SISC III
HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
AUGUST 16, 2006 - 1:00 P.M.

A G E N D A

I. **CONSENT CALENDAR**

A. Approval of Minutes for July 2006 Board of Directors Meeting — Russell Bigler

B. Report of Activity for the Month of July 2006 and ratification of payment as follows: — Russell Bigler

DELTA DENTAL CLAIMS	$3,970,384.67	
DELTA DENTAL ASO	260,854.28	
DENTAL COALITION CLAIMS	903,739.42	
DENTAL COALITION ASO	59,375.69	
DELTACARE/PMI PREMIUM	4,631.56	
TOTAL DENTAL		$5,198,985.62
VISION SERVICE PLAN CLAIMS	$ 1,002,544.99	
ASO	81,773.20	
MES CLAIMS	$ 17,100.25	
ASO	2,735.10	
TOTAL VISION		,104,153.54
PACIFICARE/BEHAV HLTH	$ 407,796.28	
CIGNA BEHAVIORAL HEALTH	$ 18,396.96	
SEC HORIZ PREM (PACIFICARE)	$ 9,856.38	
SENIOR ADVANTAGE PREMIUM (KAISER)	$ 34,670.00	
SENIORITY PLUS PREMIUM (HEALTHNET)	$ 87,259.58	
BLUE SHIELD HMO PREMIUM	$ 1,301,535.62	
HEALTH NET PREMIUM	$ 808,672.99	
CALIFORNIA CARE PREMIUM	$ 692,954.08	
KAISER PREMIUM	$ 2,074,199.29	
PACIFICARE PREMIUMS	$ 18,164.37	
PACIFIC UNION DENTAL PREMIUM	$ 2,319.41	
UNITED HEALTHCARE (LIFE INSURANCE)	$ 157,012.20	
NAT'L BENEFIT RESOURCES (STOP LOSS)	$ 64,721.22	
BLUE CROSS HEALTH CLAIMS	$30,692,640.88	
BLUE SHIELD HEALTH CLAIMS	$ 1,330,989.81	
BEHAVIORAL HEALTH CLAIMS	$ 235,131.58	
ITS CLAIMS	$ 1,059,655.52	
COMPANION CARE CLAIMS	$ 129,857.64	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS		$ 33,448,275.43

BLUE CROSS NETWORK ASO	$ 901,212.38	
FOUNDATION ADJUDICATION ASO	$ 459,565.26	
BLUE SHIELD ASO	$ 99,155.56	
BEHAVIORAL HEALTH ASO	$ 134,436.19	
ITS ASO	$ 122,838.56	
COMPANION CARE ASO	$ 23,914.05	
TOTAL BLUE CROSS AND BLUE CHILD ADMIN		$ 1,741,122.00
TOTAL BLUE CROSS AND BLUE SHIELD		$35,189,397.43
MERCK CLAIMS	$ 9,239,026.77	
ASO-COPAY	$ 273,791.90	
M/O - DISCOUNT CARD	$ 79,164.84	
ASO - DISCOUNT CARD	$ 2,653.49	
TOTAL MERCK CLAIMS		$9,594,637.00
TOTAL BC, BSC AND MERCK		$44,784,034.43

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Financial Report - Financial Statements For Prior Month Presented For Approval — Cindy Sproles

IV. DISCUSSION AND INFORMATION ITEMS

A. Monthly Blue Cross/SISC PPO Trend History Through July 2006 — Russell Bigler

B. Provide Each Board Member With List of All Board Members — Russell Bigler

C. Mention SISC's Size at VSP — Russell Bigler

D. Show the Board an Article on Outsourcing Medical Care — Russell Bigler

E. Show the Board an Article on Wellpoint, Inc. — Russell Bigler

F. Show the Board an Article on Transparency Concerning Prescription Drug Pricing — Russell Bigler

G. Show the Board an Article on Dental Implants — Russell Bigler

H. Update the Board on Getting Prescriptions Filled at Costco — Russell Bigler

I. Comments from the Board of Directors Will Be Heard

J. Adjournment

K. Next Meeting: Wednesday, September 27, 2006
1:00 p.m.
SISC Board Room - City Centre

SISC III
HEALTH BENEFITS TERMINOLOGY

Adjudication: Determination of the amount of payment for a claim.

Administrative Services Only (ASO): An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group but does not assume any financial risk for the payment of benefits.

Balance bill: Refers to the leftover sum that a provider bills to the patient after insurance has only partially paid the charge that was initially billed.

Calendar Year Deductible: The dollar amount for covered services that must be paid during the calendar year (January 1 – December 31) by members before any benefits are paid by the Plan.

Centers of Expertise (COE) Network: The network of health care providers that have entered into contracts with the carrier and/or one or more of its affiliates. These providers have agreed to participate in a transplant program or other designated specialty program that is/are to be based upon the member's benefit agreements.

Coinsurance: An arrangement under which the member pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the member responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Coinsurance Maximum: The total amount of coinsurance that an individual pays each year before the carrier pays 100% of allowable charges for covered services. Coinsurance amounts differ with each contract.

Coordination of Benefits: The anti-duplication provision to limit benefits for multiple group health insurance in a particular case to 100% of the covered charges and to designate the order in which the multiple carriers are to pay benefits. Under a COB provision, one Plan is determined to be primary and its benefits are applied to the claim. The unpaid balance is usually paid by the secondary Plan to the limit of its liability.

Co-Payment: The fixed dollar amount a patient pays for a medical service.

Deductible: An amount the covered person must pay before payments for covered services begin. The deductible is usually a fixed amount. For example, an insurance plan might require the insured to pay the first $250 of covered expense during a calendar year.

Dependent: Person, (spouse or child), other than the subscriber who is covered under the subscriber's benefit certificate.

Employee Assistance Program (EAP): A worksite-based program that is designed to assist in the identification and resolution of productivity problems associated with personal concerns of employees. The program provides employees and their dependents with access to confidential, short-term counseling by qualified practitioners, in person or over the phone.

Explanation of Benefits (EOB): A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

Flexible Spending Account: Accounts that let workers set aside pre-tax money from their paycheck toward premiums or costs not covered by their health plan, such as co-payments. All the money must be used within the plan year or it is lost.

Health Assessment – More companies are asking workers to fill out such assessments, which give health improvement tips. Companies can give workers financial incentives to do so.

Health Insurance Portability and Accountability Act (HIPAA): A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, restricts pre-existing condition exclusion periods to ensure portability of health-care coverage between plans, group and individual; requires guaranteed issue and renewal of insurance coverage; prohibits plans from charging individuals higher premiums, co-payments, and/or deductibles based on health status.

Health Maintenance Organization (HMO): An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment; a prepaid health care plan under which people may enroll by paying a set annual fee. Members then receive all the medical services they need through a group of contracting doctors and hospitals, often with no additional copayments or fees. Members are generally limited to using providers designated by the HMO.

Health Savings Account – The accounts are paired with a high deductible. Employees can fund these accounts, tax-free, to help offset the deductible. Employers can also fund such plans. Money not used within the plan year is rolled over to the next year.

ID Card/Identification Card: A card issued by a carrier to a covered person, which allows the individual to identify himself or his covered dependents to a provider for health care services. The card is subsequently used by the provider to determine benefit levels and to prepare billing statement.

IBNR: An acronym for "incurred but not reported". This is an accounting estimate used by health plans to accrue for care that was provided "incurred" in one accounting period, but not paid or "reported" until another accounting period.

In-Network: Refers to the use of providers who participate in the carrier's provider network. Many benefit plans encourage covered persons to use participating (in-network) providers to reduce the individual's out of pocket expense.

Lifetime Maximum: Maximum amount the plan will pay toward a member's coverage in a lifetime.

Medigap: A private insurance policy purchased by many of the elderly to pay for expenses not covered by Medicare.

Negotiated Rate: The amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Open Enrollment: For employers with a dual or multiple choice of health plans, the annual time period in which employees can select among the plans offered.

Out-Of-Network: The use of health care providers who have not contracted with the carrier to provide services. HMO members are generally not reimbursed if they go out-of-network except in emergency situations. Covered persons of preferred provider organizations and HMOs with point-of-service options may go out-of-network, but must pay additional costs including deductibles and co-insurance.

Participating Provider: A physician, hospital, pharmacy, laboratory or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a health benefit plan.

Pre-Authorization: A procedure used to review and assess the medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided.

Preferred Provider Organization (PPO): A type of managed care organization that has a panel of preferred providers who are paid according to a discounted fee schedule. The enrollees do have the option to go to out-of-network providers at a higher level of cost sharing.

Reasonable and Customary: The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community) and the reasonable cost of services for a given patient after medical review of the case. Also known as Usual and Customary (U&C) or Customary and Reasonable (C&R).

Skilled Nursing Facility: An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services.

Subscriber: The individual in whose name a contract is issued or the employee covered under an employer's group health contract.

Transparency. With regard to medical care it means: The ability for patients to have easy access to understandable information about the cost and quality of their health care options. They should be able to obtain this information from their health plan and medical providers prior to the time of treatment.

SISC III

HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
WEDNESDAY, JULY 19, 2006
1:00 P.M.

M I N U T E S

The regular meeting of the Board of Directors of SISC III Health Benefits Program was called to order at 1:00 p.m. on Wednesday, July 19, 2006, in the SISC Board Room on the Fifth Floor of the Kern County Superintendent of Schools Office, 1300 17tth Street, Bakersfield, California, with the following in attendance:

MEMBERS PRESENT:
Russell Bigler
Karen Cox
Ken Hochnadel
Doug Miller
Dan Munis
Gary Pickavet
Dennis Scott

ALTERNATES PRESENT:
Paul Baxter
Richard Graham
Judy Marty
John Stenerson
Adolph Wirth

OTHERS PRESENT:
Wanda Carl
Cindy Sproles
Bonnie Bowles
Carmen Gonzeles
Cherie Payne
Lauri Phillips
Ken Hammer
Janet Clary, Kern Foundation
Steve Beargeon, FMC of Tulare
Joe Anna Reynoso – Buckman-Mitchell
Judy Fussel – Buckman-Mitchell
Dan Bly – Delta Dental of California
Kelly Cooper - Keenan
Mary Bouchard – Kaiser Permanente

CONSENT CALENDAR

Motion was made by Director Scott, seconded by Director Miller and carried to approve the Consent Calendar as follows:

Minutes. Minutes for the June 2006 Regular Board of Directors Meeting.

Report of Activity for the Month of June 2006 and Ratification of Payment as follows:

DELTA DENTAL CLAIMS	$ 4,526,744.85	
DELTA DENTAL ASO	297,407.14	
DENTAL COALITION CLAIMS	996,651.98	
DENTAL COALITION ASO	65,480.03	
DELTACARE/PMI PREMIUM	4,787.68	
TOTAL DENTAL		$5,891,071.68
VISION SERVICE PLAN CLAIMS	$ 775,710.33	
ASO	82,300.08	
MES CLAIMS	$ 14,800.91	
ASO`	2,721.00	
TOTAL VISION		$875,532.32
PACIFICARE/BEHAV HLTH	$ 405,113.05	
CIGNA BEHAVIORAL HEALTH	$ 18,541.30	
SEC HORIZ PREM (PACIFICARE)	$ 9,856.38	
SENIOR ADVANTAGE PREMIUM (KAISER)	$ 33,764.00	
SENIORITY PLUS PREMIUM (HEALTHNET)	$ 86,341.58	
BLUE SHIELD HMO PREMIUM	$ 1,638,470.14	
HEALTH NET PREMIUM	$ 846,226.00	
CALIFORNIA CARE PREMIUM	$ 703,450.88	
KAISER PREMIUM	$ 2,170,819.85	
PACIFICARE PREMIUMS	$ 10,941.16	
PACIFIC UNION DENTAL PREMIUM	$ 2,412.19	
UNITED HEALTHCARE (LIFE INSURANCE)	$ 157,367.41	
NAT'L BENEFIT RESOURCES (STOP LOSS)	$ 64,755.42	
BLUE CROSS HEALTH CLAIMS	$ 29,895,463.66	
BLUE SHIELD HEALTH CLAIMS	$ 1,487,324.83	
BEHAVIORAL HEALTH CLAIMS	$ 262,138.78	
ITS CLAIMS	$ 944,286.06	
COMPANION CARE CLAIMS	$ 114,541.87	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS		$ 32,703,755.20
BLUE CROSS NETWORK ASO	$ 906,391.09	
FOUNDATION ADJUDICATION ASO	$ 462,199.43	
BLUE SHIELD ASO	$ 88,041.94	
BEHAVIORAL HEALTH ASO	$ 135,082.13	
ITS ASO	$ 91,639.01	
COMPANION CARE ASO	$ 23,619.30	
TOTAL BLUE CROSS AND BLUE CHILD ADMIN		$ 1,706,972.90
TOTAL BLUE CROSS AND BLUE SHIELD		$34,410,728.10
MERCK CLAIMS	$ 12,759,442.12	
ASO-COPAY	$ 329,077.20	
M/O - DISCOUNT CARD	$ 145,509.37	
ASO - DISCOUNT CARD	$ 3,974.00	
TOTAL MERCK CLAIMS		$13,238,002.69
TOTAL BC, BSC AND MERCK		$47,648,730.79

PUBLIC COMMENT

ACTION ITEMS

Financial Report. Cindy Sproles reviewed with the Board the Financial Report for the period ending June 30, 2006, noting that the LAIF rate is 4.7%. After discussion, motion was made by Director Hochnadel, seconded by Director Munis and carried approving the Financial Report as presented.

Election of Vice Chairman for the 2006-2007 Fiscal Year. Director Bigler advised the Board that Article VIII(c) provides that the Board shall, at the regular July meeting of each year, elect from its membership a vice chairman, a secretary and a treasurer to serve as officers of the Board for a term of one (1) year. After discussion, motion was made by Director Miller, seconded by Director Baxter and carried appointing Dennis Scott as Vice Chairman for the 2006-2007 Fiscal Year.

Election of Secretary/Treasurer for the 2006-2007 Fiscal Year. Motion was made by Director Scott, seconded by Director Munis and carried appointing Doug Miller as Secretary/Treasurer for the 2006-2007 Fiscal Year.

INFORMATION AND DISCUSSION ITEMS

Monthly Blue Cross/SISC PPO Trend History Through June 2006. John Stenerson reviewed with the Board the Blue Cross/SISC PPO monthly trend history for the month of June 2006.

Show the Board a Newspaper Article on High Deductible Accounts. Director Bigler reviewed with the Board an article on high deductible accounts and how they are growing in popularity.

Show the Board a Newspaper Article on Holistic Dentists. Director Bigler reviewed with the Board an article from the Los Angeles Times about insurers denying claims from holistic dentists.

Review the Investment Policy. Cindy Sproles advised the Board that pursuant to Ed. Code we are required to bring the SISC Investment Policy to the Board on an annual basis. We are not requesting any changes at this time.

Update the Board on Our Prilosec OTC Program. Director Bigler reviewed with the Board a recent press release and early figures on our Prilosec OTC Program. Director Pickavet commented that he has been receiving complaints from subscribers about the 30-40 minute wait for these prescriptions at the Costco facilities in the Santa Barbara area. Director Bigler mentioned that he would check into this.

Review Policies for New Board Members. Director Bigler reviewed with the Board Policies on Public Participation at Board Meetings, Relations Between Other Governmental Agencies and Professional Organizations, Late Premium Payments, Claims Experience, and Funding Stabilization Reserve.

Retirement of Ken Hochnadel. Director Bigler announced that Ken Hochnadel is retiring from the Board effective this month and that he would be missed. Ken mentioned that John Caudle with the Tulare Office of Education, would be taking his place.

Comments From the Board. There were no comments from the Board at this time.

ADJOURNMENT

There being no further business to come before the Board, motion was made by Director Scott, seconded by Director Baxter and carried adjourning the meeting at 1:40 p.m.

NEXT MEETING

The next meeting of the Board of Directors will be held **Wednesday, August 16, 2006,** at 1:00 p.m. in the SISC Board Room on the Fifth Floor of the Kern County Superintendent of Schools Office, 1300 17th Street, Bakersfield, California.

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DOUG MILLER, Secretary

SISC III
INFORMATION ITEMS

A. **Monthly Blue Cross/SISC PPO Trend History Through July 2006** John Stenerson will review the monthly Blue Cross/SISC PPO Trend history through July 2006.

B. **Provide Each Board Member With a List of All Board Members.** (See attached list.)

C. **Mention SISC's Size at VSP.** SISC is VSP's sixth largest client in California and 21st largest throughout the United States.

D. **Show the Board an Article on Outsourcing of Medical Care.** Although this is more suited for an employee with a health plan that has a high deductible with a large copayment, this is happening more and more.

E. **Show the Board an Article on Wellpoint, Inc.** If a person doesn't understand the concept of Self-Insurance they read these articles and think this has a huge effect on their SISC premium.

F. **Show the Board an Article on Transparency Concerning Prescription Drug Pricing.** Not long ago I mentioned that we were putting in a new word "transparency" in our Health Benefits Terminology Section. John Stenerson will go over this article with us.

G. **Show the Board an Article on Dental Implants.** Dental implants are becoming more a part of dentistry.

H. **Update the Board on Getting Prescriptions Filled at Costco.** We received a response on this matter from Craig Norman, Vice President of US Pharmacy Operations for Costco. His response seemed like a pretty thorough review of how they handle things and suggests there may be some staffing issues they have already moved to address. He mentioned that their standard wait time at the Goleta location is typically around 30 minutes for patients that present in person and notify them they will wait for their prescription. This could easily swell to 40 to 45 minutes if there were any issues with the prescriptions that had to be verified or if the patient was a new customer to Costco. Given the above, additional ancillary staff were just put on the payroll in the last couple of weeks. He also mentioned that Santa Barbara is a very tough market to find qualified pharmacists and they are currently trying to fill a fulltime position but this has been supplemented with relief staff until the proper candidate is recruited.

I. **Comments From the Board of Directors.** Comments from members of the Board will be heard at this time.