Geneseo CUSD 228
2009 Levy Points

	Maximum Rate	2008 Levy	2008 Extended	Actual Rate
Education	**2.35000**	$ 7,167,500.00	$ 7,156,187.88	**2.3500**
OBM	**0.50000**	$ 1,525,000.00	$ 1,522,593.17	**0.5000**
Transportation	**0.20000**	$ 610,000.00	$ 609,037.27	**0.2000**
Working Cash	**0.05000**	$ 152,500.00	$ 152,259.32	**0.0500**
Special Education	**0.04000**	$ 122,000.00	$ 121,807.45	**0.0400**
Tort		$ 350,000.00	$ 350,196.43	**0.1150**
Social Security		$ 265,000.00	$ 265,235.73	**0.0871**
IMRF		$ 255,000.00	$ 255,186.61	**0.0838**
Lease	**0.05000**	$ 152,500.00	$ 152,259.32	**0.0500**
Health/Life Safety	**0.05000**	$ 152,500.00	$ 152,259.32	**0.0500**
Bond & Interest		$ 1,593,190.00	$ 1,601,463.49	**0.5259**
		$ 12,345,190.00	$ 12,338,485.99	*4.0518*
		Extension w/o Bonds	$ 10,737,022.50	3.5259

2008 Rate Setting EAV	$ 304,518,633.00
2007 Rate Setting EVA	$ 291,510,965.00
Increase 07 to 08	$13,007,668.00

4.46%

2009 Projected Levy

	Maximum Rate	2009 Levy	Projected Rate	09 Levy to 08 Extended Difference 09 to 08
Education	**2.35000**	$ 7,379,000.00	2.3500	222,812.12
OBM	**0.50000**	$ 1,570,000.00	0.5000	47,406.83
Transportation	**0.20000**	$ 628,000.00	0.2000	18,962.73
Working Cash	**0.05000**	$ 157,000.00	0.0500	4,740.68
Special Education	**0.04000**	$ 125,600.00	0.0400	3,792.55
Tort		$ 250,000.00	0.0796	(100,196.43)
Social Security		$ 235,000.00	0.0748	(30,235.73)
IMRF		$ 275,000.00	0.0876	19,813.39
Lease	**0.05000**	$ 157,000.00	0.0500	4,740.68
Health/Life Safety	**0.05000**	$ 157,000.00	0.0500	4,740.68
Bond & Interest		$ 1,757,834.00	0.5598	156,370.51
		$ 12,691,434.00	*4.0419*	352,948.01
		Maximum Rates		
	Levy w/o Bonds	$ 10,933,600.00		
Assumption EAV	314,000,000		Rate Change	-0.994%
Increase in EAV	103.11%			

Increase 09 Levy to 08 Extended $ 352,948.01

102.8605%

Tax Rate 2008 Actual **4.0518** Does not require Truth in Taxation Hearing
Tax Rate 2009 Request **4.0419**

Board, Nov 09

PERMISSION TO SEEK BIDS FOR 2010-2011

The Business Office requests Board of Education permission to seek bids for items that are anticipated to be needed for the next school year. Some of the items are for future Health/Life Safety projects. The list of District items is as follows: vehicles, mowing equipment, floor coverings, bakery items, tables, chairs, desks, milk, pizza, gasoline, diesel fuel, fence, cafeteria equipment, band instruments, HVAC service agreements, computer hardware and software, copier maintenance agreements, janitorial cleaning supplies, glass replacement, security systems, tuckpointing, waste removal, roof work, gutters and downspouts, plumbing work, construction projects, ventilation work (including air conditioning), windows, temperature control systems, boiler repair, lockers, dust collection systems, kitchen equipment, intercom systems, geothermal systems, and doors. If other items are found to be needed, permission to bid will be requested on them.

SB 2293 (Maloney, D-Chicago) is now Public Act 95-0990, effective October 3, 2008. Previously, a school district would have to award all contracts in excess of $10,000 to the lowest responsible bidder through a competitive bidding process. Now, a district must use the bidding process for expenditures in excess of $25,000. For repair, maintenance, remodeling, or construction projects, the threshold is increased from $20,000 to $50,000.

Board Policy outlines the competitive methods of acquisition of exempt contracts by a) telephone quotation when items are urgently needed or in small quantity orders or b) written quotations used to purchase materials or services when time requirements allow. Whenever possible, quotations should be received from at least 2 competitors.

Jack Schlindwein

Geneseo Schools CUSD#228

January 1, 2010
Contribution Scenarios

	Current Enrollment	2009 Premium Equivalent Rates	2009 Participant Contribution $'s	2009 Participant Contributions %'s	2010 Premium Equivalent Renewal Rates	2010 Premium Equivalent Renewal Rates EMPLOYER Costs	2010 Premium Equivalent Renewal Rates EMPLOYEE Costs	Option 1 Maintain 2009 Contributions	Option 2 2% above Renewal Rates (~ 7% INCR)	Option 3 4% above Renewal Rates (~ 9% INCR)	Option 4 6% above Renewal Rates (~ 11% INCR)
PPO					5% Increase	5% Increase	5% Increase				
- Single (Incl Single Wrap)	113	$382.06	$0.00	0.0%	$401.16	$543,977.03	$0.00	$0.00	$0.00	$0.00	$0.00
-Retiree Single	12	$382.06	$382.06	100.0%	$401.16	$0.00	$57,767.47	$382.06	$409.19	$417.21	$425.23
- Family	83	$1,003.38	$155.33	15.5%	$1,053.55	$886,890.69	$162,444.11	$155.33	$166.36	$169.62	$172.88
-Retiree Family	3	$1,003.38	$1,003.38	100.0%	$1,053.55	$0.00	$37,927.76	$1,003.38	$1,074.62	$1,095.69	$1,116.76
-Retiree Medicare	15	$247.93	$247.93	100.0%	$260.33	$0.00	$46,858.77	$247.93	$265.53	$270.74	$275.95
-Family Wrap or Dental/ Vision	7	$454.84	$72.78	16.0%	$477.58	$33,697.69	$40,116.56	$72.78	$487.13	$496.68	$506.23
-Retiree Family A (1 Medicare Single, 1 Single)	1	$632.94	$632.94	100.0%	$664.59	$0.00	$7,975.04	$632.94	$677.88	$691.17	$704.46
-Retiree Family B (2 Medicare Single)	7	$495.85	$495.85	100.0%	$520.64	$0.00	$43,733.97	$495.85	$531.06	$541.47	$551.88
	241	**TOTAL CONTRIBUTION (PARTICIPANTS + DISTRICT)**	**PARTICIPANTS $s**		**TOTAL CONTRIBUTION (PARTICIPANTS + DISTRICT)**	**78.68%**	**27.09%**				
	TOTALS	**$1,740,658**	**$345,834**		**$1,861,389**	**$1,464,565**	**$396,824**				

	Current Enrollment	Option 1 EMPLOYER COSTS	Option 1 EMPLOYEE	Option 2 EMPLOYER COSTS	Option 2 EMPLOYEE COSTS	Option 3 EMPLOYER COSTS	Option 3 EMPLOYEE COSTS	Option 4 EMPLOYER COSTS	Option 4 EMPLOYEE COSTS
PPO		NO CHANGE	NO CHANGE	~7% INCREASE	~7% INCREASE	~9 % INCREASE	~9 % INCREASE	~11% INCREASE	~11% INCREASE
- Single (Incl Single Wrap)	113	$518,073.36	$0.00	$554,856.57	$0.00	$565,736.11	$0.00	$576,615.65	$0.00
-Retiree Single	12	$0.00	$55,016.64		$58,922.82		$60,078.17		$61,233.52
- Family	83	$844,657.80	$154,708.68	$904,628.50	$165,693.00	$922,366.32	$168,941.88	$940,104.13	$172,190.76
-Retiree Family	3	$0.00	$36,121.68		$38,686.32		$39,444.87		$40,203.43
-Retiree Medicare	15	$0.00	$44,627.40		$47,795.95		$48,733.12		$49,670.30
-Family Wrap or Dental/ Vision	7	$32,093.04	$6,113.21	$34,371.65	$6,547.02	$35,045.60	$6,675.40	$35,719.55	$6,803.77
-Retiree Family A (1 Medicare Single, 1	1	$0.00	$7,595.28		$8,134.54		$8,294.05		$8,453.55
-Retiree Family B (2 Medicare Single)	7	$0.00	$41,651.40		$44,608.65		$45,483.33		$46,358.01
	241								
		$1,394,824	**$345,834**	**$1,493,857**	**$370,388**	**$1,523,148**	**$377,651**	**$1,552,439**	**$384,913**
		Total Option 1 Contributions	**$1,740,658**	**Total Option 2 Contributions**	**$1,864,245**	**Total Option 3 Contributions**	**$1,900,799**	**Total Option 4 Contributions**	**$1,937,353**

2010 Projected costs based on 241 employees are estimated at between $1,632,3275 and $1,693,481, depending on the timing of a very large claim payment and ISL level.

GENESEO SCHOOL DISTRICT #228

HEALTH CARE PLAN

RESTATED – EFFECTIVE DATE :

JANUARY 1, 2010

APPROVED BY DISTRICT 228 BOE

DECEMBER 10, 2009

Geneseo School District #228
Health Care Plan

INTRODUCTION

Geneseo Community Unit School District #228 Health Care Plan ("Plan") is a self-funded health plan established to provide medical, dental, and vision benefits for employees of Geneseo School District #228 ("Employer"). This Plan represents the efforts of the Employer to provide its employees and their dependents with the best possible health benefits at an affordable cost.

This booklet provides you with a description of all benefit provisions in the Plan, your rights under federal law, how you establish and/or lose eligibility, and how to appeal if a claim is not handled satisfactorily. Thus, we are asking you to review this booklet and familiarize yourself with the rules and requirements and the benefits to which you may be entitled.

In reviewing this booklet, you will note that a number of terms and phrases are capitalized. This usually means that there is a definition of these terms contained in the Definitions Section of the Plan. It will be helpful to refer to these definitions as you review your benefits.

If you would like to contact the Contract Administrator, you may do so between 8:00 A.M. and 5:00 P.M., Central Time, Monday through Friday, using the telephone numbers listed on the General Information page. However, any information that you obtain over the phone in this manner concerning your rights and benefits may not be relied upon as a guarantee of your rights or that benefits will be paid in that manner. The availability of benefits is determined solely on the basis of the terms of the Plan as contained in this booklet. A final determination of your rights and benefits cannot be made until all necessary documentation and information is submitted to the Insurance Committee and your claim is fully adjudicated.

GENERAL INFORMATION

The following information, together with the information contained in this booklet, form the master plan and SUMMARY PLAN DESCRIPTION of the Plan.

1. Name of Plan:

   Geneseo Community Unit School District #228 Health Care Plan.

2. Name and Address of Plan Sponsor and Plan Administrator:

   Geneseo School District #228
   209 S College Ave
   Geneseo IL 61254
   309-945-0450

3. Employer Identification Number (EIN): 36-6004648

4. Type of Plan:

   Welfare benefit plan providing medical, dental, and vision benefits.

5. Funding:

   The Plan is self-funded by Geneseo School District #228.

6. Contract Administrator:

   Mutual Medical Plans Inc
   416 Main Street Suite 1025
   Peoria IL 61602
   309-674-0888
   800-448-4689

7. COBRA Notice Coordinator: Geneseo School District #228

8. Agent for Service of Legal Process:

   Geneseo Community Unit School District #228
   209 S College Ave
   Geneseo IL 61254
   309-945-0450

9. Sources of Contributions to the Plan:

   The cost of providing benefits under the Plan is shared by the Employer and Employees. A schedule will be distributed periodically setting forth the contributions required of the Employees participating in the Plan. Contributions are held in trust by the trustee.

10. Fiscal Year of the Plan:

    January 1 to December 31

11. Effective Date of the Plan:

    January 1, 1989

12. Effective Date of Plan Restatement:

    January 1, 2010

EMPLOYEE ELIGIBILITY

Eligibility Requirements

Regular full time employees (35 hours per week) become eligible for coverage on the first of the month following the 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 new-born or spouse provided you were already enrolled for dependent coverage prior to acquiring 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.

Spouses of all insured Plan members covered by this Plan will not be eligible for this Plan if the spouse's employer or previous employer has medical coverage available to employees or retirees or if the spouse is eligible for TRIP because they were a TRS member. An employee may appeal this. Any exceptions to this provision must be approved by the Plan Sponsor. Not applicable to Dental/Vision.

NOTICES

I. It is the Covered Person's or Covered Dependent's responsibility to notify the Employer or Plan Administrator within fifteen (15) days of any event which would cause such person or a family member to (i) gain or lose eligibility for coverage under the Plan, (ii) become eligible for or entitled to any Plan benefit, or (iii) lose eligibility for or entitlement to any Plan benefit; unless the Plan elsewhere specifically provides for a longer notice provision. The foregoing includes, but is not limited to, the following:

a) Notifying the District Office of an address change within fifteen (15) days of such change;

b) Notifying the District Office of a name change within fifteen (15) days of such change; and

c) Notifying the District Office of a change in dependent child status within fifteen (15) days of such change; and

d) Notifying the District Office when a spouse becomes eligible for other medical coverage or loses other medical coverage.

II. It is the covered person's or covered dependent's responsibility to notify the employer or plan administrator within 60 days of (i) the termination of Medicaid CHIP coverage or (ii) the eligibility for Medicaid or CHIP coverage.

III. 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.

IV. Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother of newborn earlier. Also under federal law, plans and issuers may not set the level of benefits or out-of-pockets costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to them other o newborn than any earlier portion of the stay. In addition, a plan or issuer may not under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 (or 96) hours. However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator

V. Federal law requires the Plan to provide the following benefits for elective breast reconstruction in connection with a covered mastectomy:

a) reconstruction of the breast on which the mastectomy has been performed

b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c) Prostheses and physical complications in all stages of mastectomy, including lymphedemas

in such a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other Plan terms and limitations.

Plan Options

Covered Persons and Covered Dependents with other employer sponsored group medical coverage are automatically provided coverage pursuant to the Wrap Around Medical Option 3, unless you choose coverage under Option 2, Dental/Vision Plan. A Covered

Person, Spouse or Covered Dependent is only entitled to coverage under one of the Plan Options at a time. A Covered Person can change coverage between Options 1, 2,or 3 and the Maxi Plan at any time with the Employer's permission.

SCHEDULE OF BENEFITS

MAJOR MEDICAL BENEFITS
OPTION 1

This Schedule is a summary of Plan benefits. Please read the remainder of this booklet carefully for a detailed explanation of Plan benefits and limitations.

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR		
Per Person	$150	$300
Per Family Unit	$300	$600
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Person (including deductible)	$550	$1,250
Per Family Unit (including deductible)	$1100	$2,500
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year. There is no out-of-pocket limit for the following: - Prescription drug card benefits - Plan Exclusions		
LIFETIME MAXIMUM	$1,000,000	
COVERED SERVICES		
Routine Preventative Care		
Mammograms*	60%	50%
Prostate Specific Antigen Tests	80%	50%
PAP Test	80%	50%
Colorectal Cancer Screening	80%	50%
Hospital Services		
Room and Board	80%	50%
Intensive Care Unit	80%	50%
Other Inpatient	80%	50%
Outpatient Surgery & Diagnostic	80%	50%
Outpatient Pre-Admission Testing	80%	50%
Inpatient Substance Abuse & Mental Illness 2 per lifetime	80%	50%
Outpatient Urgent Care Room	80%	50%
Hospice Facility	80%	50%
Occupational Therapy	80%	50%
Physical Therapy	80%	50%
Respiratory Therapy	80%	50%
Outpatient Emergency Room	$100 co-pay then 80%	$100 co-pay then 50%
	$100 co-pay waived if admitted	
	ER co-pays do not count toward deductible or oop max	

***for routine Mammograms scheduled outside of the District's Pre-arranged services at Hammond Henry, which are paid at 100%**

Skilled Nursing Facility (when billed same as the hospital)	80%	50%
Physician Services		
Inpatient Visits	80%	50%
Office visits, labs and x-rays Includes routine preventive office visits for PSA, PAP & Colorectal Cancer Screening	80%	50%
Surgery	80%	50%
Occupational Therapy	80%	50%
Physical Therapy	80%	50%
Respiratory Therapy	80%	50%
Home Health Care	80%	50%
Private Duty Nursing	80%	50%
Hospice Care	80%	50%
Ambulance Service	80%	50%
Durable Medical Equipment	80%	50%
Prosthetics	80%	50%
Orthotics (except foot orthotics)	80%	50%
Medical Supplies	80%	50%
Maternity	80%	50%
Voluntary Sterilizations	80%	50%
Bariatric Surgery	80% - $20,000 Max	50% - $15,000 Max
Mental Illness/Substance Abuse		
Inpatient Mental Illness (2 admits per lifetime)	80%	50%
Inpatient Substance Abuse (2 admits per lifetime)	80%	50%
All Outpatient and partial hospitalization 15 visits per year	50%	
Chiropractic Treatment/Spinal Manipulation	80% Maximum of $1,200 per year	
Organ Transplants	80%	50%
All Other Covered Services	80%	50%
Bariatric Surgery	80% up to $20,0000	50% up to $15,000

This Schedule is a summary of Plan benefits. Please read the remainder of this booklet carefully for a detailed explanation of Plan benefits and limitations

PRESCRIPTION DRUG PROGRAM BENEFITS
Medco Drug Card

Pharmacy (30 day supply)	**Copayment Amounts**
Generic Drugs	$10
Brand Name Drugs	$25
Brand Name Drugs with Generic Substitute	$40

Insulin, needles and most prescription only drugs when purchased from a pharmacy may be obtained with your drug card after copays of $10 for generic, $25 for formulary, and $40 for non-formulary per prescription. The copays 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 specialty drugs may be purchased with a special authorization processed through the Claim Administrator.

TPN, and other FDA approved intravenous drug therapy when not covered under the prescription drug card program, and cost exceed $500 per month, must be approved by the Plan on a case by case basis.

OPTION 2 BENEFITS – DENTAL / VISION PLAN

If you have other group medical plan coverage, you may elect the following Dental/Vision benefits for 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:

Covered Services	**Plan Coinsurance**
• Routine oral exams, prophylaxis (cleaning and polishing), bitewing x-rays and fluoride treatment (to age 19) twice in a calendar year.	**80%**
• Full mouth x-rays once in a consecutive 24 month period	**80%**
• Fillings consisting of amalgam,silicate and plastic restorations	**80%**
• Extractions, oral surgery and related anesthesia except general anesthesia for 3 or less simple extractions.	**80%**
• Denture repair and relining, and recementing of inlays, onlays and crowns.	**80%**
• Endodontics including pulpotomy, pulp capping and root canal	

therapy. • Periodontics (disease of the gum) and apicoectomy. • Space maintainers and emergency treatment. • Gold foil restorations, inlays and onlays, and crowns or crown buildups, full and partial dentures, fixed and removable bridges. Or (active appliances of all types, including diagnostic services, the treatment plan, the fitting, making, and replacing of the active appliance, and all related office visits including post-treatment stabilization) • Orthodontics (to age 19). Or (Any preventative, Primary, or Major Dental Service connected with orthodontic treatment to age 19 • Surgical exposure of impacted or un-erupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthetics, and post-surgical care)	**80%** **80%** **80%** **50%** **50%** **50%**

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 1-1-1996, 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 Major Medical herein, this plan pays 100% of the first $500 and 20% of the balance up to a maximum of $1500 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, (c) school medical exams required for dependent children, and (d) copays under another drug card. 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 Major Medical Plan, plus 100% of drug plan copays. The Maxi Plan does not have a deductible or coinsurance. Covered expenses are payable at 100% with no deductible or dollar limit except on inpatient hospital expenses, which are payable to a maximum of $1500 per admission. A covered individual may change from Maxi Plan to the Major Medical or to the Maxi Plan from the Major Medical at any time.

Major Medical Benefits - Option 1

Reasonable and Customary Expenses Incurred on behalf of each Covered Person or Covered Dependent for:

Inpatient Hospital Services

- Hospital Services:

  (1) regular Room and Board (semi-private room rate);

  (2) confinement in an Intensive Care Unit; and

  (3) Necessary Services and Supplies.

- Skilled Nursing Facility Confinement: (new benefit)

  (1) Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, benefits available for Room and Board will not exceed the average semi-private rate charged by the facility or a representative cross section of similar institutions in the area;

  (2) Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physician's fees; and

  (3) Drugs, biological, solutions, dressings, and casts furnished for use during the convalescent period, but no other supplies.

A Covered Person or Covered Dependent shall be eligible for benefits under this Subsection only to the extent confinement in a Skilled Nursing Facility:

(1) Is certified by a Physician as essential for recuperation from Sickness or Injury that caused such Hospital Confinement;
(2) Is not incurred for custodial care; and

Out-Patient Services

- Partial Hospitalization Treatment Program: Treatment is a planned therapeutic treatment program of a Hospital or Substance Abuse Treatment Facility in which patients with mental Illness or Substance Abuse spend days or nights.

- Out-Patient Treatment: Reasonable and Customary Expenses Incurred for the following Out-Patient Treatment:

  (1) Surgery and related diagnostic service received on the same day as the Surgery, whether as Out-Patient Treatment or in a Physician's office, including Physician's surgical charges;

  (2) Diagnostic testing related to Surgery or medical care; and

  (3) Services provided in a licensed Ambulatory Surgical Facility.

- Emergency Room Treatment: Reasonable and Customary Expenses Incurred for initial Emergency Treatment of a Sickness or Injury in a Hospital emergency room or by a Physician.

- Pre-Admission Testing: Reasonable and Customary Expenses Incurred for pre-admission testing which is performed either:

  (1) at a Hospital on an out-patient basis; or

  (2) at an out-patient facility if the test results are accepted by the Hospital to which the patient is admitted.

Physician Services

- Physician's services for surgical procedures, diagnostic services, Mental Illness, and Substance Abuse treatment.

- Office visits, house calls, or visits to a Hospital or facility by a Physician.

- Second surgical opinions and, if the second surgical opinion does not confirm the first opinion, a third opinion is also covered.

- Anesthetics and their administration by a professional anesthetist or anesthesiologist.

- Dental Services rendered by a dentist or Physician which are required as a result of accidental Injury to the jaws, teeth, mouth or face.

- Special treatments, on an inpatient or outpatient basis, if rendered by a Physician or Hospital:

  1) X-ray and radiation therapy treatments;

  2) Chemotherapy;

  3) Shock therapy treatments;

  4) Renal dialysis treatments up to $7,500 per month and when necessary, plan will negotiate additional payments

  5) Allergy shots and allergy surveys

Other Covered Services

- Private duty professional nursing services by a Registered Nurse or Licensed Practical Nurse that does not reside in the same household as the patient, but only in the home, if the services provided are of such a nature that they cannot be provided by non-professional personnel.

- Physical therapy (whether rendered by a Physician or licensed physical therapist).

- Services of a qualified Physician or qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to Injury, stroke, or Surgery.

- Services of a Physician or registered occupational therapist for constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

- Phase I and Phase II cardiac rehabilitation services.

- Professional air or ground ambulance service to transport a patient to the nearest hospital where required medical treatment can be provided, or transport to a skilled nursing facility when care by that facility is covered by the Plan.

- Processing and administration of blood or blood components, including the cost of the actual blood or blood components, unless replaced.
- Diagnosis and treatment of autism spectrum disorders for children under age 21

- Rehabilitative service to enhance the ability of a child to function with congenital, genetic or early acquired disorder

- Shingles vaccine for age 60 and over

- The following medical supplies:

  (1) prosthetic appliances required to replace all or part of an organ or tissue or the function of an organ or tissue, including adjustment or repair (but not replacement) of such devices where required due to wear or a change in the patient's condition, but specifically excluding dental appliances or vision appliances other than cataract lenses or standard glasses required promptly after, and because of, cataract surgery;

  (2) Durable medical equipment rental, or purchase at the claim administrator's option, when prescribed by a physician and where such rental type equipment is not customarily used except for medical purposes.

  (3) dressings, sutures, casts, splints, trusses, crutches, braces or other necessary medical supplies with the exception of dental braces or corrective shoes;

  (4) oxygen and rental equipment for its administration;

  (5) leg, back, arm and neck braces required due to Sickness or Injury;

  (6) prescription drugs and injectable drugs not obtained through the prescription drug card program; and TPN and other FDA approved intravenous drug therapy when not covered under the prescription drug card program and cost exceed $500 per month must be approved by the Plan on a case by case basis.

- prescription drugs, insulin and disposable needles, pursuant to the terms of the drug card program maintained by the Employer.

- Chiropractic services performed by a chiropractor or physician.

- Services obtained at a Birthing Center.

- Services for voluntary sterilization for a Covered Person or the Covered Person's dependent spouse.

- Routine preventive prostate specific antigen tests, PAP tests and colorectal cancer screening.

- Treatment of Mental Illness and Substance Abuse.

- Hospice care for terminally ill persons certified by a Physician as having a life expectancy of less than six (6) months, limited as follows:

  (1) Room and Board;

  (2) necessary services and supplies at a facility or in the home;

  (3) part-time nursing care;

  (4) consultation and case management services by a Physician;

  (5) physical therapy;

  (6) medical supplies and prescription drugs otherwise covered by the Plan; and

  (7) bereavement counseling.

- Home Health Care Expense Benefits, as follows:

  (1) Benefits

Reasonable and Customary Expenses Incurred for services and supplies furnished in the home of the Covered Person or Covered Dependent in accordance with a Home Health Care Plan.

Expenses covered under this Section include:

(A) part-time or intermittent nursing care by or under the supervision of a Registered Nurse;

(B) physical therapy, occupational therapy, respiratory therapy and speech therapy provided by the Home Health Care Agency; and

(C) medical supplies, drugs and medications prescribed by a Physician, and laboratory services, to the extent such items would have been paid by the Plan if the Covered Person or Covered Dependent had remained in the Hospital or Skilled Nursing Facility.

(2) Limitations

No Benefits are payable under this Section for:

(A) services or supplies not covered by the Home Health Care Plan;

(B) Services performed by an individual who ordinarily resides in the Covered Person's or Covered Dependent's home or is a member of the Covered Person's or the Covered Dependent's Immediate Family;

(C) Services of any social worker;

(D) Expenses Incurred for transportation; or

(E) Services or supplies rendered during any period in which the Covered Person or Covered Dependent is not under the continuing care of a Physician.

- The following benefits for a elective breast reconstruction in connection with a covered mastectomy:

(1) reconstruction of the breast on which the covered mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prosthesis and physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient.

- Diabetic care coverage for diabetes self-management training, including medical nutrition education, limited to one (1) Medically Necessary visit to a qualified provider upon initial diagnosis of diabetes by the patient's Physician.

- Cornea, kidney, heart, lung, and bone marrow human organ transplants.

Limitations Major Medical Option 1

(a) Shared Expenses

During each calendar year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for the deductible, copayment, and coinsurance requirements listed in the Schedule of Benefits.

(b) Maximum Lifetime Benefits While Covered Under This Plan

The maximum benefit while covered under this Plan for any Covered Person or Covered Dependent shall not exceed the amount listed in the Schedule of Benefits.

(c) Pre-Existing Conditions

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 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.

(d) Maternity Benefits

Expenses Incurred as a result of the pregnancy will be eligible for benefits the same as any other Sickness under the Plan, except that the following provisions shall be applicable:

(1) a minimum of forty-eight (48) hours of inpatient Hospital care for the mother and newborn child shall be provided following a vaginal delivery; and

(2) a minimum of ninety-six (96) hours of inpatient Hospital care for the mother and newborn child shall be provided following a delivery by Caesarean section.

A shorter inpatient Hospital stay may be provided if a Physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn child meet the appropriate guidelines for a shorter stay, based upon an evaluation of the mother and newborn child and taking into consideration the availability of a post-discharge visit within forty-eight (48) hours following the discharge, with either a Physician in his office or with an R.N., or L.P.N. supervised by an R.N., in the child's home.

A mother and newborn child are considered separate persons for all purposes under the Plan, except that routine inpatient Hospital nursery charges are available for the child even if the mother is covered under the Plan and there is no dependent coverage in effect at the time of birth to provide benefits under the Plan for the child.

(e) Mental Illness/Substance Abuse

Notwithstanding any provision herein to the contrary, benefits available for treatment of Mental Illness or for Substance Abuse are limited as described in the Schedule of Benefits. In addition, benefits are only available for treatment of Mental Illness for services provided by or under the direction of a Physician, psychologist or licensed clinical social worker.

(f) Benefits Obtained from a Non Preferred Provider - Refer to Addendum A for Preferred Provider Listing

The Employer has entered into one or more Preferred Provider Agreements with certain health care service providers. Those participating providers are designated as Preferred Providers. As a result, benefits under the Plan vary significantly as described in the Schedule of Benefits depending on the use or non-use of Preferred Providers. A complete listing of all Preferred Providers is available free of charge from the Employer and the internet and is subject to change at any time. Refer to Addendum A.

Notwithstanding the above, care obtained from a non-Preferred Provider shall be considered to be received from a Preferred Provider if (i) the care is not available at a Preferred Provider within the service area of the provider providing the care and (ii) any additional time to transport the patient to a Preferred Provider would jeopardize the patient's health

Limitations Dental/Vision Option 2

(1) Shared Expenses/Coinsurance

Notwithstanding any provision herein to the contrary, during each calendar year, a Covered Person or Covered Dependent shall be responsible for a portion of Reasonable and Customary Expenses Incurred pursuant to this Dental Benefits Section as specified in the Schedule of Benefits.

(2) Maximum Dental Benefits

Notwithstanding any provision herein to the contrary, the maximum annual dental benefits available for each Covered Person or Covered Dependent shall not exceed the amounts specified in the Schedule of Benefits.

(3) Limitations

The following limitations apply to benefits provided pursuant to this Section in addition to those limitations specified elsewhere in the Plan. Pursuant to these additional limitations, no benefits will be provided under this Section for:

(A) Dental Services not ordered by a Physician or dentist;

(B) Dental Services which do not meet the standards set by the American Dental Association;

(C) Dental Services incurred due to loss or theft of dentures or bridges;

(D) Dental Services obtained for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance;

(E) Hospital charges related to dental extractions, periodontal treatments, fillings or crowns;

(F) Implants or bridges involving implants;

(G) Placement of crowns, bridges, and dentures or the relining of a denture more than once per five (5) year period;

(H) Athletic mouth guards, appliances for harmful habits and splinting;

(I) Counseling and oral hygiene; and

(J) Temporomandibular joint syndrome or any other procedure to alter vertical dimension.

CLAIM PROVISIONS

Annual Information Statement

An annual information statement must be completed each year by the Covered Person and properly signed as required by the Employer. The completed form must be submitted to the Contract Administrator. The procedures outlined below must be followed by Covered Persons and Covered Dependents ("claimants") to obtain payment of benefits under the Plan.

Benefit Claims

(a) Discretion of Plan Administrator

All claims must be filed with the Contract Administrator or other appropriate entity as directed by the Plan Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with applicable law. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan is delegated to the Contract Administrator orother appropriate entity as directed by the Plan Administrator, provided, however, that the Contract Administrator or other appropriate entity, is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

(b) When Claims Must Be Filed

Claims must be filed with the Contract Administrator within one (1) year of the date charges for the service was incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

(c) 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 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 no later than 90 days after a claim is denied. A decision on the appeal will be sent to you within 60 days after an appeal with sufficient details is received. Geneseo CUSD #228's decision on an appeal shall be final and not subject to litigation.

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Contract Administrator. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

Facility of Payment

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.

Minor or Incompetency

If a Covered Person or Covered Dependent is a minor or, in the opinion of the Contract Administrator, not competent to give a valid receipt for payment of any benefit due him under the Plan and if no request for payment has been received by the Contract Administrator from a duly appointed guardian or other legally appointed representative of that person, the Contract Administrator may, at its option, make direct payment to the individual or institution appearing to the Contract Administrator to have assumed the custody or the principal support of that person.

Discharge

Any payment by the Contract Administrator in accordance with these provisions will discharge the Employer and the Contract Administrator from all further liability to the extent of the payment made.

Time Limitations

If any time limitations provided in the Plan for giving notice of claims, furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

Claims Mistakenly Paid

The Contract Administrator shall have the right to recover any payment of claims which have been mistakenly paid on behalf of a claimant. This includes the right to recover benefits paid on the basis of claims filed which were fraudulently or intentionally misstated by the claimant. The claimant will be notified in writing and given an opportunity for review in accordance with the claims procedures herein. A payment by the Contract Administrator in accordance with the Plan is not an admission by the Employer or Contract Administrator that the Expenses Incurred with respect to which a claim for benefits is filed are eligible for benefits under this Plan.

ADMINISTRATION

Withholding of Benefit Payments

In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Contract Administrator to withhold such payment until there shall have been made an adjudication of such question or dispute which in the Employer's sole judgment is satisfactory to it, or until the Employer and Contract Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

Medical Examination

The Contract Administrator shall have the right, through a Physician of its choice, to examine an Employee or Eligible Dependent as often as may be reasonable during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

The Contract Administrator shall be entitled to receive any and all reports regarding such examinations or autopsies.

Right to Receive and Release Information

The Contract Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Contract Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other

applicable law, the Plan Administrator or Contract Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Contract Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

(a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make available protected health information in accordance with 45 C.F.R. 164.524;

(g) Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;

(j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq.* Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

Right to Recovery

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.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation/reimbursement rights.

Coordination of Benefits

In addition to benefits payable under this Plan, a Covered Person may be entitled to benefits from other plans, payable on account of the same Sickness or Injury. The other plans are those which provide benefits or services for or by reason of medical or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not, by any government or tax-supported program (including Medicare) or any similar plan or program. This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan and under all plans covering an individual exceed the total Expenses Incurred.

One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of allowable Expenses Incurred. No plan will pay more than it would have paid without this special provision.

The following rules apply to determine which plan is Primary and which plan is Secondary:

(a) If one plan has no coordination of benefits provision, it is automatically Primary.

(b) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual as a Dependent.

(c) If an individual is covered as a Dependent under two or more plans, the plan which covers the individual as a Dependent of the person whose birthday falls earlier in the year is Primary. If both individuals share the same date of birth, the plan covering the individual for the longer period of time is Primary.

(d) In the case of children of divorced parents, in the absence of court-determined responsibility, the plan covering the parent with custody is Primary. If the parent without custody has court-determined responsibility, but does not have health benefits available for children, then the plan covering the parent with custody is Primary.

(e) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual (i) as a former Employee, (ii) as a retiree, or (iii) as an individual who has elected to continue benefits under the Plan pursuant to the Continuation of Benefits Sections herein.

(f) If none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time.

Information necessary to the administration of this Section will be required at the time a claim is submitted.

Student coverage will be primary. Any coordination of benefits issue arising which is not addressed herein or within the Pan's other provisions will be settled using the NAIC guidelines adopted by the state of Illinois.

Case Management

In the case where the patient's condition is expected to be or is of a serious nature, the Employer or Contract Administrator, pursuant to the reasonable exercise of its discretion, may arrange for review and/or case management services from a professional qualified to perform such services. Upon the advice of such professional, the Contract Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result can be achieved without a sacrifice to quality of patient care.

Qualified Medical Child Support Order

The Plan shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

(a) An order which purports to be a QMCSO must be served on the Contract Administrator.

(b) The Contract Administrator shall, within twenty (20) days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

(1) a clause which creates or recognizes the existence of a dependent's right to receive benefits under the Plan;

(2) the name and last known mailing address of the Covered Person with respect to whom the order is issued and each dependent covered by the order;

(3) a reasonable description of the type of coverage to be provided by the Plan to each dependent;

(4) the time period to which the order applies; and

(5) the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

(c) An order which, in the judgment of the Contract Administrator, does not meet the requirements of a QMCSO shall be returned to legal counsel who prepared the order for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.

(d) When the Contract Administrator makes a preliminary determination that an order satisfies the requirements of a QMCSO, it shall forward the order to the Employer for review. The Employer shall make the final determination of the status of the order.

(e) The Contract Administrator shall notify all parties involved, including a designated representative of the Covered Dependent, of the Employer's decision and of the respective parties' entitlement to benefits.

Termination of Coverage

(a) Termination of Covered Person Coverage:

The coverage of any Covered Person with respect to himself shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

(1) The date the Plan is terminated, or with respect to a specific benefit, the date the specific benefit is terminated;

(2) The end of the month during which the Covered Person ceased to be in a class of employees eligible for coverage;

(3) The date beginning the period for which the Covered Person has failed to make any required contribution for coverage;

(4) The end of the month during which the Covered Person's employment with the Employer terminates; or

(5) The date of the Covered Person's death.

(b) Termination of Covered Dependent Coverage:

The coverage of any Covered Dependent shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

(1) The date coverage terminates for the Employee upon whom Covered Dependents depends for eligibility;

(2) The date such dependent ceased to be an Eligible Dependent as defined herein;

(3) The date the Plan is modified to terminate dependent coverage;

(4) The date beginning the period for which the Covered Person or Covered Dependent has failed to make any required contribution for dependent coverage, if contributions are required;

(5) The date the dependent child becomes eligible for coverage under the Plan as an Employee;

(6) The date the Plan is terminated or, with respect to a specific benefit, the date the specific benefit is terminated; or

(7) The date of the Covered Dependent's death.

(8) Covered employees who are unable to work due to illness or injury will continue in the Plan until the plan sponsor terminates employment in accordance with its own internal policy. Retired IMRF employees may continue single or family coverage under the Plan but may not add dependents or reenter the Plan once coverage is dropped. Retired certified employees age 65 or older who are not eligible for Medicare may not participate in the Plan (TRIP coverage is available). A spouse of a retired employee may continue coverage in the Plan as the subscriber if the retired employee terminates coverage to transfer to the TRS medical plan. Coverage may be continued under IMRF or COBRA. IMRF or COBRA details are available in the Superintendent's office.

Extension of Benefits

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, without regard to the continuation of benefits provisions of the Plan, benefits under the Plan can nevertheless be extended under the specific circumstances enumerated below. Any extension of benefits period provided pursuant to this Section shall postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section.

(a) Disability
If coverage under the Plan would otherwise terminate with respect to a Covered Person who is unable to work due to illness or injury, benefits may continue in the Plan under FMLA or USERRA military leave guidelines, or other employer approved leave of absence, or until the plan sponsor terminates employment in accordance with its own internal policy

(b) State Mandate, Collective Bargaining Agreement, or Employer Personnel Policy

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, benefits will continue to be provided for those individuals to the extent required by law, a collective bargaining agreement in effect with respect to the Employer, or the Employer's personnel policies.

(c) Dependent Child age 19 or over during a leave of absence from post secondary educational institution or institution of higher education.

If coverage under the plan would otherwise terminate with respect to a Covered Dependent, benefits will continue to be provided for those individuals for a Medically Necessary Leave of Absence that (i) commences while such child is suffering from a serious sickness or Injury, (ii) is certified in writing by treating Physician as suffering from a serious Sickness or Injury that the leave of absence from Postsecondary educational institution or institution of higher education is medically necessary, and (iii) terminates upon the earlier of (a) the date the leave of absence no longer meets the requirements of (i) or (ii) above, (b) the date the child is no longer an Eligible Dependent upon 12 months of extended coverage.

General Limitations

In addition to any limitations or exclusions stated elsewhere in the Plan, no benefits are payable under this Plan for Expenses Incurred:

(a) for charges which exceed the Reasonable and Customary charge for the service rendered or charges for which payment is not legally required;

(b) for treatment paid for by any agency of the United States Government or any state or political subdivision, or provided by or in a Hospital operated by any agency of the United States Government or any state or political subdivision, unless the Covered Person or Covered Dependent is legally required to pay such charges;

(c) Expenses payable by Medicare or which would have been payable had the person enrolled in Medicare, except where contrary to law.

(d) for or in connection with:

(1) Sickness or Injury for which the Covered Person or Covered Dependent is entitled to benefits under any workers' compensation law, employers' liability law, or similar laws; 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.

(2) Hospital, surgical, and medical services or supplies unless such expense is incurred upon the recommendation of a Physician for diagnosis or treatment of an Injury or Sickness;

(3) Injury or Sickness arising out of war, declared or undeclared, or service in any military forces or civilian non-combatant unit serving with such forces;

(4) services or supplies which constitute personal comfort or beautification items, television or telephone use, education or training, or expenses actually incurred by persons who are not Covered Persons or Covered Dependents;

(5) cosmetic surgery, except for treatment necessitated by accidental Injury or for correction of a congenital malformation of a dependent child evidenced in infancy.

(6) services performed by any person who is a member of the Covered Person's or Covered Dependent's Immediate Family, or who normally resides in the Covered Person's or Covered Dependent's home;

(7) suicide, attempted suicide, or intentionally self-inflicted Injury or Sickness (to the extent allowed by law);

(8) services, supplies or treatments not Medically Necessary for the diagnosis and/or treatment of an active Sickness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value; or drugs not approved for use by the U.S. Food and Drug Administration;

(9) charges incurred outside the United States if the Covered Person or Covered Dependent traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies;

(10) hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, immunizations or tests not connected with the actual Sickness or Injury, except as otherwise specified herein;

(11) routine hearing examinations;

(12) the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices except as otherwise specified herein. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery;

(13) replacement of glasses lenses after cataract surgery when a prescription change is not required;

(14) professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's or Covered Dependent's life, and unless such care is specifically listed as a benefit elsewhere in the Plan;

(15) treatment of obesity, including Morbid Obesity except as specifically listed as a benefit elsewhere in the Plan

(16) diagnosis and treatment of infertility or restoration or enhancement of fertility, including but not limited to, therapeutic injections, fertility and other drugs, Surgery, artificial insemination, in-vitro fertilization,

(17) contraceptive medications, devices or appliances, including the administration of any contraceptive medication and surgical reversal of elective sterilizations;

(18) IQ testing or educational testing;

(19) vitamins or dietary supplements;

(20) elective abortions, except where necessary to preserve the life of the mother;

(21) housekeeping or custodial care;

(22) weak, unstable or flat feet, or bunions, unless an open cutting operation is performed or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed, purchase of orthopedic shoes or other devices for support of the feet, or custom molded foot orthotics;

(23) enrollment in a health, athletic, or similar club or weight loss, non- smoking or similar programs, except as otherwise specifically provided herein;

(24) purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattress or waterbeds;

(25) purchase or rental of: motorized transportation equipment, escalators, or elevators, saunas, steam baths, swimming pools, or blood pressure kits;

(26) keratotomy, keratoplasty, or other eye Surgery to correct near or far sightedness;

(27) premarital or school physical examinations;

(28) court ordered treatment;

(29) expenses denied by an HMO or other plan for lack of pretreatment approval;

(30) hair prosthesis, wigs, and hair pieces;

(31) Sex changes;

(32) penile implants, pharmaceuticals, treatment for sexual impotence, or counseling for sexual dysfunction;

(33) steroid epidurals for back pain;

(34) jaw Surgery, except for fracture repair;

(35) religious, sexual, marital, or family counseling;

(36) insulin pumps and related supplies;

(37) breast reductions or enlargements, except as specifically provided herein, or mastectomy in the absence of a malignancy, unless preapproved by the Claims Administrator;

(38) acupuncture;

(39) biofeedback;

(40) medical treatment of any complications arising from services not covered by the Plan;

(41) Any limitations on benefits contained in the Schedule of Benefits;

(42) services and supplies not specifically mentioned in the Plan; or

(e) Expenses for Experimental or Investigational Treatment.

(f) 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.

(g) 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

CONTINUATION OF BENEFITS

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specified conditions.
For the purpose of this Section, "Qualified Beneficiary" means any beneficiary defined as such pursuant to Section 607(3) of ERISA, and generally includes any Covered Person or Covered Dependent whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this Section. A Qualified Beneficiary also includes a child who is born to or placed for adoption with the Covered Person during the continuation coverage elected under this Section, provided such child qualifies as an Eligible Dependent.

Eligibility to Make Election

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

(a) the Covered Person's death;

(b) termination of the Covered Person's employment or reduction of the Covered Person's hours (whether voluntarily or involuntarily);

(c) divorce or legal separation of the Covered Person and his spouse;

(d) the Covered Person becoming entitled to Medicare benefits;

(e) a Covered Person's child ceasing to be an Eligible Dependent; or

(f) a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer if the Covered Person is a retiree.

Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation coverage if the Covered Person's termination of employment is for gross misconduct as determined by the Employer. In the case of bankruptcy proceedings as described in (f) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one (1) year before or after the date of commencement of the proceedings.

Election Period and Procedure

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending sixty (60) days after the later of (i) such date, or, (ii) if applicable under the Administrative Section, the date when the Qualified Beneficiary is notified of the right to make such election. A Qualified Beneficiary's failure to comply with the procedures and requirements established by the Employer for making the election, as described herein or in the Employer's notice of election, shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Qualified Beneficiary (or by the Covered Person or his spouse on behalf of a Qualified Beneficiary) of the election to continue coverage shall terminate the Qualified Beneficiary's right to later make an election, unless the Qualified Beneficiary revokes the waiver within the sixty (60) day election period described above. However, if a waiver is revoked, continuation coverage will be effective on the date the revocation is made and will not be retroactive to the date of the event described in the Eligibility to Make Election Section.

Benefits

A Qualified Beneficiary who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Covered Person or Covered Dependent under similar circumstances is otherwise entitled. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Qualified Beneficiary's election of continuation coverage, each Qualified Beneficiary will be entitled to benefits comparable to those available to a Covered Person or Covered Dependent under similar circumstances.

Payment for Benefits

A Qualified Beneficiary is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Qualified Beneficiaries shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium which shall be described in the Employer's notice of election form. A Qualified Beneficiary's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the Qualified Beneficiary's termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Qualified Beneficiary shall be precluded from extending, renewing, or reelecting such continuation coverage.

Duration of Continuation Coverage

A Qualified Beneficiary electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the earliest of the following events:

(a) the date eighteen (18) months after the date of a Covered Person's termination of employment or reduction in hours;

(b) the date thirty-six (36) months after the date of any other event described in the Eligibility to Make Election Section other than a Covered Person's termination of employment or reduction in hours (except that if a Covered Person who is an Employee has a termination of employment or reduction in hours entitling him to continuation coverage within eighteen (18) months of the date of his entitlement to Medicare then the period of Continuation Coverage for the Qualified Beneficiaries other than the Covered Person shall not terminate prior to the close of the thirty-six (36) month period beginning on the date the Covered Person became entitled to Medicare);

(c) the date the Employer ceases to provide any health benefit plan for any of its employees;

(d) the date the Qualified Beneficiary first becomes covered after the date of his election of continuation coverage (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or the date the Qualified Beneficiary becomes entitled to benefits under Medicare;

(e) the date which is the last day of the period for which the Qualified Beneficiary's Continuation Premium payments have been paid (regardless of any grace period if the Employer establishes such a period) as determined by the Employer; or

(f) in the case of a Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act ("Act"), to have been disabled at any time during the first sixty (60) days of continuation coverage, the earlier of (i) the date twenty-nine (29) months after the date of the commencement of such continuation coverage, but only if the Qualified Beneficiary has provided notice of such determination under ERISA Section 606(3) within sixty (60) days of the receipt of the determination notice under the Act and before the expiration of eighteen (18) months from the date of occurrence of the qualifying event, or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

If more than one event that would entitle the Qualified Beneficiary to elect continuation coverage occurs (as described in the Eligibility to Make Election Section herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Section. In addition, the maximum period available for continuation coverage pursuant to the Continuation of Benefits Section is measured from the date of occurrence of the qualifying event specified in the Eligibility to Make Election Section, except where specifically indicated to the contrary.

Administration

(a) Notice on Death, Termination, Reduction of Hours, or Entitlement to Medicare Within thirty (30) days of a Covered Person's death, termination of service, reduction of hours, or entitlement to Medicare, the Employer shall inform the Plan Administrator of:

(1) the Qualified Beneficiaries eligible to elect continuation coverage;

(2) the event precipitating such notice; and

(3) the date of the event.

The COBRA Notice Coordinator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect pursuant to procedures established by the Employer and applicable law.

(b) Notice of Change in Marital Status or Dependent Status

If a Covered Dependent ceases to be eligible for coverage under the Plan because that person becomes divorced or legally separated from the Covered Person, or if a child of a Covered Person ceases to be eligible for coverage under the Plan because he is no longer an Eligible Dependent, either the Covered Person, the Covered Person's former spouse or the Covered Person's child must notify the COBRA Notice Coordinator of these events within sixty (60) days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage. The notice may be provided to the COBRA Notice Coordinator orally or in writing and must disclose:

(1) the name and Plan identification numbers of the Covered Person and the individuals affected by the event;

(2) the individual's divorce, separation, or loss of status as an Eligible Dependent; and

(3) the date of such event.

Notice by a Qualified Beneficiary of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of divorce, legal separation, or change in dependent status, the COBRA Notice Coordinator, if notified within the time period specified in this Subsection (b), shall notify the Qualified Beneficiaries of their eligibility to elect continuation coverage.

(c) Notice of Disability

If a Covered Person or Covered Dependent is determined, under Title II or XVI of the Act to have been disabled at any time during the first sixty (60) days of continuation coverage, the Covered Person or Covered Dependent as the case may be must notify the COBRA Notice Coordinator of the determination under the Act within sixty (60) days of the latest to occur of the following:

(1) The date of the Social Security Administration disability determination (sometimes referred to as the "award letter");

(2) The date of the termination of employment or reduction in hours entitling the Qualified Beneficiary to COBRA continuation coverage;

(3) The date the Qualified Beneficiary otherwise loses coverage under the Plan as a result of the termination of employment or reduction in hours; or

(4) The date the Qualified Beneficiary is informed of the obligation to provide notice of disability as provided herein.

Notwithstanding the above, the notice of determination must be provided the COBRA Notice Coordinator before the expiration of eighteen (18) months from the date of occurrence of the termination of employment or reduction in hours. The notice must be provided to the COBRA Notice Coordinator in writing and must disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the determination notice provided pursuant to the Act to the disabled Covered Person or Covered Dependent. The Qualified Beneficiaries must also notify the COBRA Notice Coordinator in writing within thirty (30) days of the date of any final determination under the Act that the Covered Person or Covered Dependent is no longer disabled. The notice shall disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the final determination Notice provided pursuant to the Act that the person is no longer disabled.

(d) Notice of Coverage Under Group Health Plan or Entitlement to Medicare

If a Qualified Beneficiary (i) becomes covered (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or (ii) becomes entitled to benefits under Medicare, the Qualified Beneficiary must notify the COBRA Notice Coordinator of such event in writing within thirty (30) days of such coverage date.

(e) General

(1) Multiple Events. If more than one event described in the Eligibility to Make Election Section occurs, the first such event occurring will determine which one of either Subsection (a) or (b) of this Section is applicable.

(2) Notices to Employer. Notices to the COBRA Notice Coordinator shall be provided to the COBRA Notice Coordinator listed on the General Information Section. If no COBRA Notice Coordinator is listed on the General Information Section then the Employer shall be considered the COBRA Notice Coordinator and notices shall be provided to the person or organizational unit of the Employer that customarily handles employee benefits matters of the Employer.

(3) Current Addresses. The notification of election rights under COBRA will generally be made by U.S. Mail to the Qualified Beneficiary's last known address. As a result, it is important for each Covered Person and Covered Dependent to timely provide the Employer with his current mailing address.

(4) Interpretation. In the event of any inconsistency or omission, this Section and the applicable provisions of the Plan shall be construed, interpreted, and administered in a manner which meets the minimum requirements of COBRA.

Election and Duration of Coverage

A Covered Person may elect to continue coverage under the Plan for himself and his Covered Dependents if coverage would otherwise cease under the Plan due to that person's absence from employment with the Employer or Subsidiary by reason of his service in the uniformed services. The maximum period of coverage available to all Covered Persons and Covered Dependents under the provisions of this Section shall be the lesser of:

(a) the twenty-four (24) month period beginning on the date on which the Covered Person's military leave began; or

(b) the day after the date on which the Covered Person fails to apply for or return to a position of employment with the Employer or Subsidiary following the expiration of the leave as set forth in Section 4312(e) of USERRA.

Benefits

Benefits under the Plan for Covered Persons and Covered Dependents under an election for military leave continuation coverage shall be the same coverage as provided to all other Covered Persons and Covered Dependents. If Benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Covered Persons and Covered Dependents.

Payment for Benefits

A Covered Person is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of coverage shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Covered Person's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Covered Person shall be precluded from extending, renewing, or reelecting such continuation coverage.

Employee Returning from Military Leave

In the case of a Covered Person whose coverage under the Plan was terminated by reason of service in the uniformed services, the Covered Person and his Eligible Dependents shall again be eligible for coverage under the Plan immediately upon return to active work. In addition, no other Plan limitation or exclusion shall apply to such returning Employee and his Eligible Dependents to the extent that such limitation or exclusion would not have applied had the

Employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Sickness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

FAMILY AND MEDICAL LEAVE

In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions.

A Covered Person who takes a leave of absence under applicable provisions of FMLA is entitled to continued coverage under the Plan for himself and his Covered Dependents. Benefits under the Plan are available to the same extent as if the Covered Person had been actively at work during the entire leave period, subject to the following terms and conditions:

(a) Coverage shall cease for a Covered Person (and his Covered Dependents) for the duration of the leave if at any time the Covered Person is more than thirty (30) days late in paying any required contribution.

(b) A Covered Person who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

(c) If a Covered Person who is a Key Employee does not return from leave when notified by the Employer or Subsidiary that substantial or grievous economic injury will result from his reinstatement, the Key Employee's entitlement to Plan benefits continues unless and until the Covered Person advises the Employer or Subsidiary that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.

(d) Any portion of the cost of coverage which had been paid by the Covered Person prior to the leave, must continue to be paid by the Covered Person during the leave. If the cost is raised or lowered during the leave, the Covered Person shall pay the new rates. If the leave is unpaid, the Covered Person and the Employer shall negotiate a reasonable means for paying the Covered Person's portion of the cost.

(e) If the Employer or Subsidiary provides a new health plan or benefits or changes the health benefits or Plan while the Covered Person is on leave, the Covered Person is entitled to the new or changed plan and benefits to the same extent as if the Covered Person were not on leave.

(f) The Employer or Subsidiary may recover its share of the cost of benefits paid during a period of unpaid leave if the Covered Person fails to return to work after the Covered Person's leave entitlement has been exhausted or expires, unless the reason the Covered Person does not return to work is due to (i) the continuation, recurrence, or onset of a

serious health condition which would entitle the Covered Person to additional leave under the FMLA; or (ii) other circumstances beyond the Covered Person's control. If a Covered Person fails to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the Employer or Subsidiary from recovering its share of the cost of benefits paid on the Covered Person's behalf during a period of unpaid leave, the Employer or Subsidiary may require medical certification of the Covered Person's or the Covered Dependent's serious health condition. The Covered Person is required to provide medical certification within thirty (30) days from the date of the Employer's or Subsidiary's request. If the Employer or Subsidiary requests medical certification and the Covered Person does not provide such certification in a timely manner, the Employer or Subsidiary may recover the costs of benefits paid during the period of unpaid leave.

MISCELLANEOUS

Non-alienation of Benefits

Benefits payable under this Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse or for any other relative of a Covered Person or Covered Dependent, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder, shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Invalid Provision

If any term or provision of this Plan or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

Governing Law

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Illinois where it has been executed, except where preempted by federal law.

Amendment/Termination

It is the intention of the Employer to maintain the Plan indefinitely. However, the Employer may amend or terminate the Plan at any time, provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a Covered Person or Covered Dependent shall have become entitled prior to such amendment or termination of the Plan.

Exclusive Benefit/Legal Enforceability

The Plan has been established, and is being maintained, for the exclusive benefit of the Employees of the Employers. The Plan terms as provided herein are legally enforceable by the Employees.

INTERPRETATION OF THE PLAN

Final authority for interpretation of the terms and provisions of the Plan is vested in the Employer. Any interpretation so required by the Employer shall be made in good faith, subject to reasonable care and prudence, and all such interpretations are final. The Employer shall have discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

DEFINITIONS

Ambulatory Surgical Facility: Means any public or private establishment, which is either independent or part of a Hospital, with:

(a) an organized medical staff of Physicians;

(b) permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

(c) continuous Physician and Registered Nursing services whenever a patient is in the facility; and

(d) which does not provide services or other accommodations for patients to stay overnight.

Ambulatory Surgical Facility does not include an office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy.

Birthing Center: Means an entity licensed, approved or authorized to provide treatment for persons during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. Such entity must:

(a) provide skilled nursing care by or under the supervision of Registered Nurses;

(b) be staffed and equipped to provide Emergency Treatment; and

(c) have written back-up arrangements with a local Hospital to provide follow-up Emergency Treatment.

Covered Dependent: Means an Eligible Dependent of any Covered Person for whom coverage became effective and has not terminated.

Covered Person: Means an eligible Employee whose coverage under the Plan became effective and has not terminated.

Disability: Means the Covered Person is completely unable, as a result of Sickness or Injury, to engage in any gainful occupation for which he is reasonably fitted by education, training, or experience, and is not performing work of any kind for wage or profit.

Eligible Dependent: An Employee's lawful spouse under Illinois law, and unmarried natural or adopted child or child where adoption is pending and primarily dependent on you for support. The term child will include a step-child or other child for whom you have assumed legal custody when such child resides in your home and is primarily dependent upon you for support. Children who meet this definition may continue coverage to their 26th birthday (30th birthday if a veteran who resides in Illinois and was honorably discharged) whether or not the child is a full time student. If you have a child that is not currently enrolled in the Plan, you may add the child to your coverage subject to the child being unmarried and primarily dependent on you for support. Primarily dependent means you are paying for more than 1/2 of the child's support. You should contact the plan administrator if you have a child that you feel might qualify and complete an evidence of good health form. An initial enrollment will run from 1-1-2010 to 3-31-2010 for children age 19 or over and under age 26 (age 30 if a veteran residing in Illinois). Evidence of good health and the pre-existing exclusion applies. Future enrollments for qualified dependents are available each year in the final month of the Plan year for dependents who have had at least 90 days of coverage with another private or public health care plan without a 63 day gap in coverage prior to the date a signed application is received by the Plan Sponsor. Note that not meeting the more restricted IRS definition of dependent may cause contributions and/or benefits to be taxable

Emergency Treatment: Means treatment required for accidental Injury or treatment of a sudden and unexpected Sickness which is life threatening or has such severe symptoms that the absence of immediate medical attention could result in serious and permanent medical consequences.

It shall not include treatment of symptoms of a chronic condition unless such symptoms are sudden, unexpected and severe.

Employee: Means a person employed by the Employer.

Employer: Means Geneseo Community Unit School District #228.

Expenses Incurred: Means charges for purchases or services rendered. An expense will be deemed to be incurred on the day the purchase is made or on the day the service is rendered for which the charge is made.

Experimental or Investigational Treatment: Services that are considered investigational, experimental or not medically necessary under Medicare criteria.

Full-Time Employee: Means an Employee who is classified by the Employer or Subsidiary as a full-time employee.

Home Health Care Agency: Means an organization, or its distinct part, which:

(a) is primarily engaged in providing skilled nursing care and other therapeutic services for, and in the private residences of, persons recovering from Sickness or Injury;

(b) qualifies as a home health care agency under Medicare and is licensed or approved according to any applicable state or local standards and is operated pursuant to policies established by a professional staff, including at least one (1) Physician and one (1) Registered Nurse;

(c) provides full-time supervision of its services by a Physician or Registered Nurse, and maintains clinical records on all of its patients;

(d) has a full-time administrator; and

(e) is not, other than incidentally, engaged in providing care or treatment of the mentally ill, or in providing custodial type care.

Home Health Care Plan: Means a program of continued care and treatment for a Covered Person or Covered Dependent, established and approved in writing by the Physician of the Covered Person or Covered Dependent. The program must be accompanied by the Physician's certification that the proper treatment of the Sickness or Injury would require confinement as a Hospital inpatient in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice: Means an entity licensed, approved or authorized to provide inpatient and at home medical relief of pain and supportive care to terminally ill persons. An inpatient facility must have on its premises:

(a) organized facilities to care for and treat terminally ill persons; and

(b) a paid staff of medical professionals to supervise such care and treatment.

Hospital: Means an institution constituted and operated in accordance with the laws pertaining to Hospitals, equipped with permanent facilities for diagnosis, Surgery, twenty-four (24) hour continuous nursing service by Registered Nurses, and a staff of one or more Physicians licensed to practice medicine available at all times for compensation, and provides for medical and surgical treatment for Injury and Sickness on an inpatient basis. The term Hospital does not include a facility specializing in dentistry or an institution which is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a convalescent home or a nursing home.

Hospital Confinement/Admission: Means being registered as a bed patient in a Hospital upon the recommendation of a Physician, or as a patient in a Hospital because of a surgical operation, or as a patient receiving emergency care in a Hospital for an Injury.

Immediate Family: Means a person's spouse and children.

Injury: Means accidental bodily injury of a Covered Person or Covered Dependent. All Injuries sustained by a Covered Person or Covered Dependent in connection with a single accident shall be considered one Injury.

Intensive Care Unit: Means a section, ward or wing within the Hospital which is separated from other Hospital facilities and:

(a) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;

(b) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and

(c) provides Room and Board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Licensed Practical Nurse: Means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing service by the state in which he performs such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Medically Necessary: Means health care services, supplies or treatment which are appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

Medically Necessary Leave of Absence: Means a leave of absence of a Covered Dependent child age 19 or over from a postsecondary educational institution or institution of higher education that (i) commences while such child is suffering from a serious Sickness or Injury, (ii) is certified in writing by treating Physician as suffering from a serious Sickness or Injury and that the leave of absence from postsecondary education institution or institution of higher education is medically necessary, and (iii) terminates upon the earlier of (a) the date the leave of absence no longer meets the requirements of (i) or (ii) above, (b) the date the child is no longer an Eligible Dependent

Mental Illness: Means those illnesses classified as mental disorders in Section II of the edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

Morbid Obesity: Means a diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the patient.

Necessary Services and Supplies: Means any charges made by a Hospital on its own behalf for necessary medical services and supplies actually administered during any Hospital Confinement/Admission other than charges for Room and Board, Intensive Care Unit, private duty nursing or Physician's services.

Out-Patient Treatment: Means treatment at a Hospital not requiring confinement and not involving a charge for Room and Board.

Physician: Means a duly licensed M.D., D.O., D.P.M., D.M.D., D.C., D.D.S., or licensed clinical social worker who is treating within the scope and limitation of that license. The term Physician will not include the Covered Person, nor his spouse, children, brothers, sisters, or parents; nor any person residing in his household.

Pre-Existing Condition: Means a condition for which a medical expense was incurred or for which such person received medical care, treatment, consultation, diagnosis, diagnostic testing, advice, services, supplies or took prescribed drugs or medications prior to the individual's effective date.

Reasonable and Customary: Means charges made for medical services or supplies essential to the care of an individual which are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received for Sickness or Injury comparable in severity to the Sickness or Injury being treated.

Registered Nurse: Means a professional nurse who has the right to use the title Registered Nurse (R.N.) other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Room and Board: Means all charges commonly made by a Hospital or other facility on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

Sickness: Means disease, mental, emotional or nervous disorders of a Covered Person or Covered Dependent. It also includes the pregnancy of a Covered Person or Covered Dependent.

Skilled Nursing Facility: Means an institution, or a distinct part thereof, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness, and:

(a) is approved by and is a participating Skilled Nursing Facility of Medicare;

(b) has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or Registered Nurse;

(c) maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and

(d) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician.

This definition does not include an institution operated primarily for care of the aged, or for treatment of mental disease, drug addiction, alcoholism or custodial care.

Substance Abuse: Means uncontrollable or excessive abuse of any addictive substance and the resultant physiological or psychological dependence which develops with continued use, requiring medical treatment as determined by a Physician.

Substance Abuse Treatment Facility: Means a facility (other than a Hospital) whose primary function is the treatment of alcohol and Substance Abuse and which is duly licensed by the appropriate state and local authority to provide such services.

Surgery: Means operative or cutting procedures including specialized instrumentations and the correction of fractures or complete dislocations.

ADDENDUM A

GENESEO SCHOOL DISTRICT #228
HEALTH CARE PLAN

Preferred Provider Organization (PPO)

BENEFITS

For

EMPLOYEES OF

Geneseo School District #228

Trinity PHO

You may access the most current listing of providers at:
www.mutualmedical.com

Hammond-Henry Hospital
600 N College Avenue
Geneseo IL 61254
309-944-69431

Kewanee Hospital
1051 W South Street
Kewanee IL 61443
309-853-3361

Mercer County Hospital
409 NW 9th Avenue
Aledo IL 61231
309-582-5301

OSF Saint Francis Medical Center
530 NE Glen Oak Avenue
Peoria IL 61637
309-655-2000
(Pre-authorization Required)

University of Iowa Hospitals & Clinics
200 Hawkins Drive
Iowa City IA 52242
563-356-1616
(Pre-authorization Required)

OSF Saint Mary Medical Center
3333 N Seminary Street
Galesburg IL 61401
309-344-3161

Trinity Medical Center – 7th Street Campus
500 John Deere Road
Moline IL 61265
309-779-5000

Trinity at Terrace Park
4500 Utica Ridge Road
Bettendorf IA 52722
563-742-5000

Trinity Medical Center – West Campus
2701 17th Street
Rock Island IL 61201
309-742-5000

Unity HealthCare
1518 Mulberry Avenue
Muscatine IA 52761
563-264-9100

ADDENDUM B

GENESEO SCHOOL DISTRICT #228
HEALTH CARE PLAN

PRESCRIPTION DRUG CARD PLAN

BENEFITS

For

EMPLOYEES OF

Geneseo School District #228

TABLE OF CONTENTS

I. INTRODUCTION:

The purpose of the Plan is to enable Eligible Persons to purchase Covered Drugs from a Pharmacy by paying only a portion (the Copayment Amount) of the full price of the particular drug. Covered Drugs are purchased from a Pharmacy by presenting to the Pharmacy both a Prescription Order (unless a refill) for the Covered Drugs and an Identification Card. The Plan will be responsible for payment of all amounts in excess of the Copayment Amount. Without the Plan, Covered Drugs could only be purchased by paying full price, which in most cases would be more than the Copayment Amount.

II. ELIGIBILITY AND PLAN PARTICIPATION:

1. Eligibility Requirements.

You and your Dependents will be eligible to participate in the Plan when you and your Dependents have satisfied the eligibility requirements for benefits under the terms of the Health Plan.

2. Participation.

You and your Dependents will begin participation on the first day which you and your Dependents have met the eligibility requirements. When you become a Participant in the Plan, the Employer will issue you an Identification Card. You must present your Identification Card at the time you purchase Covered Drugs from a Pharmacy in order to take advantage of the Plan's benefits.

III. DEFINITIONS:

CODE - Means the Internal Revenue Code of 1986, as amended from time to time.

COPAYMENT AMOUNT - Means the amount which an Eligible Person is required to pay for a Covered Drug in accordance with the Health Plan.

COVERED DRUG - Means any Prescription Legend Drug and such other drugs as may be set forth from time to time on the list maintained by the Employer, and made a part of the Plan, when ordered by a Physician by means of a Prescription Order.

DEPENDENT - Means an individual who meets the definition of a Covered Dependent as set forth in the Health Plan.

ELIGIBLE PERSON - Means an individual described in an Identification Card who is entitled to Covered Drug expense benefits in accordance with and under the terms of the Plan, and his/her Dependents.

EMPLOYEE - Means a person employed by the Employer or Subsidiary.

EMPLOYER - Means Geneseo School District #228.

HEALTH PLAN - Means Geneseo School District #228 Health Care Plan.

IDENTIFICATION CARD - Means a card or cards issued as proof of eligibility for Covered Drug expense benefits in accordance with and under the terms of the Plan.

PARTICIPANT - Means an Employee who has satisfied the Eligibility Requirements and has elected to participate in the Plan.

PHARMACY - Means a pharmacy doing business as a licensed pharmacy under an applicable state license or registration number and which has entered into a Prescription Drug Agreement with Express Scripts.

PRESCRIPTION LEGEND DRUG - Means any medicinal substance the label of which is required by the Federal Food, Drug and Cosmetic Act to bear the legend--"Caution: Federal Law prohibits dispensing without prescription."

PRESCRIPTION ORDER - Means a request for medication by a Physician.

PHYSICIAN - Means a doctor of medicine, a doctor of osteopathy, a doctor of dental surgery, a doctor of dental medicine or a podiatrist, who is legally licensed to prescribe medications within the scope of that license.

IV. BENEFITS

Each Eligible Person may purchase Covered Drugs from a Pharmacy by presenting their Identification Card and paying the applicable Copayment Amount. Covered Drugs may be purchased from those Pharmacies listed on the Participating Pharmacy Listing, a copy of which may be reviewed at the location of the Contract Administrator, or at such other sites as the Contract Administrator deems necessary. Pharmacies may be added to or deleted from the Participating Pharmacy Listing from time to time.

V. PENALTIES FOR IMPROPER USE:

Eligible Persons may not use their Identification Cards to obtain Covered Drugs after having received notification of the cancellation of their benefits or for persons other than Eligible Persons. Any Eligible Person who makes an improper use of his Identification Card may be guilty of a Class C misdemeanor in accordance with the provisions of Section 512-8(c) of the Illinois Insurance Code and may be liable to the Administrator or Employer for amounts the Contract Administrator or Employer has paid as a result of any improper use of his Identification Card.

The Contract Administrator may request such amounts be paid immediately, and, if not paid when due, may take appropriate action to recover such amounts.

VI. CLAIMS:

1. Filing of a Claim.

There may be certain instances in which an Eligible Person cannot use the Identification Card to receive prescription drug benefits from a Pharmacy. At those times, a claim may be submitted in accordance with the Claim Provisions Section set forth in the Health Plan for consideration of expenses incurred that exceed the Copayment Amount. The claim for prescription drug benefits must have the following information:

(a) the name of the patient;

(b) the Employee's name and social security number;

(c) the name of the Pharmacy dispensing the drug;

(d) the name, strength, and quantity of the drug dispensed;

(e) the date the drug was dispensed; and

(f) the price of the drug.

2. Denial of Claims.

If your claim for benefits is denied, the Claim Section Provisions of the Health Plan sets forth your rights regarding claims review procedures.

VII. GENERAL:

1. Questions/Forms/Information.

Any questions, requests for forms, or other inquiries should be directed to the Contract Administrator or the Employer.

2. Nondiscrimination.

It is the intent of the Employer that the Plan not discriminate in favor of any Employee or group of Employees. If the Employer determines that the Plan is discriminatory, the Employer shall select and exclude from coverage under the Plan such Participants, or reduce the contributions and/or benefits of such Participants, as shall be necessary to comply with the nondiscrimination provisions of the Code.

S.A.F.E.
FINANCIAL REPORT - FY10

REVENUE			
AMOUNT BUDGETED	ACCOUNT NUMBER	AMOUNT COLLECT.	PERCENT
$111,000.00	10R000 1790 0000	$51,384.13	46.29%
EXPENSES			
AMOUNT BUDGETED	ACCOUNT NUMBER	AMOUNT SPENT	PERCENT
Salaries			
$91,000.00	10E000 3000 1150	$46,042.68	50.60%
Life Insurance			
$64.00	10E000 3000 2210	$26.00	40.63%
Medical Insurance			
$4,642.00	10E000 3000 2220	$1,910.30	41.15%
Travel			
$0.00	10E000 3000 3320	$0.00	0.00%
Other Purchases			
$309.00	10E000 3000 3900	$0.00	0.00%
Supplies			
$850.00	10E000 3000 4100	$1,375.10	161.78%
Food			
$3,700.00	10E000 3000 4150	$1,756.06	47.46%
$100,565.00		$51,110.14	50.82%
Budget Total		Amt. Spent YTD	
Updated 11/30/09			

S.A.F.E.
9 YEAR HISTORY

SCHOOL YEAR	REVENUE	SALARY EXPENSE	LIFE INSUR. EXPENSE	MEDICAL INSUR. EXPENSE	TRAVEL EXPENSE	OTHER PURCH.	SUPPLY EXPENSE	FOOD EXPENSE	TOTAL EXPENSES	OVER/UNDER BUDGET
2001-02	$106,826.32	$103,525.00	$98.60	$2,448.00	$93.40	$477.50	$477.50	$4,498.24	$111,618.24	-$4,791.92
2002-03	$104,271.94	$109,353.59	$119.00	$2,784.00	$79.29	$643.44	$643.44	$4,140.82	$117,763.58	-$13,491.64
2003-04	$113,626.68	$112,694.59	$122.40	$3,066.00	$165.41	$836.50	$836.50	$3,219.90	$120,941.30	-$7,314.62
2004-05	$113,127.11	$116,511.13	$156.40	$3,278.88	$57.41	$902.50	$902.50	$4,006.71	$125,815.53	-$12,688.42
2005-06	$121,690.39	$117,666.77	$112.80	$3,525.36	$9.04	$640.00	$2,387.64	$3,621.86	$127,963.47	-$6,273.08
2006-07	$135,378.96	$123,488.36	$62.40	$3,844.02	$0.00	$300.00	$833.10	$3,579.08	$132,106.96	$3,272.00
2007-08	$118,307.54	$106,392.77	$62.40	$4,228.38	$0.00	$345.00	$1,172.97	$3,113.86	$115,315.38	$2,992.16
2008-09	$110,592.52	$85,487.40	$62.40	$4,507.20	$0.00	$300.00	$835.38	$4,076.39	$95,268.77	$15,323.75
2009-10	$51,384.13	$46,042.68	$26.00	$1,910.30	$0.00	$0.00	$1,375.10	$1,756.06	$51,110.14	$273.99
TOTALS	**$975,205.59**								**$997,903.37**	**-$22,697.78**
	Updated 11/30/09									

S.A.F.E. RATE COMPARISON
Current Rates as of November 12, 2009

PROGRAM	BEFORE SCHOOL	AFTER SCHOOL	BEFORE AND AFTER SCHOOL	ALL DAY
Growth-Geneseo	$15.00	$15.00	$15.00	27.50*
Wonders of Children - Geneseo	$6.40	$9.00	$12.00	$25.00
S.A.F.E. - Geneseo	$6.50	$9.00	$11.75	$24.00
*Breakfast and lunch served - included in price				
ALL Programs provide A.M. and P.M. snacks.				
	Updated 11/30/09			

SAFE RATES

EFFECTIVE 6/1/08 - CURRENT RATES - NO INCREASE IN 2009

Before School		1st Child	$6.50	4% increase
		2nd Child	$5.75	
		3rd Child	$5.25	
After School		1st Child	$9.00	2.9% increase
		2nd Child	$8.25	
		3rd Child	$7.75	
B & A School		1st Child	$11.75	6.8% increase
		2nd Child	$10.25	
		3rd Child	$9.25	
All Day		1st Child	$24.00	26.3% increase
		2nd Child	$20.00	
		3rd Child	$18.00	
Half Day - During school year only		1st Child	$14.00	7.7% increase
		2nd Child	$12.25	
		3rd Child	$11.75	
Before School AND half day (Same day; during school year)*		1st Child	$19.00	N/A
		2nd Child	$17.00	
		3rd Child	$15.00	

RECOMMENDED RATES - EFFECTIVE 6/1/10

Before School		1st Child	$6.50	No Increase
		2nd Child	$6.00	4.2% Increase
		3rd Child	$5.50	4.4% Increase
After School		1st Child	$9.00	No Increase
		2nd Child	$8.50	3% Increase
		3rd Child	$8.00	4.1% Increae
B & A School		1st Child	$12.00	2.1% Increase
		2nd Child	$10.50	2.4% Increase
		3rd Child	$9.50	2.6% Increase
All Day		1st Child	$25.00	4% Increae
		2nd Child	$21.00	4.8%% Increae
		3rd Child	$19.00	5.3% Increase
Half Day - During school year only		1st Child	$15.00	6.7% Increase
		2nd Child	$12.50	2% Increase
		3rd Child	$12.00	2.1% Increase
Before School AND half day (Same day; during school year)*		1st Child	$20.00	5% Increase
		2nd Child	$18.00	5.6% Increase
		3rd Child	$15.00	No Increase

Life Safety Amendments

Scott Johnson of Richard L. Johnson Associates, Inc. sent to ISBE the following Health/Life Safety Amendment for Northside Elementary School. This amendment is outlined below. All of the other schools in Geneseo already have an access control system. Southwest has a door monitor/buzzer system. After the School Board's approval at the December 10, 2009 meeting, this will be forwarded to the R.O.E. for their review. Approval from the State will then follow.

GENESEO CUSD #228 LIFE SAFETY AMENDMENT – 12/10/09

Location	Item	Amend. #	Amount
Northside	Install a card access control system including electronic strikes, card readers, control panels, and wiring. Also install a camera, monitor, and buzzer for the front door entry.	#19	$16,000
	10% Contingency		$ 1,600
	A/E Fees		$ 250
	TOTAL		**$17,850**

Jack Schlindwein

Geneseo Community Unit School District No. 228

209 SOUTH COLLEGE AVENUE • GENESEO, ILLINOIS 61254 • (309) 945-0450 • FAX: (309) 945-0445
www.geneseoschools.org

Dr. Joni L Swanson	Mr. Jack B. Schlindwein	Mr. Scott D. Kuffel
Assistant Superintendent	Director of Operations	Superintendent

COPIER MAINTENANCE AGREEMENT PROPOSAL
GENESESO CUSD #228

13 copiers to be placed on the maintenance agreement. All of the copiers are to be black print copiers similar in capabilities to the ones we currently have in the District. See list below for copiers that are being requested (currently, 11 copiers are on the maintenance agreement; one has been added to Millikin and one has been added to Southwest).

LOCATION	TYPE PRINTER NOW HAVE AND/OR REQUEST FOR PROPOSAL
Geneseo H.S. (4)	1. Gestener 618D w/Doc Feed, 3 paper drawer, FAX, Stand
	2. Kyocera 3035 w/Doc Feed, HDD, LCC, Fax
	3. Kyocera 5035 with Doc Fee, LCC, HDD
	4. Toshiba E-Studio 45 w/Doc Feed, LCC, HDD
Geneseo M.S. (1)	1. Kyocera 5035 with Doc Fee, LCC, HDD
Millikin (2)	1. Kyocera 5035 with Doc Fee, LCC, HDD
	2. Kyocera 5035 with Doc Fee, LCC, HDD
Northside (2)	1. Kyocera 5035 with Doc Fee, LCC, HDD
	2. Kyocera 5035 with Doc Fee, LCC, HDD
Southwest (2)	1. Kyocera 5035 with Doc Fee, LCC, HDD
	2. Kyocera 5035 with Doc Fee, LCC, HDD
Unit Office (1)	1. Kyocera 5035 with Doc Fee, Stapler/Finisher, LCC, HDD, Print/Scan
Rock River (1)	1. Kyocera 3035 w/Doc Feed, HDD, Stand

1. NO color copiers should be in placed in the buildings.
2. NO printers are to be calculated into the price quote.
3. ALL copiers are to have IP Printing capabilities.
4. The copier company will assist the District's technology specialists in the conversion of computers to copier printing capabilities.
5. A five year contract will be developed. The beginning date for the contract will be February 3, 2010 and it will conclude on February 2, 2015.
6. For the first year of the contract, February 3, 2010 to February 2, 2011, the price quoted should be for 4,000,000 (four million) copies per year. This quote should be **cost per copy**, and it should include the following:

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Assistant Superintendent	Director of Operations	Superintendent

A. ALL service, parts, drums, developers, etc. to the machines are included in this price. The service on a non-operating machine is expected within 24 hours of the service call (unless parts need to be ordered). This is a TOTAL maintenance, service agreement. The only items excluded are paper and staples for the machines.

B. Toner for the machines is included.

C. **All new machines**. The company providing the service is the owner of the machines, NOT the school District. The signed agreement will not include any leasing or purchasing components. At the end of the five year contract, the machines are property of the maintenance company.

7. Before agreeing to a contract, the maintenance company must present the District with specifications and literature related to the proposed copiers.
8. NO mileage fees will be added on to the contract, and this should be stated in the service contract.
9. At the end of the first year, and every year thereafter, the District will either be accessed an additional 50% cost per copy over the 4,000,000 copies per year allotment OR credited at 50% cost per copy under this yearly figure.
10. Before December 1, 2010, the maintenance company and the Director of Operations will meet to review the contract. At this time, the option of adding printers to the contract can be reviewed and discussed.
11. Five (5) references regarding the company's maintenance capabilities, within a 50 mile radius of Geneseo, IL, must be attached to this proposal. Three (3) of these references must be school districts.
12. The cost proposal is due at the Geneseo Unit Office by **Nov. 30, 2009**.

Cost per copy (based on 4,000,000 per year) **$_____ per copy**

Company _____

Address _____

City/State/Zip _____

_____ _____

Signature **Date**

COPIER MAINTENANCE AGREEMENT
5 YEAR TOTAL SERVICE

11/30/09

COMPANY	COST PER COPY BASED ON 4,000,000 COPIES PER YEAR	COST PER YEAR	COST PER MONTH
RK DIXON DAVENPORT, IA	0.01237	$49,480.00	$4,123.33
OMC ROCK ISLAND, IL	**0.01050**	**$42,000.00**	**$3,500.00**
ADVANCED BUSINESS SYSTEMS MOLINE, IL	0.01130	$45,200.00	$3,766.67
SBM STERLING, IL	NO BID		

GENESEO SCHOOL DISTRICT #228

Bid Opening 11/30/09 2:00 P.M.

KITCHEN EQUIPMENT

BIDDER	PRESSURE STEAMER		Delivery/Warranty
Central Restaurant Products	Vulcan# C24GA10 ~~$11,899.00~~	2 compartment steamer smaller than size on bid	4 week lead time 1 year limited parts & labor
Edward Don	Cleveland# PGM200-3 $17,474.57		21 days 1 year standard
Hawkeye Food Service	Cleveland# PGM200-3 $17,750.00		3-4 weeks -
Reinhart Food Service School Promotion for Cleveland equipment	**Cleveland# PGM200-3 $16,750.00**	**Additional $580 with filter system**	**21 days 2 yr parts & labor. 3rd year on water related components if shipped w/filter.**
Star Food Service	Southbend# GC-3S (85) $19,623.00		25 working days (5wks) 1 year

The sealed bid results for the pressure steamer replacement at the high school are shown above. The bid from Central restaurant has been thrown out as the steamer that was bid is smaller than the bid specifications. We would like to recommend that we purchase the Cleveland Pressure Steamer from **Reinhart Food Service** who has the lowest bid and meets specifications. We have asked our maintenance department to review the specs to see if they can install, otherwise there will be an additional fee for installation.

Jack Schlindwein and Michele Hepner

GENESEO SCHOOL DISTRICT #228

Bid Opening 11/30/09 2:00 P.M.

KITCHEN EQUIPMENT

BIDDER	STEAM JACKETED KETTLE		Delivery/Warranty
Central Resturant Products	Vulcan# GL40 $12,299.00 full		4 week lead time 1 year limited parts & labor
Edward Don	Cleveland# KGL-40 $9,759.90 2/3		21 days (4wks?) 1 year standard
Hawkeye Food Service	Cleveland/Groen? $10,150.00		3-4 weeks -
Reinhart Food Service School Promotion for Clevland equipment	Cleveland# KGL-40 $9,962.00 2/3		21 days (4wks?) 2 yr parts & labor. 3rd year on water related components if shipped w/filter .
Star Food Service	Southbend# KSLG-40 (85) $9,654.00 2/3 $14,218.00 full	No specs sent	25 working days (5wks) 1 year

The sealed bid results for the steam jacketed kettle replacement at the high school are shown above. The bid specs requested a fully jacketed kettle, but most venders bid a 2/3 jacket. In the interest of fairness and competition, we would like to recommend we **reject** all kettle bids and re-bid the kettle as a 2/3 jacket. The steam jacketed kettle will be readvertised and new bids will be accepted prior to the January 14, 2010 School Board Meeting. Another recommendation will be presented at that meeting.

Jack Schlindwein and Michele Hepner