SISC III
HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
SEPTEMBER 27, 2006 - 1:00 P.M.

A G E N D A

I. **CONSENT CALENDAR**

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

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

DELTA DENTAL CLAIMS	$5,402,050.73	
DELTA DENTAL ASO	355,002.76	
DENTAL COALITION CLAIMS	1,133,181.97	
DENTAL COALITION ASO	74,362.03	
DELTACARE/PMI PREMIUM	4,787.68	
TOTAL DENTAL		$6,969,385.17
VISION SERVICE PLAN CLAIMS	$ 1,131,451.37	
ASO	81,903.14	
MES CLAIMS	$ 16,578.79	
ASO`	2,751.10	
TOTAL VISION		$1,232,684.40
PACIFICARE/BEHAV HLTH	$ 403,374.19	
CIGNA BEHAVIORAL HEALTH (MCC SELECT)	$ 18,399.65	
SEC HORIZ PREM (PACIFICARE)	$ 8,479.80	
SENIOR ADVANTAGE PREMIUM (KAISER)	$ 33,766.00	
SENIORITY PLUS PREMIUM (HEALTHNET)	$ 84,036.83	
BLUE SHIELD HMO PREMIUM	$ 429,571.66	
BLUE SHIELD FULLY INSURED PPO	$ 19,584.70	
HEALTH NET PREMIUM	$ 750,284.25	
CALIFORNIA CARE PREMIUM	$ 661,358.07	
KAISER PREMIUM	$ 1,864,675.33	
PACIFICARE PREMIUMS	$ 17,933.04	
PACIFIC UNION DENTAL PREMIUM	$ 1,814.51	
UNITED HEALTHCARE (LIFE INSURANCE)	$ 95,092.53	
NAT'L BENEFIT RESOURCES (STOP LOSS)	$ 79,247.10	
BLUE CROSS HEALTH CLAIMS	$ 34,355,265.70	
BLUE SHIELD HEALTH CLAIMS	$ 1,654,310.10	
BEHAVIORAL HEALTH CLAIMS	$ 225,582.63	
ITS CLAIMS	$ 1,579,072.42	
COMPANION CARE CLAIMS	$ 160,145.81	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS		$39,974,376.66

BLUE CROSS NETWORK ASO	$ 900,047.51	
FOUNDATION ADJUDICATION ASO	$ 458,963.89	
BLUE SHIELD ASO	$ 99,786.12	
BEHAVIORAL HEALTH ASO	$ 134,365.08	
ITS SO	$ 144,899.77	
COMPANION CARE ASO	$ 22,733.60	
TOTAL BLUE CROSS AND BLUE SHIELD ADMIN		$ 1,760,795.97
TOTAL BLUE CROSS AND BLUE SHIELD		$39,735,172.63
MERCK CLAIMS	$ 9,158,145.46	
ASO-Co-Pay	$ 270,418.81	
M/O - DISCOUNT CARD	$ 85,828.35	
ASO - DISCOUNT CARD	$ 2,584.95	
TOTAL MERCK		$ 9,516,977.57
TOTAL BLUE CROSS, BLUE SHIELD AND MERCK		$49,252,150.20

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Financial Report - Financial Statements For Prior Month Presented For Approval — Bonnie Bowles

B. Request Approval of the 2006-2007 Budget — Bonnie Bowles

C. Request Approval of the 2006-2007 Specific Stop Loss Coverage Quote — Russell Bigler

IV. DISCUSSION AND INFORMATION ITEMS

A. Monthly Blue Cross/SISC PPO Trend History Through August 2006 — John Stenerson

B. Recognize the Tulare Kings Foundation — Russell Bigler

C. Update the Board on Companion Care As It Relates to Medicare D — Russell Bigler

D. Newspaper Article on Wal-Mart and Generic Drugs — Russell Bigler

E. Comments from the Board of Directors Will Be Heard

F. Adjournment

G. Next Meeting: Wednesday, October 18, 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.

September 27, 2006

TO: SISC III Board of Directors

FROM: Russell E. Bigler, Chief Executive Officer

SUBJECT: Approval of 2006-2007 Budget

BACKGROUND INFORMATION

The 2006-2007 budget will be presented at the Board Meeting.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the budget for the 2006-2007 fiscal year.

REB:wkc

September 27, 2006

TO: SISC III Board of Directors

FROM: Russell E. Bigler, Ed.D., Chief Executive Officer

SUBJECT; Specific Stop Loss Coverage Quote

BACKGROUND INFORMATION

As you are aware, our current specific rate is $1.14 per contract per month with an attachment point of $775,000 and is with United Health Care Insurance Company.

We directed the company to give us several options. Bob Hunter made several spreadsheets showing an actuarial of each option. After reviewing each option we believe the following option is best for SISC III.

- Increase the rate to $1.17.
- Increase the attachment point to $825,000.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the specific stop loss quote at the $825,000 attachment point with United Health Care Insurance Company at $1.17 per contract per month.

REB:wkc

SISC III

INFORMATION AND DISCUSSION ITEMS

SEPTEMBER 27, 2006

A. **Monthly Blue Cross/SISC PPO Trend History Through August 2006.** The monthly Blue Cross/SISC PPO Trend History through August 2006 will be presented.

B. **Recognize the Tulare Kings Foundation.** SISC III has its Blue Cross PPO claims processed at several locations and we see monthly printout on turnaround time. While all locations do a good job, the Tulare Kings Foundation has met or exceeded the goal Blue Cross has set for turnaround time for the past 42 consecutive months (3-1/2 Years).

C. **Update the Board on Companion Care As It Relates to Medicare D.** John Stenerson will give you an update on this using the attached August 21, 2006 memo.

D. **Newspaper Article on Wal-Mart and Generic Drugs**. The attached newspaper article mentions that Wal-Mart will offer 291 generic drugs for $4.00. Although that is only a small fraction of the 1,800 or so generics available at Walgreens pharmacies, it is symbolic. With SISC's program at COSTCO and many other entities pushing generics the question is changing from "Do I have to buy a generic?" to "Is there a generic available?"

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