



Health Care Plan

Plan Description with Revisions through 1-1-04

PLAN SPONSOR / AGENT FOR LEGAL PROCESS: Geneseo Community Unit School District
No. 228, 209 South College Avenue, Geneseo, Illinois 61254. Telephone (309) 945-0450.

CLAIM ADMINISTRATOR: Mutual Medical Plans, Inc., 416 Main St., Suite 1025, Peoria, IL 61602.
Telephone (309) 674-0888 or (800) 448-4689.

AMENDMENTS: The plan sponsor reserves the right to amend or discontinue the Plan.

CONTRIBUTIONS: You contribute to the Plan in amounts determined by the plan sponsor. The balance of cost is paid by the plan sponsor.

ELIGIBILITY: Regular full time employees (35 hours per week) become eligible for coverage on the first of the month following date of employment. If you do not enroll yourself or dependents by the date you first become eligible, evidence of good health acceptable to the Plan must be provided before coverage will become effective. Evidence of good health will not be required of a newborn or new spouse provided you were already enrolled for dependent coverage prior to acquiring the new addition to your family. Evidence of good health will also not be required if you did not have dependents at the time you enrolled in the Plan and you acquire your first dependent either through birth, adoption or marriage. However, you must apply within 30 days of such event and coverage will become effective on the date of birth, adoption, marriage, or the date you sign the enrollment card, whichever is later. Evidence of good health will not be required if you or you and your dependents transfer from optional plans 2 or 3 as described herein.

TERMINATION: Coverage will terminate at the end of the month in which your employment terminates, when you fail to make required contributions, when you elect termination, or when you are no longer eligible. Retired employees may continue single or family coverage under the Plan but may not add dependents or reenter the Plan once coverage is dropped. Coverage may be continued under legislation commonly referred to as COBRA. COBRA details are available in the Superintendent's office.

DEFINITIONS:

"You" and "Employee" means an employee or retiree of the plan sponsor.

"Plan" means the group health care plan described herein.

"Dependent" means your lawful spouse and unmarried natural or adopted child under age 19, or under age 25 if a full time student, and dependent upon you for support. Otherwise eligible students completing the spring term will be covered until September 1, and students completing the fall term will be covered until April 1 of the same year. The term "child" will also include a stepchild or other child for whom you have assumed a legal responsibility and is dependent upon you for support. Coverage will not be terminated due to age if your dependent child is incapable of earning a living due to mental or physical handicap.

"Hospital" means an institution providing care for the sick under supervision of a staff of physicians and nurses on a 24 hour basis. It does not include health resorts or nursing homes but does include a state licensed surgery center or a substance abuse treatment center approved by the Plan or has an agreement with the Plan or the Claim Administrator.

"Physician" means a duly licensed M.D., D.O., D.P.M., D.D.S., D.C., or in the case of outpatient mental care, a licensed clinical psychologist.

"Reasonable and Customary" means the fee most commonly charged for a service by other health care providers in a similar area as determined by the claim administrator.

OPTION 1 BENEFITS

For expenses incurred in a calendar year, the deductible is \$150 per person (\$300 family) for Trinity PHO providers and \$300 per person (\$600 family) for non-PPO providers. The Plan pays 80% for PPO and 60% for non-PPO up to an out-of-pocket maximum, including the deductible, of \$550 per person (\$1100 family) for PPO and \$1100 per person (\$2200 family) non-PPO. The out-of-pocket expense limit does not apply to amounts paid at 50%, amounts over reasonable and customary, or other non-covered expenses. An optional second surgical opinion will be paid at 100% with no deductible.

1. Hospital room and board charges up to the hospital's semi-private rate and the hospital's most common semi-private rate when a private room is used; full charges for intensive care, coronary care or similar special care units; and necessary inpatient or outpatient hospital miscellaneous extras.
2. Physician fees, except that outpatient mental health care is payable at 50% up to a maximum of 15 visits per person per calendar year. Services of a dentist are payable only for surgical fees to remove bone impacted teeth, tumors or cysts, or surgery and other services to correct traumatic injuries suffered while covered under this Plan or the program it replaced.
3. Leg, arm, neck and back braces or services of a registered physical therapist when prescribed by a physician.
4. Professional ambulance service when medically necessary to transport a patient to or from the nearest hospital where required medical treatment can be provided.
5. Durable medical equipment rental, or purchase at the claim administrator's option, when prescribed by a physician and where such equipment is not customarily used except for medical purposes.
6. Private duty nursing services of an R.N. when prescribed by a physician and when such R.N. is not a member of the employee or dependent's family and does not normally reside in the patient's home.
7. Artificial limbs and other prosthetic appliances for illnesses or accident incurred while covered under this Plan or the program it replaced.
8. Oxygen, blood and related administration charges.
9. Charges by a licensed speech therapist to restore speech loss due to an injury, stroke or surgery. Growth hormones, TPN, or other injectable medications when FDA approved and medically necessary.

The maximum lifetime benefit per individual is \$1 million.

PRESCRIPTION DRUG CARD

Insulin, needles and most prescription only drugs when purchased from a pharmacy may be obtained with your drug card at \$15 per prescription for brand name drugs and \$5 per prescription for generic equivalent drugs. The \$15/\$5 deductibles are not eligible expenses under the benefits described above. Birth control pills, fertility drugs, cosmetic drugs, drugs for hair growth or sexual enhancement are not covered by the program. Certain maintenance drugs may be purchased up to a 90 day supply. Injectable medications, other than insulin, may only be obtained with a special authorization processed through the Claim Administrator.

OPTION 2 BENEFITS - DENTAL / VISION PLAN

If you have other group medical plan coverage, you may elect the following Dental/Vision benefits for either yourself or you and your dependents. The vision care benefits per individual are \$35 for an exam and \$75 for frames, lenses or contact lenses once in a 24 consecutive month period. The plan will pay reasonable and customary fees of licensed dentists up to a maximum of \$1000 per individual for expenses incurred in a calendar year on the following basis:

80%

- Routine oral exams, prophylaxis (cleaning and polishing), bitewing x-rays and fluoride treatment (to age 19) twice in a calendar year.
- Full mouth x-rays once in a consecutive 24 month period.
- Fillings consisting of amalgam, silicate and plastic restorations.
- Extractions, oral surgery and related anesthesia except general anesthesia for 3 or less simple extractions.
- Denture repair and relining, and recementing of inlays, onlays and crowns.
- Endodontics including pulpotomy, pulp capping and root canal therapy.
- Periodontics (disease of the gum) and apicoectomy.
- Space maintainers, and emergency treatment.

50%

- Gold foil restorations, inlays and onlays, and crowns or crown buildups.
- Dentures, full and partial.
- Bridges, fixed and removable.
- Orthodontics (to age 19).

Lost or misplaced dentures, cosmetic dentistry, implants or bridges involving implants, or the placement of crowns, inlays, bridges and dentures and the relining of dentures more than once in a consecutive five year period are not covered.

OPTION 3 - WRAP-AROUND MEDICAL PLAN

If you have other employer sponsored group health care plan coverage and you enter the Plan on or after 1-1-96, you will automatically be covered under Option 3 Wrap-Around Plan benefits unless you elect the Option 2 Dental/Vision benefits. Any exception must be approved by the Plan sponsor. Individuals covered by other than an employer sponsored health plan may elect the Wrap-Around Plan to give you greater overall benefits when combined with another major medical program. For expenses covered under Option 1 herein, this plan pays 100% of the first \$300 and 20% of the balance up to a maximum of \$1000 per individual for expenses incurred in a calendar year. In addition, Option 3 pays 100% of reasonable and customary charges for: (a) routine gynecological exams including pap smears and routine mammograms not related to a symptom or condition of illness, (b) well baby care immunizations and related office visits, and (c) school medical exams required for dependent children. If you receive less benefits under the Wrap-Around Plan, when combined with the contractual benefits of your other coverage, than you would have received had you been covered under the Major Medical benefits, the Plan will pay the difference.

OPTION 4 - MAXI MEDICAL PLAN

The Maxi Plan covers the same scope of benefits as the regular Medical Plan, plus 100% of drug plan deductibles. The Maxi Plan does not have a deductible or co-insurance. Covered expenses are payable at 100% with no deductible or dollar limit except on inpatient hospital bills, which are payable to a maximum of \$1000 per admission. An individual covered under the Maxi Plan may elect to change to the regular plan benefits at any time.

ENROLLMENT CONSIDERATIONS

If you are enrolled in Option 2 or 3 and lose other health plan coverage on yourself and/or your dependents, you will immediately be switched to Option 1 benefits (same Single or Family coverage you previously had in Option 1) without any waiting period for pre-existing conditions and without evidence of good health. You may not be covered under a Wrap-Around or similar coverage at more than one place of employment.

LIMITATIONS AND EXCLUSIONS

The Plan will not pay for:

1. Hospital room and board or related physician charges during inpatient admissions primarily for care which can be provided safely on an outpatient basis (an inpatient Pre-admission Certification form is available for you to clarify coverage before inpatient admissions or you may call the claim administrator). Hospital emergency room charges in non-accident cases except for the sudden onset of an emergency medical condition which could result in permanent medical consequences in the absence of immediate medical attention.
2. Charges exceeding reasonable and customary as determined by the claim administrator. Job related injuries or diseases compensable or pending under Worker's Compensation or similar legislation, or for which a final decision has not been made by the Industrial Commission on a claim that was filed under Worker's Compensation, unless this provision is waived by the Plan. Expenses payable by Medicare or which would have been payable had the person enrolled in Medicare, except where contrary to law; and custodial care, education or training, or expenses for which you are not liable for payment.
3. Routine physical exams except physician inpatient visits for a well newborn, pre-marital exams, school medical exams, immunizations or vaccinations, orthotics or routine foot care such as trimming nails or callouses, eyeglasses or hearing aids and tests for the fitting thereof unless specifically covered under Option 2; expenses denied by an HMO or other health care plan for lack of pre-treatment approval, multiple surgical opinions or improper claim filing procedures.
4. Hospital admissions commencing or other services received before an individual's effective date of coverage or after termination from the Plan.
5. Personal comfort items such as television rental, barber services, special or guest meals, telephone calls, travel expenses, expenses including complications related to a non-covered cosmetic service, or expenses not listed as a benefit of the Plan.
6. Cosmetic surgery except to correct traumatic injuries sustained while covered under the Plan or program it replaced, or to correct congenital deformities evidenced in infancy; expenses related to sex changes, penile implants, weight reduction, exercise or fitness programs, radial keratotomy, mastectomy in the absence of malignancy, breast reductions or enlargements except for post mastectomy reconstruction, otoplasty or blepharoplasty, artificial insemination; jaw surgery or TMJ treatment except for fracture or meniscus repair or for an abscess; services of a dentist except as specifically provided for those in Option 2, to remove tumors, cysts or bone impacted wisdom teeth, or to repair facial damage sustained in an accident.
7. Injury or illness due to war or act of war or while serving in the armed forces; expenses not authorized by a physician as necessary treatment; services which do not meet accepted medical or dental standards or which are experimental in nature; expenses related to organ transplants other than cornea, kidney, bone marrow, heart valve, parathyroid (heart, lung, heart-lung, liver or pancreas transplants are not covered).
8. Inpatient mental care beyond 2 admissions per lifetime benefit per person, or inpatient admissions for drug or alcohol abuse beyond 2 admissions in an individual's lifetime.
9. Expenses covered by or pending under auto, property and casualty, or liability insurance or for which another party is liable. Upon completion of the Plan's reimbursement agreement, these expenses may be paid on an interim basis at the claim administrator's option while settlement with such other insurance or party is pending.
10. Benefits in excess of \$500 during the first 6 months of coverage for a condition which existed prior to the individual's effective date of coverage (this includes expenses related to maternity). This exclusion does not apply to a newborn child if you had dependent coverage in the Plan prior to the birth of the child or if the individual is entering Option 1 from Option 2 or 3. It also does not apply to Option 2.

CLAIM PROCEDURES

Always present your Geneseo Schools Health Care Plan ID card when receiving covered medical services because the card contains billing instructions for your hospital and doctor. Hospitals and physicians may send their standard form or an itemized bill with diagnosis and your ID number directly to Mutual Medical. You may also file claims directly to Mutual Medical along with a completed Medical Claim form.

If you are in Option 2, obtain the appropriate Dental or Vision form from your employer, complete the employee portion, and have the provider of service complete the balance of the form and file it directly to Mutual Medical.

Benefits will normally be paid to the provider of service, but the Plan reserves the right to pay benefits directly to you or in the case of your death to a relative as determined by the claim administrator. Benefits are not assignable.

CLAIM REVIEW AND APPEAL

Mutual Medical will review a claim at your verbal or written request. If you do not agree with Mutual Medical's final decision on a claim, you may file a written appeal setting forth all of the details and reasons you feel the claim is covered under the Plan including specific Plan language to support your appeal. Claim appeals should be sent to the Superintendent's office. A decision on the appeal will be sent to you within 60 days after an appeal with sufficient details is received. No action at law shall be taken until a claim has been duly denied, reviewed, appealed, and the appeal answered as set forth herein and no such action shall be valid unless taken within 180 days after your appeal has been answered.

COORDINATION OF BENEFITS AND RECOVERY RIGHTS

If you or a dependent have any other health care plan coverage, benefits will be coordinated so that not more than 100% of covered charges are paid or reimbursed. Your spouse's coverage will be primary on him or her. If you have other coverage as the subscriber or as a survivor, it will be primary unless you acquired such other coverage after your most recent effective date in this Plan. The Plan will be secondary to any plan, including individual medical policies not purchased through the plan sponsor, which do not have a coordination of benefits provision. In the case of a dependent child, the parent whose birthday falls earliest in the year will be considered primary. In the case of children with divorced parents, in the absence of court determined responsibility, the parent with custody will be primary. Student coverage will be primary. Any coordination of benefits issue arising which is not addressed herein or within the Plan's other provisions will be settled using the NAIC guidelines adopted by the state of Illinois.

If benefits which should have been paid by the Plan are made by another organization, the Plan shall have the right to pay over to any such organization making such payments any amounts it shall determine to be warranted to satisfy this provision and the plan shall be discharged from liability. The Plan reserves subrogation rights and the right to recover overpayment of benefits from any person or organization.

LEGISLATION

If provisions of the Plan conflict with Federal or State law, present or future, such legislation shall prevail.