

## Open Mortgage - Plan 1227

Effective Date: 11/01/2005

### Comprehensive Medical Insurance with a Preferred Provider Organization

This summary of medical and prescription drug coverage from Principal Life Insurance Company supplements any materials presented by your employer. You'll receive a benefit booklet with details about your coverage.

#### Your Benefits at a Glance

	When You Use PPO Providers	When You Use Non-PPO Providers
<b>Calendar Year Deductible</b>	\$1,000 per person, \$3,000 per family.	\$2,000 per person, \$6,000 per family.
<b>Coinsurance</b>	After any required copays and deductibles, the coverage pays 80% and you pay 20%.	After any required copays and deductibles, the coverage pays 60% and you pay 40%.
<b>Out-of-Pocket Expense Limit</b>	\$3,000 per person, \$6,000 per family.	\$6,000 per person, \$12,000 per family.
<b>Lifetime Maximum Benefit</b>	\$5 million per person.	
<b>Primary/Specialist Physician Office or Clinic Visits</b>	You pay a \$20 physician visit copay, then the coverage pays 100% up to \$500 per visit, then calendar year deductible and coinsurance.	You pay calendar year deductible and 30% coinsurance.
<b>Emergency Room Visits</b>	You pay calendar year deductible and coinsurance. The copay is waived if you're admitted. If you need emergency care and can't reach a PPO provider, benefits for treatment of that medical emergency will be paid as if treatment were provided by a PPO provider (non-PPO prevailing fees apply). Treatment received for conditions not a result of that medical emergency will be paid at the non-PPO provider level.	You pay a \$100 copay, followed by calendar year deductible and coinsurance.
<b>Hospital Admissions</b>	You pay calendar year deductible and coinsurance.	You pay a \$500 copay, followed by calendar year deductible and coinsurance.
<b>Adult Wellness Services</b>	You pay a \$20 physician visit copay, then the coverage pays 100% up to \$500 per visit, then calendar year deductible and coinsurance.	You pay calendar year deductible and 30% coinsurance.
<b>Well Child Visits</b> (includes well child immunizations)	You pay a \$20 physician visit copay, then insurance pays 100% of covered charges up to \$500 per visit, then calendar year deductible and coinsurance.	You pay calendar year deductible and 30% coinsurance.
Benefits will be paid according to state requirements.		
<b>Outpatient, Clinic or Office-Based Surgery</b>	You pay applicable calendar year deductible and coinsurance for services performed at a hospital, ambulatory surgery center or physician's office.	
<b>Outpatient Back, Neck &amp; Spine Services</b> (including chiropractic care)	You pay a \$20 physician visit copay, then the coverage pays 100% up to \$500 per visit, then calendar year deductible and coinsurance.  There is a maximum calendar year benefit of \$1,000 per person.	You pay calendar year deductible and 30% coinsurance.
<b>Outpatient Occupational, Physical &amp; Speech Therapy</b> (excluding back, neck and spine services)	You pay a \$20 physician visit copay, then the coverage pays 100% up to \$500 per visit, then calendar year deductible and coinsurance.  There is a maximum calendar year benefit of \$2,500 per person.	You pay calendar year deductible and 30% coinsurance.



<b>Other Medical Services</b>	You pay applicable copay, calendar year deductible and coinsurance.
<b>Prescription Drugs Copay</b>	For each prescription or refill filled at a pharmacy (up to a 30-day supply), you pay a prescription drug copay of: <ul style="list-style-type: none"> <li>• \$10 for tier 1 drugs</li> <li>• \$25 for tier 2 drugs</li> <li>• \$40 for tier 3 drugs</li> </ul>
<b>Mail Service Drug Program</b>	For each drug prescription or refill filled through the mail service member pharmacy by mail, you pay two and a half prescription drug copays for a 90-day supply.
<b>Note:</b> When covered treatments or services are not available from PPO providers or for a dependent child subject to court or administrative order residing outside the PPO service area, benefits will be paid as if treatment or service was received from a PPO provider.	

### Covered Charges

The insurance covers a broad range of medical expenses, including:

- Physician care
- Hospital, birthing center and ambulatory surgery center services
- Pregnancy
- Mammograms, x-rays and lab tests
- MRIs, CATs, PETs, SPECTs, and other similar imaging tests including related services and supplies (you pay calendar year deductible and coinsurance)

Restrictions apply to certain treatments and services, including:

- Ambulance services
- Craniofacial abnormalities
- Home health care
- Home infusion therapy
- Hospice care
- Skilled nursing facility care
- Prosthetics
- Dental services to repair accidental damage to jaws and sound natural teeth
- Durable medical equipment
- Inpatient rehabilitative services

### Transplant Services

Principal Life contracts with the United Resource Network of transplant providers.

- Deductibles, coinsurance, out-of-pocket expense limits, lifetime maximums and limitations that apply to other treatments and services apply to covered transplants
- You'll receive PPO benefits when you use transplant network providers, even if the provider is outside of your PPO network
- Covered transplants are heart, lung, simultaneous heart/lung, liver, kidney, kidney-pancreas, pancreas, small bowel and bone marrow transplant, or peripheral stem cell infusion for specific conditions
- Benefits for skin and cornea transplants are paid the same as any other benefits and the Transplant Services provisions do not apply

- When you use transplant network providers, certain travel and lodging expenses are also covered
- Benefit maximums apply to transplants from providers outside of the transplant network

### Mental Health or Behavioral, and Alcohol or Drug Abuse Treatment Services

Benefits for mental health or behavioral, and alcohol or drug abuse treatment services include separate provisions. You must satisfy the same copays, deductibles and limitations that apply to medical benefits as well as those described here.

Outpatient laboratory services and prescription drugs and medicines received outside of a hospital, partial hospitalization or day treatment facility are covered under your medical or prescription drug benefits and these provisions do not apply.

### Mental Health or Behavioral Treatment Services (for other than serious mental illness)

#### Coinsurance

- The coverage pays 60% (50% for non-PPO providers) and you pay 40% (50% for non-PPO providers) for covered charges
- Coinsurance amounts you pay do not apply toward the out-of-pocket expense limit and continue after the out-of-pocket expense limit is met

#### Benefit Limits

- Benefit maximum for inpatient services – 10 days per person per calendar year, with a lifetime maximum of three inpatient hospital admissions
- Each day of partial hospitalization or day treatment services will reduce the inpatient hospital services by one half day
- Benefit maximum for covered outpatient services – 12 visits per insured per calendar year, with a lifetime maximum of 25 visits (limited to specific services)



## **Alcohol or Drug Abuse Treatment Services**

---

### **Coinsurance**

- The coverage pays 80% (60% for non-PPO providers) and you pay 20% (40% for non-PPO providers) for covered charges.
- Coinsurance amounts you pay apply toward the out-of-pocket expense limit and end after the out-of-pocket expense limit is met

### **Benefit Limits**

Three separate series of treatments per person per lifetime. A series of treatment is a structured program to promote chemical-free status through one or more types of treatment including inpatient detoxification or rehabilitation, partial hospitalization or day treatment, or intensive outpatient treatment. A series of treatment ends when the insured is discharged or fails to comply with the program for 30 consecutive days.

### **Limitations for Mental Health or Behavioral, and Alcohol or Drug Abuse Treatment Services**

---

In addition to the general limitations, covered charges do not include and no benefits are paid for:

- Residential mental health or behavioral treatment or service, unless treatment or service would otherwise require hospitalization is provided under an individual treatment plan in a crisis stabilization unit or residential treatment center for children and adolescents
- Recreational, art, music, dance or wilderness therapy
- Psychoanalysis and aversion therapy
- Social detoxification
- After-care treatment programs for alcohol or drug abuse

### **Prescription Drugs Expense Insurance**

This managed prescription drug program is provided by Principal Life and administered by CAREMARK. Benefits paid under the Prescription Drugs Expense Insurance do not count toward your medical coverage lifetime maximum benefit. Prescription coverage ends when your medical coverage ends.

Covered drugs and medicines include:

- Covered prescription drugs, including prenatal vitamins, oral contraceptives, vaginal rings and contraceptive patches
- Insulin
- Diabetic supplies

The maximum covered charge is the amount allowed under the payment schedule Principal Life established with CAREMARK. You may choose a brand name drug, even if a generic drug is available, but you must pay the copay for the brand name drug plus the difference in drug price. If the physician indicates “dispense as written” when prescribing a brand name drug, the copay for the brand name drug will

apply. Principal Life reserves the right to require pre-approval before dispensing or to limit quantities of covered drugs.

When you use any member pharmacy, you pay your copay. If you use any other pharmacy, you pay the full cost of the prescription and file a claim with CAREMARK. CAREMARK will reimburse you directly for the covered amount less the copay and any amount over the maximum covered charge.

### **Hospital Admission Review**

For any hospital stay, you, your representative or your provider must call the hospital treatment review number:

- At least two working days before admission for planned hospital stays
- Within two working days after admission for emergency hospital stays

New mothers and newborns receive automatic authorization for a 48-hour stay following a normal delivery or a 96-hour stay following a cesarean section (excluding day of delivery). Automatic authorization is also applicable for 48-hours following a mastectomy and 24-hours following a lymph node dissection. If a longer stay is anticipated, you, your representative or your provider must call for review before the end of the authorized time frame.

Your medical ID card lists a phone number to call for authorization. If you do not obtain a required review, benefits are reduced 25%, up to \$2,000 per person per calendar year. The penalty applies to the entire stay, even if a review is requested during the stay. The penalty does not count toward your out-of-pocket expense limit.

### **Benefit Advice**

If you have questions, call Benefit Advice via the toll-free number on your medical ID card – especially if a doctor plans surgery, a hospital stay or expensive treatment. The Benefit Advice staff can help you understand your benefits.

### **Dependent Coverage**

If you enroll, you may elect coverage for eligible dependents. Your spouse, natural and legally adopted children, stepchildren, foster children and disabled dependents may qualify.

### **Continuation/Conversion**

You may have certain rights to continue or convert your coverage upon termination. Check with your employer to see if these provisions are part of your coverage.

### **Coordination of Benefits/Subrogation**

Principal Life coordinates benefits with other group coverage. Principal Life may also have the right to recover

benefit payments from another person or company liable for covering your medical loss.

### Preexisting Condition Exclusion

In some circumstances, a preexisting condition exclusion may apply to your coverage, meaning you won't receive benefits for preexisting conditions until you're covered for a

certain amount of time. A preexisting condition is a physical or mental condition (except pregnancy) for which medical advice, diagnosis, care or treatment was recommended or received during the six months before your coverage begins. A 12-month exclusion applies to initial enrollees (if your group did not have at least 12 months of previous coverage) and a six-month exclusion applies to late enrollees.

---

### Limitations

The following limitations apply to covered charges, except as required by state law or as otherwise described in the group policy.

#### Comprehensive Medical and Prescription Drug Limitations

Covered charges do not include and no benefits are paid for treatment or service that is:

- Not considered a covered charge; experimental or investigational; a complication of excluded treatment or service
- Provided at no charge or a different charge in the absence of insurance or for which the insured has no financial liability (not applicable to tax-supported institutions of the state of Texas); or paid for or furnished by the U.S. government or one of its agencies except as required under Medicaid provisions or federal law
- Billed incorrectly or separately if an integral part of another billed service
- A result of war, act of war or participation in criminal activities
- Covered by medical expense insurance issued under the group policy's Individual Purchase Rights, if available in your state, or a Medicare supplement insurance plan
- The result of a sickness covered by Workers' Compensation (or similar legislation) or a work-related injury if the insured is eligible for coverage under Workers' Compensation (or similar legislation). This limitation does not apply to the injuries of the owners, partners, and officers of participating small employer groups.
- Provided outside the United States except for emergency care
- Provided for weight loss or reduction of obesity, including surgical procedures and any drug used for weight control
- Related to sexual transformation or intersex surgery

In addition, covered charges do not include and no benefits are paid for:

- Drugs or medicines that do not require a physician's prescription, have not been approved by the Food and Drug Administration for general marketing, including DESI drugs
- Prescription or non-prescription vitamins or minerals, nutritional supplements or special diets

- The services of or drugs or medicines prescribed or dispensed by any person in the insured's immediate family
- Smoking cessation or nicotine addiction

#### Additional Comprehensive Medical Limitations

Covered charges do not include and no benefits are paid for treatment or service that is:

- Over the prevailing charge
- Related to the restoration of fertility or promotion of conception (including the reversal of voluntary sterilization)
- Provided by a health care practitioner not otherwise covered by the group policy
- Subject to a preexisting condition exclusion

Covered charges also exclude treatment or service for:

- Cosmetic treatment or service or related complications unless it results from (1) a congenital disease or anomaly of a newborn child which has resulted in a defect or (2) a sickness or accidental injury that is completed within 18 months
- More than one anesthesia provider during the same anesthesia period
- Non-synostotic plagiocephaly (head banding)
- Insertion, removal or revision of breast implants (including any resulting sickness or condition) unless provided post-mastectomy
- Work-hardening programs, vocational rehabilitation services, education or training, developmental delay or learning disorders
- Human-to-human organ or bone marrow transplants, animal-to-human transplants or implants of artificial or mechanical devices designed to replace human organs, or complications of non-covered transplants
- Foot care related to corns, calluses, trimming of toenails, flat feet, fallen arches, chronic foot strain, symptomatic complaints of the feet, casting for orthotics, or any appliance (including orthotics)
- Hyperhidrosis (excessive sweating); gynecomastia (abnormal breast enlargement in males)
- Custodial care, maintenance therapy, supportive care, or when maximum therapeutic benefit has been attained
- Travel, transportation services, or lodging

In addition, covered charges do not include and no benefits are paid for:

- Kerato-refractive eye surgery for myopia, hyperopia or astigmatism; eye examinations for the correction of vision or fitting of glasses; vision materials; or vision or orthoptic therapy
- Devices used specifically as safety items or to affect performance in sports related activities
- Dental services or materials including dental implants
- Hearing aids, wigs or hair prostheses
- Acupressure or acupuncture treatment
- Unattended home sleep studies
- Sports, immigration, or employment physicals
- Personal hygiene, comfort or convenience items; protective devices; "barrier free" home modifications; heating pads, ice bags, cooling units or cold therapy units; or non-implantable communication-assist devices
- Cryopreservation or storage
- Social counseling, marital counseling or sexual disorder therapy
- Behavior modification or group therapy, gambling addiction or stress management
- Charges for telephone calls, telephone consultations, missed appointments, email communications or consultations; additional charges for after hours, Sunday, holiday, week-end and stand-by services
- Related to physician overhead
- Nursing services
- Dietetic counseling

#### **Additional Prescription Drug Limitations**

Covered charges do not include and no benefits are paid for drugs and medicines:

- Dispensed by a hospital, skilled nursing facility, rest home or other institution in which the insured is confined

#### **Terms**

**Calendar Year Deductible** – The amount you pay each year before the coverage begins paying. Each covered person must satisfy a calendar year deductible, with a maximum for your family in total. There are separate PPO and non-PPO calendar year deductibles. Payments that count toward one do not count toward the other.

**Copay** – The fee you pay each time you receive certain medical services. Copays do not count toward your calendar year deductible or out-of-pocket expense limit and continue after these amounts are met.

**Medical Emergency** – A sudden and severe medical condition that would cause a prudent person with an average knowledge of health and medicine to expect the following would happen if immediate medical attention was not sought: serious impairment to bodily functions, serious dysfunction of any body organ or part, serious disfigurement, or overall health would be placed in serious jeopardy.

**Out-of-Pocket Expense Limit** – The amount you pay annually in calendar year deductibles and coinsurance before the coverage begins paying 100% for most covered charges, up to the benefit maximums. Each covered person has an out-of-pocket expense limit, with a maximum for your family in total. There are separate PPO and non-PPO out-of-pocket expense limits. Payments that count toward one do not count toward the other.

**Prescription Drug Copay** – The amount you pay for each prescription and refill. Prescription drugs copays do not count toward the comprehensive medical calendar year deductible or out-of-pocket expense limit and continue after these amounts are met.

- Delivered or administered by the prescriber
- That are lost, stolen or spilled
- That are labeled "Caution -- limited by Federal law to investigational use," or experimental, even though a charge is made to the individual
- Prescribed for nail fungus

Covered charges also exclude and no benefits are paid for:

- Non-oral contraceptives or levonorgestrel (Norplant), growth hormones, dietary supplements, or hematinics (for example, iron)
- Infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables or any prescription directing parenteral administration or use
- Therapeutic devices or appliances
- Administration of any drug or medicine
- Any prescription or refill in excess of the number directed by the physician or dispensed more than one year after the prescription date
- Cosmetic, health and beauty aids; dermatologicals used as hair growth stimulants; any drug or medicine used for cosmetic purposes; or topical dental fluorides
- Compound medications that include an injectable drug
- Smoking deterrent medications containing nicotine or any other smoking cessation aids

Some prescription drugs and related items that are excluded under the Prescription Drugs Expense Insurance may be covered under your general medical coverage.

The group policy is insured, which means Principal Life assumes the risk for all medical and prescription drug claims. Because this material is a summary of your medical insurance, it does not state all insurance contract provisions, restrictions of coverage, benefits, conditions, limitations, or provisions required by state or federal law. If any provision presented here is found to be in conflict with federal or state law, that provision will be applied to comply with federal or state law. The group policy determines all rights, benefits, exclusions and limitations of the insurance described here.

© 2005 Principal Financial Services, Inc.



GP 51064-2 TX

**Principal Life Insurance Company**  
Des Moines, Iowa 50392-0002

page 6 of 6  
06/2005  
GO 129  
11/07/2005