HAWKER BEECHCRAFT
OPTION 11
SUMMARY OF BENEFITS
PENDING KID APPROVAL

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. In addition, 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.

BENEFIT CATEGORY	*PCP OPTION*	*SELF-REFERRAL OPTION*
PHYSICIAN OFFICE VISIT	$20 Copayment per office visit	30% of Allowed Amounts after Deductible
WELL-WOMAN EXAM (a referral is not required)	$20 PCP or OB/GYN Copayment (rendered by your PCP or contracting OB/GYN)	30% of Allowed Amounts after Deductible (rendered by a Non-Contracting Provider)
WELL-MAN EXAM	$20 Copayment (rendered by your PCP or contracting urologist)	30% of Allowed Amounts after Deductible (rendered by a Non-Contracting Provider)
DEDUCTIBLE (per Benefit Period) Individual Family	 $200 $400	 $400 $800
	At least two (2) family members must contribute toward the family Deductible. The following do not count toward meeting the Deductible: Copayments; outpatient behavioral health and substance abuse (BH/SA); or difference between the actual billed charges of a Non-Contracting Provider and Allowed Amounts.	
COINSURANCE (after Deductible)	The Member is responsible for 10% of Allowed Amounts unless otherwise noted	The Member is responsible for 30% of Allowed Amounts, **after your Deductible is met unless otherwise noted**
	Refer to your Certificate for the definition of Allowed Amounts	
OUT-OF-POCKET COINSURANCE MAXIMUM Individual Family	After Satisfaction of Deductible $600 $1,200	 $2,100 $4,200
	The out-of-pocket Coinsurance maximums for the PCP Option and Self-Referral Option are accumulated separately. After the out-of-pocket Coinsurance 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 Coinsurance maximum: Copayments; Deductible; outpatient behavioral health and substance abuse (BH/SA); 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.	
MEDICAL LIFETIME MAXIMUM	$2,500,000 This lifetime maximum will include medical benefits accumulated under another PPK Plan offered by the same employer prior to this coverage.	
OUTPATIENT LAB AND X-RAY	Covered at 100% of Allowed Amounts	30% of Allowed Amounts after Deductible
DIAGNOSTIC TESTING	10% of Allowed Amounts after Deductible	30% of Allowed Amounts after Deductible
INPATIENT BENEFITS (Semi-Private Room, ICU, Hospice)	10% of Allowed Amounts after Deductible	30% of Allowed Amounts after Deductible
SKILLED NURSING FACILITIES	100% of Allowed Amounts (Deductible does not apply) Maximum benefit limited to sixty (60) days per Benefit Period	

DEPENDENT CHILDREN OUT OF AREA CARE	Physician office visit $20 Copayment Physical Therapy $20 Copayment per visit 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.	30% of Allowed Amounts after Deductible Maternity care for out of area dependents will be covered at the Self-Referral Option only
MATERNITY	One (1) $20 Copayment, then covered at 100% of Allowed Amounts	30% of Allowed Amounts after Deductible
OUTPATIENT SURGERY	10% of Allowed Amounts after Deductible	30% of Allowed Amounts after Deductible
IMMUNIZATIONS		
Members up to 72 months of age	100% of Allowed Amounts (Deductible does not apply)	
Members over 72 months of age	10% of Allowed Amounts after Deductible	30% of Allowed Amounts after Deductible
INPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE	Subject to inpatient benefits Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita). Maximum benefit limited to thirty (30) days per Benefit Period. Each partial day session will count as one-half inpatient day toward the thirty (30) day benefit.	30% of Allowed Amounts after Deductible
INPATIENT BIOLOGICALLY BASED MENTAL ILLNESS	Subject to inpatient benefits Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita). Maximum benefit limited to forty-five (45) days per Member, per Benefit Period. Each partial day session will count as one-half inpatient day toward the forty-five (45) day benefit.	30% of Allowed Amounts after Deductible
OUTPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE	100% of Allowed Amounts for the first three (3) visits per Member; per Benefit Period, combined PCP and Self-Referral Options (Deductible does not apply) then Member responsible for $20 Copayment per visit Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita).	then Member responsible for 50% of Allowed Amounts (Deductible does not apply)
OUTPATIENT BIOLOGICALLY BASED MENTAL ILLNESS	$20 Copayment per visit Services must be prior authorized by PPK by calling 316-609-2541 or 1-866-338-4281 (outside Wichita). Maximum benefit limited to forty-five (45) visits per Member, per Benefit Period, combined PCP and Self-Referral Options.	30% of Allowed Amounts after Deductible
EMERGENCY SERVICES ***There is no coverage for non Emergency Medical Conditions treated in a Hospital emergency room.***	$20 urgent care Facility Copayment $100 Hospital emergency room Copayment If admitted, Copayment will be waived and inpatient benefits will apply. An observation stay of twenty-four (24) hours or longer will be treated as an inpatient admission. 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.	
AMBULANCE	$30 Copayment	30% of Allowed Amounts after Deductible
DURABLE MEDICAL EQUIPMENT	100% of Allowed Amounts (Deductible does not apply)	
DISPOSABLE MEDICAL SUPPLIES	100% of Allowed Amounts (Deductible does not apply) Coverage for disposable medical supplies is limited to the following: - Ostomy (appliance pouches, skin care agents, support belts) - Open wound (gauze pads, wound packing strips, ABD pads) - Venous access catheter (alcohol pads, benzoin, dressings) - Urinary supplies (catheter and bag supplies) - Tracheostomy supplies - Compression stockings - Inhaler supplies (aero chamber masks, spacers, peak flow meters)	

DIABETIC EQUIPMENT AND SUPPLIES	100% of Allowed Amounts (Deductible does not apply)	
RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY	Subject to inpatient benefits Outpatient surgery-10% of Allowed Amounts after Deductible	30% of Allowed Amounts after Deductible
	Coverage will be provided in a manner determined in consultation with the treating Physician and the Member for reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses and physical complications during all stages of the mastectomy, including lymphedema.	
HOME HEALTH CARE	$20 Copayment per visit	30% of Allowed Amounts after Deductible Maximum benefit limited to sixty (60) visits per Benefit Period
INTRAVENOUS AND INJECTABLE MEDICATIONS	100% of Allowed Amounts	30% of Allowed Amounts after Deductible
OUTPATIENT HOSPICE SERVICES	100% of Allowed Amounts	30% of Allowed Amounts after Deductible
TMJ	100% of Allowed Amounts	30% of Allowed Amounts after Deductible
	Maximum benefit limited to $1,000 of Allowed Amounts per Benefit Period; $5,000 of Allowed Amounts per lifetime	
OUTPATIENT REHABILITATION	$20 Copayment per visit	30% of Allowed Amounts after Deductible
	Speech therapy is limited to one (1) session, per Member, per day. Inpatient Rehabilitation is subject to Inpatient Benefits. For Spinal manipulation services refer to the Spinal Manipulation Services section of this Schedule of Benefits and your Certificate.	
SPINAL MANIPULATION SERVICES	$20 Copayment per visit	30% of Allowed Amounts after Deductible
	Member may self refer to a Contracting Provider to receive the PCP Option benefit level. Spinal manipulation services are limited to twelve (12) visits per Member, per Benefit Period, combined PCP and Self-Referral Options. For PCP Option services, only one Copayment applies for all services provided on the same date of service.	
ORTHOTICS AND PROSTHETICS	100% of Allowed Amounts	100% of Allowed Amounts (Deductible does not apply)
ORAL SURGERY AND RELATED SERVICES	Subject to applicable Copayment	30% of Allowed Amounts after Deductible
	Services for accidental injury to sound natural teeth will be covered if provided within twelve (12) months from the date of injury.	
TRANSPLANT SERVICES	Subject to applicable Copayment	30% of Allowed Amounts after Deductible
	Members are entitled to receive benefits for human organ and tissue transplant services through Contracting Providers. Transplants covered include: Bone marrow (allogenic or autologous); Cornea; Heart; Heart-Lung; Lung (single or double); Intestine; Liver; Kidney; Pancreas; and Kidney-Pancreas. All Organ Transplants must be Prior Authorized with PPK prior to the transplant. This applies to both PCP Option and Self-Referral Option. PCP Option transplant limitations will be determined at time of Prior Authorization.	
HEARING		
Exam	$15 Copayment; Maximum benefit limited to one (1) visit per Benefit Period	Reimbursed at Allowed Amount, minus $15 Copayment
Devices	$400 per device per ear, once every three (3) Benefit Periods	
PRESCRIPTION DRUGS Certain medications require Prior Authorization Preferred Options Network	30 Day Supply Copayment: - $7 Generic - $20 Brand Formulary - $40 Brand Non-Formulary	Member reimbursed the Allowed Amount minus the Member's responsibility
	90 Day Supply Copayment: - $14 Generic - $40 Brand Formulary - $80 Brand Non-Formulary	
Please refer to your Prescription Drug Endorsement for complete plan provisions and limitations.	The benefits under this section will apply to Covered Prescriptions dispensed at a Contracting Mail Order or Retail Pharmacy who agrees in writing to the same terms and conditions that apply to the contractual agreement offered to any Contracting Mail Order Pharmacy.	

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 316-609-2555 or 1-866-618-1691 (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 (except Emergency Services, annual well-woman exam, annual diabetic retinal eye exam, and prospective parent PCP visit) rendered outside his/her office. Behavioral health, substance abuse, and Biologically Based Mental Illness services do not require a PCP Referral Authorization; however, they must be prior authorized by PPK.

Limitations and Exclusions

*Services not provided, ordered or referred by your PCP, (except for emergency services, annual well-woman exam, annual diabetic retinal eye exam, and prospective parent visit).

*Services not medically necessary.

*Cosmetic treatment/surgery primarily to restore or alter appearance, surgical treatment of obesity (including morbid obesity), medical services in conjunction with prescription weight loss therapy, and weight loss programs unless approved by PPK.

*Experimental and investigational treatment unless otherwise specified in Certificate.

*Services for injuries or diseases related to employment and covered under a Workers Compensation program and services resulting from injuries related to a motor vehicle accident and should be or are covered under automobile insurance.

*Duplication of benefits provided by Federal, State or local law, such as Medicare, CHAMPUS, and services in any veteran's facility.

*Services from non-contracting providers unless referred by your PCP and prior authorized by PPK.

*Items not strictly to treat a medical condition, including but not limited to, shower chairs, breast pumps, prenatal cradle.

The Certificate you will receive when you enroll will contain complete benefit descriptions, exclusions and limitations.