	
Pharmacy Deductible	Individual	$100 per calendar year	
		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			
• **Adult Routine Physical Exams , Age 19 & Older**		80%	70%
• **Routine Cancer Screenings**		80%	70%
• **Eye Exams**		80%	70%
• **Immunizations, Age 19 & Older**		80%	70%
• **Well Child Care , Physical Exams & Immunizations, Birth to Age 18**		100%. The deductible does not apply.	100% The deductible does not apply.
• **Allergy Shots**		80%	70%
Services Received in the Physician's Office			
• **Office Visits for Illness of Injury**		80%	70%
• **Lab and X-ray**		80%	70%
• **Surgical Services**		80%	70%
Chiropractic Care		80%	70%
Services Received in a Hospital or Surgicenter			
• **Inpatient Hospital**			
Facility		80%	70%
Physician		80%	70%
• **Outpatient Hospital**			
Facility		80%	70%
Physician		80%	70%
• **Outpatient Lab and X-ray**			
Facility		80%	70%
Physician		80%	70%
Urgent or Emergency Care			
• **Urgent Care Center**		80%	See below
• **Hospital Emergency Room**		80%	See below
• **Emergency Ambulance**		80%	See Below
Emergency Services from Non-Preferred Providers		80% after deductible is satisfied. Non-emergency services paid at 70%.	
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		80%	70%
Hospital		80%	70%
• **Postnatal Services**		80%	70%
Prescription Medications Received at a Pharmacy *Up to a 34-day supply per prescription.*		Formulary: 80% per prescription unit or refill. Non-Formulary: 60% per prescription unit or refill.	Formulary: 80% per prescription unit or refill. Non-Formulary: 60% per prescription unit or refill.

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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 *Up to a 34-day supply per prescription for specialty prescription drugs received from a designated specialty pharmacy.*	Formulary: 80% per prescription unit or refill for specialty prescription drugs. Non-Formulary: 60% 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**	80%	70%
• **Inpatient Services**	80%	70%
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**	80%	70%
• **Inpatient Services**	80%	70%
Rehabilitative Therapy Received in the Provider's Office or Hospital		
• **Physical Therapy**	80%	70%
• **Occupational Therapy**	80%	70%
• **Speech Therapy**	80%	70%
Durable Medical Equipment and Prosthetics	80%	70%
Home Health Care	80% except you pay nothing for high-risk prenatal care services. For high-risk prenatal care services, the deductible does not apply.	70% except you pay nothing for high-risk prenatal care services. For high-risk prenatal care services, the deductible does not apply.

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 of Coverage you receive will provide a more complete and detailed list of exclusions. Please refer to your Policy of Coverage for specific information about excluded services or supplies.

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 or not a covered health service.
Health services that are not medically necessary.
Services and prescriptions for or related to assisted reproductive technology / (ART).

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 International Classification of Diseases.
Services by persons who are family or of the same legal residence.
Dental procedures, except as outlined in the Policy.
Services prohibited by law or regulation.
Cosmetic services
Refractive eye surgery

Autopsies.
Injuries that occur while on military duty.
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).
Travel, transportation or living expenses.
Recreational therapy.
Services for or related to inpatient treatment in a hospital located outside of Minnesota for a covered person's mental or nervous disorder, except as specified in the Policy.

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.

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