

**Cobham Mission Systems Division
Medical Benefits Summary- UHC**

Deductible	\$250 Individual
	\$500 Family
Coinsurance	10%
Out-of-Pocket Maximum (Calendar Year)	\$1500 Individual
	\$3000 Family
Lifetime Maximum	\$1,000,000
Physician Services (deductible does not apply):	
<i>Excludes mental health and substance abuse services</i>	
Office Visits	\$10 copay
Routine Physical Exam	\$10 copay
Well Child Care	\$10 copay
Allergy Testing	\$10 copay
Office Surgery	\$10 copay
Home Visits	\$10 copay
Immunizations	\$0 copay
Allergy Injections	\$0 copay
Maternity Care	\$100 copay
Hospital Services (deductible applies):	
Inpatient	
Hospital (Semi-Private Room)	10% Coinsurance
Maternity (Semi-Private Room)	10% Coinsurance
Physician Inpatient Hospital Visits	10% Coinsurance
Physician Surgical Services	10% Coinsurance
Outpatient	
Outpatient Facility or Surgi Center Services	10% Coinsurance
Physician Outpatient Consultations	10% Coinsurance
Physician Surgical Services	10% Coinsurance
X-Ray & Lab Services (deductible does not apply):	
Outpatient	10% Coinsurance
As part of a preventative examination	\$0 copay
Office	10% Coinsurance
Emergency Services (deductible does not apply):	
Ambulance	\$0 copay
Emergency Room Facility	\$50 copay
Emergency Room Physician	10% Coinsurance
Outpatient Therapies (deductible applies):	
Physical~Speech~Occupational	10% Coinsurance
<i>Member is limited to 60 outpatient treatment days per disability per calendar year</i>	
Nursing Facility Services (deductible applies):	
<i>Maximum 100 days per calendar year</i>	
Physician Nursing Facility Visits	10% Coinsurance
Home Health Care (deductible applies):	
<i>Must be approved in advance by UHC</i>	
Durable Medical Equipment (deductible applies):	10% Coinsurance

**Carleton Life Support Systems
Medical Benefits Summary- UHC**

Mental Health Services (<i>deductible applies</i>):	
20 inpatient facility days per calendar year	10% Coinsurance
20 inpatient Physician visits per calendar year	10% Coinsurance
30 outpatient facility days per calendar year	10% Coinsurance
30 outpatient Physician visits per calendar year	10% Coinsurance
20 Physician office visits per calendar year	10% Coinsurance
Substance Abuse Services (<i>deductible applies</i>):	
20 inpatient facility days per calendar year	10% Coinsurance
20 inpatient Physician visits per calendar year	10% Coinsurance
30 outpatient facility days per calendar year	10% Coinsurance
30 outpatient Physician visits per calendar year	10% Coinsurance
20 Physician office visits per calendar year	10% Coinsurance
Prescription Drugs:	
Generic Equivalent	\$10 copay
Formulary Brand Name	\$20 copay
Non-Formulary Brand Name	\$35 copay
Birth Control:	
Generic Equivalent	\$10 copay
Formulary Brand Name	\$20 copay
Non-Formulary Brand Name	\$35 copay
Diabetic Supplies:	
Insulin Syringes	\$10 copay
Test strips, lancets, glucose monitors	10% Coinsurance
Vision Benefits Summary- UHC (Optional)	
Lens or Lenses	
Single Vision	\$10 copay
Bifocal	\$10 copay
Trifocal	\$10 copay
Lenticular	\$10 copay
Contact (<i>max \$100 per calendar year</i>)	\$20 copay
Frames (<i>max \$100 per calendar year</i>)	
	\$10.00
Routine Vision Care Examinations	
Ophthalmologist~Optometrist~Optician	\$10 copay