



## Hawker Beechcraft Corporation

BENEFIT CATEGORY	IN-NETWORK	OUT-OF-NETWORK
<b>DURABLE MEDICAL EQUIPMENT</b> Including Foot Orthotics and Prosthetic Devices	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>HOME HEALTH CARE</b>	Subject to deductible/coinsurance. Rehabilitation services are subject to \$25 office visit copay.	*Subject to deductible/coinsurance
<b>DIABETIC EQUIPMENT</b> Insulin pumps, insulin pump supplies, glucose monitor	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>HOSPICE CARE</b>	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>SHORT-TERM THERAPIES</b> Physical, Speech and Occupational, Respiratory and Cardiac <b>Inpatient</b> <b>Outpatient</b>	Subject to deductible/coinsurance \$25 copay	*Subject to deductible/coinsurance *Subject to deductible/coinsurance
<b>SPINAL MANIPULATIONS</b> (including x-rays)	\$25 copay  Combined 26 visits per calendar year	*Subject to deductible/coinsurance
<b>PHYSICAL MEDICINE</b> TMJ Vision Therapy Biofeedback Acupressure/Acupuncture	\$25 copay \$25 copay \$25 copay  \$25 copay, combined 26 visits per calendar year	*Subject to deductible/coinsurance *Subject to deductible/coinsurance *Subject to deductible/coinsurance
<b>MENTAL ILLNESS &amp; SUBSTANCE USE DISORDERS</b> +Inpatient +Requires a pre-admission certification from New Directions Behavioral Health 1-800-952-5906  Outpatient Services	Subject to deductible/coinsurance  \$25 copay, then 100% of allowed amounts	*Subject to deductible/coinsurance  *Subject to deductible/coinsurance
<b>PRESCRIPTION DRUGS — RETAIL</b> Generic Formulary Brand Non-Formulary Brand	\$10 copay \$30 copay \$60 copay  Diabetic supplies such as insulin syringes and lancets are covered under generic copay. Test strips are covered under either the formulary or non-formulary copay.  The quantity per prescription shall be the greater of a 34-day supply or 100 unit dosage, or the quantity sufficient for a standard course of treatment as specified by the FDA guidelines. For maintenance drugs, the maximum quantity dispensed shall be up to a three-month supply with a total of three co-payments. Other quantity limits will apply for certain prescriptions.	If a non-network pharmacy is used, the member is reimbursed the amount that would have been paid to a network pharmacy minus the copay.
<b>PRESCRIPTION DRUGS — MAIL ORDER</b> Generic Formulary Brand Non-Formulary Brand	\$20 copay per 90-day supply \$60 copay per 90-day supply \$120 copay per 90-day supply	N/A N/A N/A

### PLAN EXCLUSION AND LIMITATIONS

The following procedures and all related services and supplies are not covered under this program. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression; duplicate benefits provided under federal, state or local laws, regulations or programs, except Medicaid; cosmetic or reconstructive surgery (except as stated in the certificate); any keratotomy procedures; charges for personal items; convalescent or custodial/maintenance care or rest cures; blood or payments to donors of blood; any service or supply related to the medical management of obesity; charges for services by immediate relatives or by members of your household; services related to temporomandibular joint dysfunction syndrome over the amount specified in the certificate; dental implants; services or supplies related to sex changes, sexual dysfunctions or inadequacies; any medically-aided insemination procedure; services related to the reversal of sterilization procedures; treatment of nervous or mental conditions over the amount specified in the certificate; hearing aids; eyeglasses or contact lenses (except after the removal of cataracts); unnecessary services and admissions; services or supplies which are experimental or investigative in nature; services not specifically listed as benefits in the certificate; services covered and payable by any medical expense payment provision of any automobile insurance policy.

### PRIOR AUTHORIZATION REQUIRED

- BCBSKS — for all inpatient hospital stays
  - NEW DIRECTIONS — for inpatient nervous and mental and substance abuse stays
- This benefit summary is designed to be a brief summary of the benefits. For complete plan details, please see employee certificate.*