

## Summary of Benefits

Blue Cross and Blue Shield of Kansas (BCBSKS) is offering a PPO benefit plan. To receive the maximum level of benefits, you must receive services from a Blue Card PPO contracting provider. If an out-of-network provider is selected, you will be responsible for the difference between the non-contracting provider's actual billed charges. In addition, the program allowance will be 20% less than the amount paid to a contracting provider for the same service. Note: PCP or referrals are not required under this plan.

BENEFIT CATEGORY	IN-NETWORK	OUT-OF-NETWORK
<b>DEDUCTIBLE</b> (Per calendar year)	\$500/individual \$1,000/family	\$1,000/individual \$2,000/family
<b>COINSURANCE</b> (Member portion for most services)	20% of allowed amounts after deductible	40% of allowed amounts after deductible
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b> <b>(includes deductible and coinsurance)</b> Copays do not apply to the annual out-of-pocket amount	\$1,500/individual \$3,000/family	*\$3,000/individual *\$6,000/family
	After the annual out-of-pocket amount has been reached (ded/coins), eligible benefits will increase to 100% of the allowed amount for the remainder of the benefit period.	
<b>MAXIMUM LIFETIME BENEFIT</b>	\$2 Million	
<b>PHYSICIAN SERVICES</b>		
Physicians Visits — home/office	\$25/\$40 copay	*Subject to deductible/coinsurance
Surgery — inpatient and outpatient	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
Maternity Care	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
Well Child & Well Baby (for children up to age 72 months)	\$25 copay then covers 100% of allowed amounts	*Subject to deductible/coinsurance
Immunizations & Allergy Injections	100% of allowed amounts	*Subject to deductible/coinsurance
Well Women — Annual Check Up	\$25 office visit copay	*Subject to deductible/coinsurance
Office Visit	100% to \$300 then subject to deductible/coinsurance <sup>†</sup>	*Subject to deductible/coinsurance
Mammogram	100% to \$300 then subject to deductible/coinsurance <sup>†</sup>	*Subject to deductible/coinsurance
Pap Smear		
Routine Physicals — Annual Check Up	\$25 office visit copay	
Office Visit	100% up to \$300 then subject to deductible/coinsurance <sup>†</sup>	
Lab & Radiology		
Radiology and Lab	100% up to \$300 then subject to deductible/coinsurance <sup>†</sup>	*Subject to deductible/coinsurance
<b>INPATIENT HOSPITAL</b>	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>OUTPATIENT HOSPITAL</b>	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>EMERGENCY SERVICES — EMERGENCY ROOM</b>	\$50 copay per visit then subject to deductible/coinsurance Copay waived if patient admitted.	\$50 per visit then subject to deductible/coinsurance Waived if patient admitted.
<b>AMBULANCE</b>	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>FREESTANDING OUTPATIENT FACILITIES AND OUTPATIENT HOSPITAL SERVICES</b> Radiology & laboratory, surgery, dialysis	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>DURABLE MEDICAL EQUIPMENT</b> Including Foot Orthotics and Prosthetic Devices	Subject to deductible/coinsurance	*Subject to deductible/coinsurance

\*The member will also be responsible for the difference between the non-contracting provider's actual billed charges and the BCBS payment allowance. Additionally, payment will be 20% less than the amount paid to a contracting provider for the same service.

<sup>†</sup> All lab and x-ray services including mammograms and pap smears apply to the \$300 lab x-ray benefit.

# Hawker Beechcraft Services, Inc.

BENEFIT CATEGORY	IN-NETWORK	OUT-OF-NETWORK
<b>HOME HEALTH CARE</b>	100% of allowable charges subject to annual maximum	*Subject to deductible/coinsurance
	\$2,500 annual maximum	
<b>DIABETIC EQUIPMENT AND SUPPLIES</b> Insulin pumps, glucose monitor	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
<b>HOSPICE CARE</b>	100% of allowable charges subject to hospice lifetime maximum	*Subject to deductible/coinsurance
	\$5,000 lifetime maximum	
<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>	Subject to deductible/coinsurance	*Subject to deductible/coinsurance
	Combined 20 visits per calendar year	
<b>PHYSICAL MEDICINE</b> TMJ (\$5,000 lifetime maximum) Vision Therapy Biofeedback	Subject to deductible/coinsurance	*Subject to deductible/coinsurance *Subject to deductible/coinsurance *Subject to deductible/coinsurance
	Combined 20 Visits per calendar year	
<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	*Subject to deductible/coinsurance
	\$25/\$40 copay, then 100% of allowed amounts	*Subject to deductible/coinsurance
<b>PRESCRIPTION DRUGS — RETAIL</b> Generic Formulary Brand Non-Formulary Brand  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. Insulin pump supplies are covered under 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 copayments. Other quantity limits will apply for certain prescriptions.	\$7 copay \$25 copay \$50 copay	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	\$14 copay per 90-day supply	N/A
	\$50 copay per 90-day supply \$100 copay per 90-day supply	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; acupuncture and admissions for acupuncture; 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; mental illness or substance use disorder services provided by a non-eligible provider; 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 and some prescriptions
- New Directions Behavioral Health — for mental illness and substance use disorder stays

*This benefit summary is designed to be a brief summary of the benefits. For complete plan details, please see employee certificate.*