OFFICE OF THE SUPERINTENDENT

Millburn Public Schools

INFORMATION ITEM

February 1, 2010

To: Board of Education Members

From: Ellen E. Mauer, PhD

Subject: Budget Discussion

This month, our budget discussion focuses on 2 items. The first is employee benefits. Attached is a document showing a summary of our medical, dental, and vision coverage. Mary has also prepared an attachment showing what we pay for single and family coverage per employee. Catherine Loney from Professional Benefits Administrators is on hand to answer questions we may have regarding coverage.

The second discussion item is that of grade level configuration. Attached you can see this year's projections from Jason and Jake. I took the same numbers and put them in a document (also attached) to show you what it would look like with the same class size parameters, but in a K-5 and a 6-8 configuration. We would be able to cut 4 positions, saving $240,000 and have equal class sizes across the district. There are also some pros and cons listed in other impacted areas. I am sure that there are many more on both sides that we can discuss. **This document is not intended to sway anyone to change the current K-8 configuration or to indicate that it is our plan for the future. It is only presented as a budget discussion item.** We need to be able to say we have looked at all possibilities when the community asks.

PBA
Professional Benefit Administrators, Inc.

900 Jorie Boulevard, Suite 250
Phone: 630-655-3755
Toll Free: 800-435-5694
www.pbaclaims.com

Cooperative 90's

Summary of Medical Benefits

Deductible and Coinsurance	*In-Network*	*Out-of-Network*
Annual Deductible		
Single	$300	
Family	$600	
Coinsurance Percentage	90%	70%
Coinsurance Limit		
Single	$1,300	$3,300
Family	$2,600	$6,600

When the amount of covered expenses paid by you and/or all your covered dependents satisfy the out-of-pocket maximum, the plan will pay 100% of covered expenses for the remainder of the calendar year except for those benefits with specific annual or lifetime maximum benefits.

The following charges do not apply to the out of pocket maximum: office visit and prescription copayments, non-compliance penalties, infertility, substance abuse, surgical treatment of obesity, TMJ treatment, charges in excess of usual and customary and ineligible charges.

LIFETIME PLAN MAXIMUM $2,000,000

Special Plan Provisions

This Plan includes a Utilization Management Requirement. If you go into the hospital as an inpatient, need surgery on an inpatient or outpatient basis or have an emergency hospital admission you must call Bowers & Associate at 1-800-841-0276. Failure to make this call will result in benefits being paid at 70%.

Preventive Services	*In-Network*	*Out-of-Network*
Routine Exams		
Birth to age 5	90%, deductible waived	70%, deductible waived
Age 6 – Adult	100% to $100 maximum per year	
Routine X-ray and Lab		
Birth to age 5	90%, deductible waived	70%, deductible waived
Age 6 – Adult	100% to $300 maximum per year	
Routine Colonoscopy	90% after deductible	70% after deductible
HPV Vaccine	80%, deductible waived	

Outpatient Services	*In-Network*	*Out-of-Network*
Diagnostic Office Visits	$15.00 copay	70% after deductible
Outpatient Surgery	90% after deductible	70% after deductible
Diagnostic X-ray and Lab	100%	100%

Limited to $300 per calendar year. Remaining charges subject to deductible and coinsurance.

Hospital Care	*In-Network*	*Out-of-Network*
Inpatient Services	90% after deductible	70% after deductible
Surgery and Related Services	90% after deductible	70% after deductible
Preadmission Testing	100%	100%
Emergency Room	90% after deductible	70% after deductible

Other Services	*In-Network*	*Out-of-Network*
Chiropractic Care Limited to a maximum visit limit as follows:	90% after deductible Days 1-30 (16 visits) Days 31-60 (12 visits) Days 61-90 (8 visits) Days 91-180 (4 visits)	70% after deductible
Home Health Care	100% after deductible	100% after deductible
Skilled Nursing Facility	90% after deductible	70% after deductible
Ambulance Service	90% after deductible	70% after deductible

Treatment of Mental Health/ Substance Abuse	*In-Network*	*Out-of-Network*
Outpatient Treatment- Mental Health (Maximum 45 visits per calendar year, may be eligible for additional days if medically necessary)	70% after deductible	70% after deductible
Outpatient Treatment- Substance Abuse (Maximum benefit of $70 per visit, $2,500 per calendar year)	70% after deductible	70% after deductible
Inpatient Treatment – Mental Health (30 days maximum per year, may be eligible for additional days if medically necessary)	90% after deductible	70% after deductible
Inpatient Treatment – Substance Abuse ($30,000 lifetime maximum)	90% after deductible	70% after deductible

Outpatient Prescription Drug Card Benefit

Short Term - Acute Drugs

When you obtain drugs from a Participating Prescription Drug Provider, there is a copayment amount of $10.00 for generic drugs, $45.00 for brand name drugs and 20% for the cost of self-administered injectables. Benefits will be provided for the remaining eligible charge. One prescription means up to a 30 consecutive day supply of a drug.

Long Term - Maintenance Drugs - Mail Order

When you obtain drugs from the Mail Order Prescription Drug Provider, there is a copayment amount of $25.00 for generic drugs, $112.50 for brand name drugs and 20% for the cost of self-administered injectables for each prescription. Benefits will be provided for the remaining eligible charge. Maintenance drug prescription means up to a 90 consecutive day supply of a drug.

NOTE: This plan outline is intended for discussion purposes only. All benefits are subject to the provisions as outlined in the Employee Benefit Booklet.

DELTA DENTAL

Cooperative 90's

Delta Dental PPO Plan Highlights — Group #10438

Introduction

The Delta Dental PPO program allows you to go to any in- or out-of-network general or specialty dentist at the time of treatment. Cooperative 90's dental enrollees have access to two managed care networks, Delta Dental PPO and Delta Dental Premier traditional fee-for-service. When you call your dentist's office to make an appointment, ask if your dentist participates in either Delta Dental PPO or Premier network. Your out-of-pocket costs will vary depending on whether he/she participates in Delta Dental PPO, Premier or neither (i.e., "out-of-network"). **You will maximize your benefits by receiving care from a Delta Dental PPO network dentist.** There are 119,500 Delta Dental PPO and 198,000 Delta Dental Premier dentist locations nationwide.

Choosing Your Dentist

Under your Dental Plan, you may go to any in- or out-of-network general or specialty dentist. However, it is to your advantage to choose a Delta Dental PPO or Premier network dentist for the following reasons:

1) Payment to Delta Dental PPO dentists is based on pre-established, reduced fees; payment to Premier dentists is based on Delta's Maximum Plan Allowances (MPAs). In both networks, you only have to pay your copayment and deductible – *you are not responsible for charges exceeding the reduced PPO fee if you receive treatment from a Delta Dental PPO dentist or the MPA if you receive treatment from a Premier dentist.**

For example, if you need a crown, assume the Delta Dental PPO fee allowance is $500 and the MPA is $600. If your plan covers crowns at 50% and your dentist normally charges $700, your out-of-pocket cost (excluding deductible) would be:

Delta Dental PPO Dentist - $250
(50% of the $500 PPO fee allowance)

Delta Dental Premier Dentist - $300
(50% of the $600 MPA)

Out-of-Network Dentist - $400
(50% of the $600 MPA plus $100 difference between the MPA and the dentist's billed charge)

2) Because we reimburse Delta Dental PPO and Premier dentists directly, they agree to charge you no more than your copayment and deductible; in other words, *you do not have to pay the whole bill up-front and wait for reimbursement.*

3) Out-of-network dentists do not accept Delta's MPAs as payment-in-full. If an out-of-network dentist's charge exceeds the MPA, you must pay the difference plus your copayment and deductible. At the dentist's discretion, *you may also have to pay the entire bill in advance.*

4) Claim forms will be completed and submitted at no charge. Out-of-network dentists may require you to complete forms yourself or to pay a service charge.

**If your Delta Dental PPO or Premier dentist inadvertently charges you for amounts payable by Delta, please call our customer service department at 1-800-323-1743.*

Non-Covered Services

There are some limitations on the expenses for which the Cooperative 90's Dental Plan pays. For further information, refer to your certificate of coverage or call our customer service department.

Finding a Network Dentist

To verify your dentist's participation status, simply ask him/her if he/she is a Delta Dental PPO or Delta Dental Premier network dentist, call our automated phone system, contact our customer service department or visit our Web site.

Visit Delta Dental of Illinois' Web site at
www.deltadentalil.com

The Cooperative 90's Dental Plan utilizes the Delta Dental PPO and Delta Dental Premier networks. To locate a network dentist, click on Dentist Search in the Subscriber section.

You can search by:
1) City, state and ZIP code
2) Specialty
3) Dentist name (optional)

Summary of Benefits and Covered Services for Cooperative 90's as of 6/01/2009

Dependents covered to age 26	Delta Dental PPO Network	Delta Dental Premier Network	Out-of-Network
Calendar Year Maximum	$2,000/person	$2,000/person	$2,000/person
Calendar Year Deductible Applies to basic/major only	No deductible	$25/person; $75/family	$25/person; $75/family
Lifetime Orthodontia Maximum	$1,500/dependent	$1,500/dependent	$1,500/dependent
Preventive/Diagnostic • oral evaluations (two per calendar year) • x-rays (bitewings - two per calendar year; full mouth - once every three years) • prophylaxis (cleaning; two per calendar year) • fluoride treatment (once per calendar year for children under age 19) • space maintainers	100% of reduced fee* (no deductible)	100% of MPA** (no deductible)	100% of MPA*** (no deductible)
Basic • fillings • posterior composites • oral surgery (extractions including surgical removal of teeth) • periodontics (non-surgical) • endodontics • general anesthesia (in conjunction with oral surgery) • sealants	80% of reduced fee* (no deductible)	80% of MPA** (deductible applies)	80% of MPA*** (deductible applies)
Major • crowns, jackets, cast restorations • fixed/removable bridges • partial/full dentures • surgical periodontics • implants	50% of reduced fee* (no deductible)	50% of MPA** (deductible applies)	50% of MPA*** (deductible applies)
Orthodontia • for dependent children under age 19	50%	50%	50%
	*You will not be "balance" billed" for charges exceeding Delta's allowed PPO fees.	**You will not be "balance billed" for charges exceeding Delta's Maximum Plan Allowances (MPAs).	***You are responsible for charges exceeding MPAs.

The preceding information is a brief summary of Cooperative 90's Dental Plan and the services it covers. If you have specific questions regarding benefit coverage, limitations or exclusions, contact Delta Dental at 1-800-323-1743.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

Cooperative 90's Prescription Program

BeneScript®
A division of HEALTHTRANS

Co-Payments	Retail	Mail Order
Generic	$10	$25
Brand	$45	$112.50
Brand with generic available	$45 + Difference in cost*	$112.50 + Difference in cost*
Max Days Supply	100 units or 34 days	90

If a participant elects to purchase a brand name medication when a generic is available and allowed by his/her physician, he must pay the brand co-pay plus the difference in cost between the generic and brand name medication.

Mail Service 1- 877-289-0616 (toll free)
HealthTrans Mail Service
PO Box 4057
Greenwood Village, CO 80155-4057

To insure your satisfaction with mail service, it is important to remember to completely fill out the Order Form-Profile Sheet and include NEW prescriptions with your initial order. Refills may be ordered via mail request, telephone or internet.

Dependent Age Max
Effective 6/1/09, the plan will adhere to the State of Illinois regulations, providing coverage to unmarried dependents to age 26, or age 30 if a military veteran. No student status will be required.

Member Website
A member portal has been created for your plan. Within this portal you will find information and downloadable forms for items such as: Participating Pharmacies, Reimbursement, Plan Benefits and Co-payments. You may also reorder your mail service prescriptions. If your pharmacy is not listed, please call the HealthTrans Helpdesk toll-free at **1-877-839-8119.**

Your plan's site can be found at:
http://members.lc.healthtrans.com

Your Plan covers the following drugs / medications:
- Anorexics (diet pills and/or weight control agents)
- Compound medications with at least one covered Federal Legend ingredient
- Contraceptive medications (oral, emergency, patch)
- Diabetic supplies (test strips, lancets)
- Federal Legend Drugs
- Injectables 20% copay (designed for self-administration) (subject to letter of medical necessity)
- Insulin & Syringes
- Items for the treatment of sexual dysfunction (Cialis, Levitra, Viagra, etc.)
- Multiple Vitamins w/Iron (Rx only)
- Prenatal vitamins (Rx only)
- Retin A (subject to age limits)

***Prior Authorization Procedures**
1) Ask your physician to fax a letter of medical necessity to Benescript at 630-420-3919 (fax)
2) Call Benescript Member Services to verify receipt of physician letter before going to the pharmacy. 630-420-3900 or 800-531-6351

Under your plan, the following drugs or medications are *not* covered:
- Allergens
- Cosmetic Drugs
- Fertility medications
- Growth hormones
- Injectables not designed for self-injection
- Investigational or experimental drugs
- Over the counter drugs
- Smoking Deterrents
- Renova
- Replacements for lost or stolen prescriptions
- Rogaine (hair growth agents)
- Therapeutic devices, medical equipment, ostomy supplies
- Vitamins other than prenatal

Administered by BeneScript, Inc.
630-420-3900 / 800-531-6351

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TruAssure INSURANCE COMPANY

COOPERATIVE 90'S

TruAssure Complete Vision Care Program Highlights Group #10438

Introduction

TruAssure Insurance Company, a subsidiary of Delta Dental of Illinois, provides vision care insurance to you (and your family, if applicable) according to the following information. Active, full-time employees are eligible for coverage.

Vision Care Services	In-Network Member Cost	Out-of-Network Allowance
Exam with Dilation as Necessary:	$20 Copay	$35
Contact Lens Fit & Follow-up: (Available once a comprehensive eye exam has been completed)		
Standard*	$0 Copay, Paid-in-full fit and two follow-up visits	$40
Premium**	$0 Copay, 10% off retail price, then apply $55 allowance	$40
Frames: (Any available frame at provider location)	$100 allowance, 20% off balance over $100	$50
Standard Plastic Lenses:		
Single Vision	$20 Copay	$25
Bifocal	$20 Copay	$40
Trifocal	$20 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Progressive (Add-on to Bifocal)	$65	N/A
Standard Anti-Reflective Coating	$45	N/A
Other Add-Ons and Services	20% discount off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	$0 Copay, $80 allowance, 15% off balance over $80	$64
Disposable	$0 Copay, $80 allowance, plus balance over $80	$64
Visually Required	$0 Copay, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include, but are not limited to, disposable and frequent replacement)

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings, other than Standard Contact Lenses (Examples include toric and multifocal)

Additional Discounts

Member will receive a 20% discount at In-Network Providers on items not covered by the program. This discount may not be combined with any other discounts or promotional offers and the discount does not apply to contact lenses or an In-Network Provider's professional services. Retail prices may vary by location.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses at In-Network Providers once the funded benefit has been used.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.TruAssure.com. The contact lens benefit allowance is not applicable to this service.

LASIK or PRK: TruAssure members can receive a discount of 15% off retail price or 5% off promotional price from select providers. Please contact us at www.TruAssure.com or 866-723-0513 for a current list of LASIK/PRK providers.

General Information

You may choose to go to any licensed optometrist, ophthalmologist and/or dispensing optician whenever you need vision care. However, there may be significant cost advantages when you receive treatment from an In-Network Provider.

We offer two easy ways to locate an In-Network Provider 7 days a week, 24 hours a day. You can either:

- search our online Provider directory at www.TruAssure.com; or
- use the automated phone system by calling 1-866-723-0513

Using Your Vision Program

1. Have your TruAssure Information Card available when scheduling and visiting an In-Network Provider. An In-Network Provider participates in the EyeMed Vision Care Provider network.
2. Present your TruAssure Information Card at the time you receive service or materials from an In-Network Provider. Pay your copayment and any other charges not covered at the time of service. No paperwork is required. You continue to save on additional eyewear purchases any time you present your card to an In-Network Provider.
3. If you select a provider who is not in the network, you do not receive preferred pricing and you may be asked to provide full payment to your Out-of-Network Provider at the time of service. To receive benefit reimbursement, submit a completed claim form (available on our website), along with itemized receipts from your provider and your prescription to:

TruAssure Insurance Company
c/o EyeMed Vision Care
Attn: Claims Processing
P.O. Box 8504
Mason, OH 45040-7111

This TruAssure vision care program is administered by

EyeMed Vision Care

Exclusions

In no event will coverage exceed the lesser of:
1. the actual cost of Covered Services or Materials or
2. the limits of the Policy, shown in the Schedule.

Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit period.

Benefits may not be combined with any discount, promotional offering or other group benefit programs.

Benefit allowances provide no remaining balance for future use within the same benefit period.

There is no coverage for professional services or materials connected with:

1. Orthoptic or vision training, sub-normal vision aids and any associated supplemental testing;
2. Aniseikonic lenses;
3. Medical and/or surgical treatment of the eye, eyes or supporting structures;
4. Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under this program;
5. Services provided as a result of any Workers' Compensation law;
6. Plano lenses (lenses that have no refractive power), non-prescription lenses and non-prescription sunglasses (except for 20% discount);
7. Two pair of glasses in lieu of bifocals.

The preceding information is a brief summary of Cooperative 90's's Complete Vision Care Program and the services it covers.

If you have specific questions regarding benefit coverage, limitations or exclusions, contact our customer service department at 1-866-723-0513.

TruAssure INSURANCE COMPANY

A subsidiary of Delta Dental of Illinois

801 Ogden Avenue
Lisle, IL 60532
800-452-1987
www.TruAssure.com

MILLBURN SCHOOL DIST. 24

INSURANCE COSTS

TEACHER – CERTIFIED

Single – District Paid

Health Insurance	$588.00/month	
Dental Insurance	$ 35.00/month	
Vision Insurance	$ 4.07/month	
Life Insurance	$ 7.00/month	
Total Annually		$7,608.84

Family

Health Insurance	$1,166.50/month	
Dental Insurance	68.50/month	
Vision Insurance	7.73/month	
Life Insurance	7.00/month	
Total Annually		$14,996.76

NON-CERTIFIED

Single – District Paid

Health Insurance	$588.00/month	
Dental Insurance	$ 35.00/month	
Vision Insurance	$ 4.07/month	
Life Insurance	$ 7.00/month	
Total Annually		$7,608.84

Family – District Paid

SAME – FAMILY PORTION IS PAID BY EMPLOYEE

Only one non-certified employee opts for family coverage

Total of 152 employees covered
Total of 217 eligible employees