SISC III
HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
MARCH 15, 2006 - 1:00 P.M.

A G E N D A

I. **CONSENT CALENDAR**

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

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

DELTA DENTAL	Claims	$ 4,237,115.84	
SISC ASO		278,378.52	
DENTAL COALITION	Claims	1,010,879.95	
DENTAL COALITION ASO		66,414.81	
DELTACARE/PMI PREMIUM		4,787.68	
TOTAL			$5,597,576.80
VISION SERVICE	Claims	$ 910,092.33	
ASO		82,346.36	
MES CLAIMS –Includes January 16-31		$ 21,691.45	
ASO – January and February		$ 5,531.10	
TOTAL			$ 1,019,661.24
PACIFICARE/BEHAV HEALTH		$ 403,893.97	
CIGNA BEHAV. HEALTH (MCC SELECT)		$ 18,368.00	
SECURE HORIZONS PREM (PACIFICARE		$ 9,866.69	
SENIOR ADVANTAGE PRE (KAISER)		$ 30,763.00	
SENIORITY PLUS PREM (HEALTHNET)		$ 81,017.25	
BLUE SHIELD HMO PREMIUM		$ 723,234.05	
HEALTH NET PREMIUM		$ 829,117.21	
CAL CARE PREMIUM		$ 684,430.46	
KAISER PREMIUM		$2,162,095.81	
PACIFICARE PREMIUM		$ 25,478.61	
PACIFIC UNION DENTAL PREMIUM		$ 2,412.19	
UNITED HEALTHCARE (LIFE INSURANCE)		$ 150,833.38	
NAT'L BENEFIT RESOURCES (Stop Loss)		$ 65,799.66	
BLUE CROSS HEALTH CLAIMS		$26,073,202.53	
BLUE SHIELD HEALTH CLAIMS		$ 1,296,153.72	
BEHAVIORAL HEALTH CLAIMS		$ 259,733.79	
ITS ASO		$ 1,008,738.25	
COMPANION CARE ASO		$ 94,076.94	
TOTAL BLUE CROSS CLAIMS			$28,731,905.23

BLUE CROSS NETWORK ASO	$ 907,130.56	
FOUNDATION ADJUDICATION ASO	$ 462,555.17	
BLUE SHIELD ASO	$ 109,252.89	
BEHAVIORAL HEALTH ASO	$ 135,830.56	
ITS ASO (INCLUDES JANUARY BLUE SHIELD	$ 80,442.92	
COMPANION CARE ASO	$ 24,169.50	
TOTAL BLUE CROSS AND BLUE SHIELD ADMIN.		$ 1,719,381.60
TOTAL BLUE CROSS AND BLUE SHIELD		$ 30,451,286.83
MERCK CLAIMS	$ 8,282,350.12	
ASO-COPAY ESTIMATE	$ 391,767.64	
M/O - DISCOUNT CARD	91,127.66	
ASO - DISCOUNT CARD	5,314.36	
TOTAL MERCK		8,770,559.78
TOTAL BC, BSC AND MERCK		$39,221,846.61

II. PUBLIC COMMENT

III. ACTION ITEMS

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

B. Request Approval of the 2006-2007 Dental Premiums — John Stenerson

C. Request Approval of the 2006-2007 Vision Premiums — John Stenerson

D. Request Approval of the 2006-2007 Behavioral Health Premiums — John Stenerson

E. Request Approval of the 2006-2007 Prescription Drug Card Premiums — John Stenerson

F. Request Approval of the 2006-2007 SISC/Blue Cross Premiums — John Stenerson

IV. DISCUSSION AND INFORMATION ITEMS

A. Show the Monthly SISC PPO Claims History Through February 2006 — John Stenerson

B. Show the Board the Calendar Showing Presentations on Plans, Rates, etc., For the 2006-2007 Fiscal Year — Russ Bigler

C. Discuss the May Board Meeting/Workshops — Russ Bigler

D. Go Over the Blue Cross Select PPO Product With the Board — Russ Bigler

E. Comments from the Board of Directors Will Be Heard

F Adjournment

G Next Meeting:
Wednesday, April 19, 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.

SISC III

HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
WEDNESDAY, FEBRUARY 15, 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 1:03 p.m. on Wednesday, February 15, 2006, in the SISC Board Room on the 5th Floor of the Kern County Superintendent of Schools Office, 1300 17th Street, Bakersfield, California, with the following in attendance:

MEMBERS PRESENT:
Russell Bigler
Dennis Franey
Nelson Heisey
Ken Hochnadel
Mike Lingo
Doug Miller
Dan Munis
Gary Pickavet

ALTERNATES PRESENT:
Richard Graham
Judy Marty
John Stenerson

OTHERS PRESENT:
Wanda Carl
Cindy Sproles
Bonnie Bowles
Carmen Gonzales
Carolyn Temple - Kern Foundation
Karen Morovich
Lauri Phillips
Jennifer Bennett
Judy Fussel, Buckman-Mitchell
JoeAnna Reynoso, Buckman-Mitchell
Cherie Payne
Lori Brackett
Mary Bouchard, Kaiser-Permanente
Jennifer Thomas – Blue Cross
Natalie Seaman – Blue Cross

CONSENT CALENDAR

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

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

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

DELTA DENTAL	Claims	$ 4,005,079.90	
SISC ASO		263,133.75	
DENTAL COALITION	Claims	753,056.20	
DENTAL COALITION ASO		49,475.80	
DELTACARE/PMI PREMIUM		4,787.68	
TOTAL			$5,075,533.33
VISION SERVICE	Claims	$ 1,070,681.21	
ASO		82,312.54	
MES CLAIMS –		$ 9,963.53	
ASO –			
TOTAL			$ 1,162,957.28

PACIFICARE/BEHAV HEALTH	$ 407,654.76	
CIGNA BEHAV. HEALTH (MCC SELECT)	$ 18,500.11	
SECURE HORIZONS PREM (PACIFICARE)	$ 10,297.99	
SENIOR ADVANTAGE PREM (KAISER)	$ 34,261.86	
SENIORITY PLUS PREM (HEALTHNET)	$ 95,055.49	
BLUE SHIELD HMO PREMIUM	$ 699,231.88	
HEALTH NET PREMIUM	$ 810,556.50	
CALIFORNIA CARE PREMIUM	$ 697,746.50	
KAISER PREMIUM	$ 2,119,293.30	
PACIFICARE PREMIUM	$ 25,478.61	
PACIFIC UNION DENTAL PREMIUM	$ 2,412.19	
LIFE – UNITED HEALTH	$ 173,141.32	
NAT'L BENEFIT RESOURCES. (STOP LOSS)	$ 64,767.96	
BLUE CROSS MEDICAL CLAIMS	$29,008,100.75	
BLUE SHIELD HEALTH CLAIMS	$ 1,379,750.85	
BEHAVIORAL HEALTH CLAIMS	$ 240,732.74	
ITS CLAIMS	$ 888,286.05	
COMPANION CARE CLAIMS	$ 132,217.04	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS		$31,650,087.43
BLUE CROSS NETWORK ASO	$ 906,185.38	
FOUNDATION ADJUDICATION ASO	$ 462,038.50	
BLUE SHIELD ASO	$ 87,884.30	
BEHAVIORAL HEALTH ASO	$ 135,202.63	
ITS ASO	$ 91,918.42	
COMPANION CARE ASO	$ 24,287.40	
TOTAL BLUE CROSS AND BLUE SHIELD ADMIN.		$ 1,707,516.63
TOTAL BLUE CROSS AND BLUE SHIELD		$33,357,604.06
MERCK CLAIMS	$ 7,769,190.27	
ASO-COPAY	$ 308,579.25	
M/O - DISCOUNT CARD	83,390.77	
ASO - DISCOUNT CARD	3,509.46	
TOTAL MERCK CLAIMS		8,164,669.75
TOTAL BC, BSC AND MERCK		$41,522,273.81

PUBLIC COMMENT

ACTION ITEMS

Financial Report. Cindy Sproles reviewed with the Board the Financial Report for the period ending January 31, 2006. The Investment Summary Report for the period October 1, 2005 through December 31, 2005 was presented as well. She advised the Board that we are continuing to monitor a couple of stocks rated Triple B by Standard and Poor's and A by Moody's. After discussion, motion was made by Director Franey seconded by Director Miller and carried approving the Financial Report as presented.

Request Approval to Support the California Health Care Coalition. Director Bigler reminded the Board that this topic has been on the Agenda several times over the past year. At the July 20, 2005, Board Meeting, the Board was asked to adopt a Resolution to Participate. At that time the Board had concerns with their stance on SB-840. SB-840 addresses the Single Payor delivery of health care insurance in California. Director Bigler reviewed with the Board the Coalition's response and advised he feels it answers the Board's concerns in such a

way that we can participate. Their goal, to reduce costs and improve medical outcomes, is something we would all agree is worth supporting. After discussion, motion was made by Director Lingo, seconded by Director Pickavet and carried approving the Resolution of the Board of Directors of the Self-Insured Schools of California Medical, Dental and Vision System Supporting the California Health Care Coalition of the California Works Foundation.

Request Approval of the 2004-2005 Independent Financial Audit. Cindy Sproles reviewed with the Board the Health and Welfare Benefits Program (SISC III) Independent Financial Audit. After discussion, motion was made by Director Lingo, seconded by Director Miller and carried to approve the audit as presented.

INFORMATION AND DISCUSSION ITEMS

Monthly SISC PPO Claims History Through January 2006. John Stenerson reviewed with the Board the SISC PPO claims history through January 2006.

Mention That 2006-2007 Rates Will Be Set At the March Board Meeting. Director Bigler advised the Board that the Rates Committee will meet at 2:00 p.m. on March 14, 2006.

Discuss an Article in the Los Angeles Times on Health Care. Director Bigler advised the Board that this article relates to what the author sees the direction the Federal Government is taking in regard to Health Care.

Update the Board on SISC's GASB-45 Program. Director Bigler advised the Board that we are starting to get requests from districts asking for presentations on GASB-45.

Discuss the State of the Union As It Relates to Health Care. The Board was advised that the President said he is going to make health care more affordable, accessible and portable. He said that one way to achieve these goals is by expanding worker participation in health savings accounts. He didn't offer any specifics.

Discuss the State of the Union As It Relates to Social Security. The Board was further advised that the President said that after failing to get Congress to take up his ideas on Social Security reform last year, he proposes forming another commission to study the issue. He said that the retirement of the baby boom generation will put staggering strains on the Social Security, Medicare and Medicaid programs – consuming almost 60 percent of the federal budget by 2030.

Share a Memo With the Board Titled "Partial Premium Holiday for Active PPO Subscriber. Director Bigler reviewed with the Board a memorandum from Central Valley Schools Health and Welfare Trust regarding a "partial premium holiday" for March 2006.

Problems With Blue Cross With Claims Payment for Spouse and Overage Dependents Will Be Discussed. Director Bigler advised the Board that Blue Cross made a change in its internal programming that is effecting its clients statewide. We have sent out information on this to the Superintendents and key contacts of SISC Blue Cross Member Districts. Blue Cross representative Natalie Seaman reviewed with the Board information on Coordination of Benefit Letters, the change of the Pursue and Pay Policy to Pay and Pursue, and Over Age Dependent Letters.

Comments From the Board of Directors. 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 Munis and carried adjourning the meeting at 2:25 p.m.

NEXT MEETING

The next meeting of the Board of Directors will be held **Wednesday, March 15, 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

March 1, 2006

TO: SISC Board of Directors

FROM: Russell E. Bigler, Chief Executive Officer
Insurance Services

SUBJECT: 2006-2007 Rates - Dental

BACKGROUND INFORMATION

The Rates Committee will meet on March 14, 2006. The Administration will have a recommendation of the 2006-2007 rates based on the actuarial and input from the Rates Committee.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the 2006-2007 rates.

REB:wkc

March 1, 2006

TO: SISC Board of Directors

FROM: Russell E. Bigler, Chief Executive Officer
Insurance Services

SUBJECT: 2006-2007 Rates - Vision

BACKGROUND INFORMATION

The Rates Committee will meet on March 14, 2006. The Administration will have a recommendation of the 2006-2007 rates based on the actuarial and input from the Rates Committee.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the 2006-2007 rates.

REB:wkc

March 1, 2006

TO: SISC Board of Directors

FROM: Russell E. Bigler, Chief Executive Officer
Insurance Services

SUBJECT: 2006-2007 Rates - Behavioral Health (Blue Cross Product)

BACKGROUND INFORMATION

The Rates Committee will meet on March 14, 2006. The Administration will have a recommendation of the 2006-2007 rates based on the actuarial and input from the Rates Committee.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the 2006-2007 rates for the Blue Cross Behavioral Health Product. The CIGNA and PacifiCare Behavioral Health Products are fully insured not self-insured.

REB:wkc

March 1, 2006

TO: SISC Board of Directors

FROM: Russell E. Bigler, Chief Executive Officer
Insurance Services

SUBJECT: 2006-2007 Prescription Drug Card Rates

BACKGROUND INFORMATION

The Rates Committee will meet on March 14, 2006. The Administration will have a recommendation of the 2006-2007 rates based on the actuarial and input from the Rates Committee.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the 2006-2007 rates.

REB:wkc

March 1, 2006

TO: SISC Board of Directors

FROM: Russell E. Bigler, Chief Executive Officer
Insurance Services

SUBJECT: 2006-2007 SISC/Blue Cross Medical Rates

BACKGROUND INFORMATION

The Rates Committee will meet on March 14, 2006. The Administration will have a recommendation of the 2006-2007 rates based on the actuarial and input from the Rates Committee.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the 2006-2007 SISC/Blue Cross Medical Rates.

REB:wkc

SISC III
INFORMATION ITEMS

A. **Monthly SISC PPO Claims History Through February 2006.** The SISC PPO claims history through February 2006 will be shown at the meeting.

B. **Show the Board the Calendar Showing Presentations on Plans, Rates, etc., for the 2006-2007 Fiscal Year**. See attached calendar. A flyer will go to each district.

C. **Discuss the May Board Meeting Workshop.** The SISC Annual Coastal Board Meeting has been scheduled for May 18 and 19, 2006, at Mandalay Beach Resort Embassy Suites in Oxnard, California. The schedule of events is as follows:

Thursday, May 18, 2006	1:30 p.m.	SISC I Board Meeting
	2:30 p.m.	SISC II Board Meeting
	3:30 p.m.	SISC III Board Meeting
	5:00-7:00 p.m.	Reception and Networking
Friday, May 19, 2006	7:00-8:30 a.m.	Breakfast
	8:30 a.m.	Program

D. **Go Over the Blue Cross Select PPO Product With the Board.** Blue Cross has put together a Select PPO product. The network, as you would imagine, is smaller. Additionally, it doesn't make financial sense in every county.

E. **Comments from the Board of Directors Will Be Heard** Comments from members of the Board will be heard at this time.

March 1, 2006

TO: Superintendents of SISC III Member Districts

FROM: John Stenerson, Deputy Executive Officer
Health Benefits

SUBJECT: Notice of Plans and Premiums Workshops for 2006/2007

The following workshops have been scheduled to review all the rates and plan options available with SISC for this coming year. These workshops represent an excellent opportunity for Superintendents, Chief Business Officials, insurance contacts and bargaining representatives to learn about all the plans and programs available through SISC.

FRESNO	Monday, April 24 10:00 A.M.	Fresno COE Conference Room 270 1111 Van Ness Avenue
MERCED	Monday, April 24 10:00 A.M.	Merced COE Clark/Newbold Room 632 West 13th Street
LAKE ELSINORE	Tuesday, April 25 10:30 A.M.	Lake Elsinore/Old Board Room 545 Chaney Street
SANTA BARBARA	Wednesday, April 26 10:00 A.M.	Santa Barbara COE Auditorium 4400 Cathedral Oaks
LAKEPORT	Thursday, April 27 11:00 A.M.	Lake COE Kesey Room 1152 S. Main Street
BAKERSFIELD	Tuesday, May 2 9:00 A.M.	University Square Conference Room US-2 2000 K Street
HOLLISTER	Wednesday, May 3 1:00 P.M.	San Benito COE Board Room 460 Fifth Street
SAN LUIS OBISPO	Thursday, May 4 10:00 A.M.	San Luis Coastal U.S.D. Conference Room J-2 1500 Lizzie Street
BISHOP	Tuesday, May 9 10:00 A.M.	Mono Title Company 873 North Main St., Bishop 2 story building behind the Sizzler
LANCASTER	Wednesday, May 10 10:00 A.M.	Antelope Valley U.H.S.D. Conference Room on 2nd Floor 44811 N. Sierra Highway

It is not necessary to have a reservation in order to attend one of our workshops.

c: District Insurance Contact Personnel
Bargaining Representatives
Brokers