



HAWKER BEECHCRAFT COMPANY
Point of Service
SUMMARY OF BENEFITS

Benefit Period: benefits accumulate from January 1 - December 31

Preferred Health Systems is offering a Point of Service (POS) benefit plan through Preferred Plus of Kansas (PPK). To enroll for coverage in PPK, employees and all covered Dependents must select a Primary Care Physician (PCP). When you or your Dependents are in need of Health Care Services, to receive the PCP Option benefit level, services must be provided or referred in advance by your PCP. Services which are not provided or referred by your PCP are covered at the Self-Referral Option. **If the Physician or Provider does not contract with PPK to accept our Allowed Amounts, you will be responsible for the difference between billed charges and Allowed Amounts in addition to the applicable Deductible and Coinsurance, which could be substantial. For Non-Covered Services or services that exceed a benefit maximum, the Covered Person will be responsible for the entire billed charges of a Provider.**

BENEFIT CATEGORY	MEMBER RESPONSIBILITY	
	PCP OPTION	SELF-REFERRAL OPTION
PHYSICIAN OFFICE VISIT PCP office visit Specialist office visit	\$25 Copayment \$40 Copayment	Not Applicable 40% of Allowed Amounts
DEDUCTIBLE (per Benefit Period) Individual Family At least two (2) family members must contribute toward the family Deductible. The following do not count toward meeting the Deductible: Copayments; charges for Non-Covered Services; or difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.	\$500 \$1,000	\$1,000 \$2,000
DEDUCTIBLE CARRYOVER Covered amounts applied towards the PPK Deductible in the last three (3) months of the Benefit Period will be credited to the next Benefit Period's Deductible. This carryover provision does not apply to the Non-Network Deductible or any prescription drug benefit.		
COINSURANCE Applies to all Covered Services unless otherwise noted. (The portion of the Allowed Amount payable by the Member after the Deductible has been met)	20% of Allowed Amounts	40% of Allowed Amounts
OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance) Individual Family The out-of-pocket maximums for the PCP Option and Self-Referral Option are accumulated separately. After the out-of-pocket maximum has been reached, benefits will increase to 100% of Allowed Amounts for the remainder of the Benefit Period. The Member will be responsible for the difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts. The following do not count towards meeting the out-of-pocket maximum: Copayments; charges related to TMJ services; the difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts; charges for any Non-Covered Services; or any out-of-pocket expenses related to routine vision services or prescription drugs.	\$1,500 \$3,000	\$3,000 \$6,000
ANNUAL MAXIMUM ON ESSENTIAL BENEFITS This annual maximum applies only to Essential Health Benefits as defined by Section 1302(b) of the Patient Protection and Affordable Care Act. Essential Health Benefits include the following benefit categories: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).	\$2,500,000	
LIFETIME MAXIMUM	None	
PREVENTIVE CARE SERVICES	\$0	40% of Allowed Amounts unless otherwise noted
OUTPATIENT LAB AND X-RAY	\$0	40% of Allowed Amounts
DIAGNOSTIC TESTING	20% of Allowed Amounts	40% of Allowed Amounts
INPATIENT BENEFITS (Semi-Private Room, ICU, Hospice)	20% of Allowed Amounts	40% of Allowed Amounts
SKILLED NURSING FACILITIES	\$0	\$0

ORTHOTICS AND PROSTHETICS	\$0	\$0
ORAL SURGERY AND RELATED SERVICES PCP office visit Specialist office visit Inpatient services Services for accidental injury to sound natural teeth will be covered up to a maximum of \$1,000 of Allowed Amounts , if provided within twelve (12) months from the date of injury. This benefit maximum does not apply to Members under 18 years of age.	\$25 Copayment \$40 Copayment Subject to inpatient benefits	Not Applicable 40% of Allowed Amounts 40% of Allowed Amounts
TRANSPLANT SERVICES PCP office visit Specialist office visit Inpatient services	\$25 Copayment \$40 Copayment Subject to inpatient benefits	Not Applicable 40% of Allowed Amounts 40% of Allowed Amounts
HEARING SERVICES Exam Maximum benefit limited to one (1) routine or one (1) hearing aid visit per Benefit Period. Non-routine hearing exams are covered as Medically Necessary. \$400 per device per ear, once every three (3) Benefit Periods	\$15 Copayment	Reimbursed at Allowed Amount, minus \$15 Copayment
PRESCRIPTION DRUGS Certain medications require Prior Authorization Retail Pharmacy: A 34-day supply, as specified by the quantity sufficient for a standard course of therapeutic treatment as defined by FDA guidelines, or 100 unit dose of tablets or capsules, whichever is less. Mail Order Pharmacy: A 90-day supply, as specified by the quantity sufficient for a standard course therapeutic treatment as defined by FDA guidelines.	34 day Supply: Generic - \$10 Copayment Brand Formulary - \$30 Copayment Brand Non-Formulary - \$60 Copayment 90 day Supply: Generic - \$20 Copayment Brand Formulary - \$60 Copayment Brand Non-Formulary - \$120 Copayment	

Some services require Prior Authorization by PPK. Prior Authorization is the process of PPK determining whether the Health Care Service is a Covered Service, Medically Necessary, and being rendered by Contracting Providers. Coverage is subject to eligibility and benefits remaining at the time services are rendered. The Prior Authorization List is subject to change. An up-to-date Prior Authorization List can be found at www.phsystems.com or by calling Member Services at 316-609-2391 or 1-888-242-0345 (outside Wichita).

Referral Process: To obtain the PCP Option level, PPK Members are responsible for obtaining a Referral Authorization from their PCP for all Health Care Services rendered outside his/her office except Emergency Services, obstetrical and gynecological care (from a contracting OB/GYN), well-man exam, and annual diabetic retinal eye exam. Contracting Providers must be utilized except for Emergency Services when you do not have control over where such services are rendered. Mental health and substance abuse services do not require a PCP Referral Authorization; however, some services must be prior authorized by PPK.

Basic Exclusions

Services of Non-Contracting Providers. *Services not medically necessary. *Cosmetic treatment/surgery. *Surgical treatment of obesity, medical services in conjunction with prescription weight loss therapy, and weight loss programs unless approved by PPK. *Experimental and investigational treatment. *Services for injuries or diseases related to employment and covered or required to be covered under a Workers Compensation program. *Services resulting from injuries related to the use of a motor vehicle which are covered or required to be covered under automobile insurance. *Duplication of benefits provided by Federal, State or local law. *Items not strictly to treat a medical condition. *Services or items for the convenience of the Member or Provider. *Services or supplies related to an excluded service and subsequent complications.

This is a brief summary of the coverage available under this plan. It is not a legal document. The complete plan provisions, limitations, and exclusions are contained in the Certificate you will receive when you enroll.

PHS retains the right to adjust benefits as necessary to comply with changes in any federal or state law, statute or regulation, including but not limited to the federal Patient Protection and Affordable Care Act, as amended.

<p>DEPENDENT CHILDREN OUT OF AREA CARE Physician office visit or Physical therapy Coverage is limited to physician office visits (including Medically Necessary lab and x-ray services), allergy shots, allergy treatment and physical therapy, if received from Contracting Providers, referred by the Dependent's PCP and prior authorized by PPK. This benefit does not include coverage for routine or preventive services such as immunizations or physicals.</p>	\$40 Copayment	40% of Allowed Amounts
<p>MATERNITY CARE (no referral required) PCP office visit Specialist office visit</p>	100% Coverage after one (1) \$25 Copayment 100% Coverage after one (1) \$40 Copayment	Not Applicable 40% of Allowed Amounts
<p>OUTPATIENT SURGERY Other services (e.g. lab, x-ray, anesthesia) are subject to applicable Copayments, Coinsurance and/or Deductible.</p>	20% of Allowed Amounts	40% of Allowed Amounts
<p>INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE Services must be prior authorized by PPK</p>	Subject to inpatient benefits	40% of Allowed Amounts
<p>OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE PCP/Specialist office visit Some services must be prior authorized by PPK This benefit includes intensive outpatient programs and partial day hospitalization. Members may self-refer to Contracting Providers and receive services at the PCP Option level of benefits.</p>	\$25 Copayment	40% of Allowed Amounts
<p>EMERGENCY SERVICES There is no coverage for non Emergency Medical Conditions treated in a Hospital emergency room. Urgent Care Facility Emergency Room <i>If admitted, the emergency room Copayment will be waived and inpatient benefits will apply.</i></p> <p>If you receive Emergency Services from a non-contracting Hospital within the Service Area under circumstances where you have the ability to determine when and where to seek such services, you will be responsible for the difference between the Provider's billed charges and Allowed Amounts. In situations where you require Emergency Services and have no control when or where such services are rendered, such services will be covered at the PCP Option level and you will not be responsible for the difference between the Provider's billed charges and Allowed Amounts.</p>	\$40 Copayment \$100 Copayment	\$40 Copayment \$100 Copayment
<p>AMBULANCE</p>	\$0	\$0
<p>DURABLE MEDICAL EQUIPMENT</p>	\$0	\$0
<p>DISPOSABLE MEDICAL SUPPLIES</p>	\$0	\$0
<p>DIABETIC EQUIPMENT AND SUPPLIES Must be purchased from Contracting Providers and referred by your PCP.</p>	\$0	\$0
<p>RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY PCP office visit Specialist office visit Outpatient surgery Inpatient services</p>	\$25 Copayment \$40 Copayment 20% of Allowed Amounts Subject to inpatient benefits	Not Applicable 40% of Allowed Amounts 40% of Allowed Amounts 40% of Allowed Amounts
<p>HOME HEALTH SERVICES</p>	\$40 Copayment	40% of Allowed Amounts
<p>INTRAVENOUS AND INJECTABLE MEDICATIONS</p>	\$0	40% of Allowed Amounts
<p>OUTPATIENT HOSPICE SERVICES</p>	\$0	40% of Allowed Amounts
<p>TMJ Maximum benefit limited to \$1,000 of Allowed Amounts per Benefit Period; \$5,000 of Allowed Amounts per lifetime. Benefit maximums do not apply to Members under 18 years of age.</p>	\$0	40% of Allowed Amounts
<p>INPATIENT REHABILITATION</p>	Subject to inpatient benefits	40% of Allowed Amounts
<p>OUTPATIENT REHABILITATION (Speech, Physical, Occupational, Cardiac, and Pulmonary) PCP office visit Specialist office visit</p>	\$25 Copayment \$40 Copayment	Not Applicable 40% of Allowed Amounts
<p>SPINAL MANIPULATION SERVICES PCP office visit Specialist office visit</p>	\$25 Copayment \$40 Copayment	Not Applicable 40% of Allowed Amounts