SISC III
HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
MAY 18, 2006 - 3:30 P.M.

A G E N D A

I. CONSENT CALENDAR

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

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

DELTA DENTAL CLAIMS	$3,663,093.95	
SISC ASO	240,665.28	
DENTAL COALITION CLAIMS	791,201.15	
DENTAL COALITION ASO	51,981.93	
DELTACARE/PMI PREMIUM	4,787.68	
TOTAL DENTAL		$4,751,729.97
VISION SERVICE PLAN CLAIMS	888,193.04	
ASO	82,494.10	
MES CLAIMS	14,002.60	
ASO	2,770.30	
TOTAL VISION		987,460.04
PACIFICARE/BEHAVIORAL HEALTH	406,880.10	
CIGNA BEHAVIIORAL HEALTH	18,514.62	
SECURE HORIZONS PREMIUM (PACIFICARE)	10,082.34	
SENIOR ADVANTAGE PREMIUM (KAISER)	36,338.00	
SENIORITY PLUS PREMIUM (HEALTHNET)	90,013.58	
BLUE SHIELD HMO PREMIUM	1,628,563.23	
HEALTH NET PREMIUMS	814,614.96	
CALIFORNIA CARE PREMIUMS	702,662.25	
KAISER PREMIUMS	2,098,047.81	
PACIFICARE PREMIUMS	20,268.57	
PACIFIC UNION DENTAL PREMIUM	2,412.19	
UNITED HEALTHCARE (LIFE INSURANCE)	149,599.37	
NATIONAL BENEFIT RESOURCES(Stop Loss)	64,512.60	
BLUE CROSS HEALTH CLAIMS	29,748,826.68	
BLUE SHIELD HEALTH CLAIMS	1,349,504.29	
BEHAVIORAL HEALTH CLAIMS	249,370.07	
ITS CLAIMS	1,107,313.33	
COMPANION CARE CLAIMS	102,854.65	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS		32,557,869.02

BLUE CROSS NETWORK ASO	906,138.96	
FOUNDATION ADJUDICATION ASO	462,030.03	
BLUE SHIELD ASO	87,963.12	
BEHAVIORAL HEALTH ASO	135,434.45	
ITS ASO (MARCH AND APRIL)	73,009.04	
COMPANION CARE ASO	24,385.65	
TOTAL BLUE CROSS AND BLUE SHIELD ADMIN		1,688,961.25
TOTAL BLUE CROSS AND BLUE SHIELD		34,246,830.27
MERCK CLAIMS	8,270,400.05	
ASO-COPAY	339,431.74	
M/O - DISCOUNT CARD	80,747.29	
ASO - DISCOUNT CARD	4,092.89	
TOTAL MERCK CLAIMS		8,694,671.97
TOTAL BC, BSC AND MERCK		42,941,502.24

II. PUBLIC COMMENT

III. ACTION ITEMS

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

B. Request Approval to Assist Driver Alliant in Administering the CSAC EIA JPA — Russell Bigler

IV. DISCUSSION AND INFORMATION ITEMS

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

B. Show the Board a Copy of the Cover Letter and Policy Number 10000.8 That Was Mailed to Member Districts — Russell Bigler

C. Show the Board a Copy of the Ad in the CASBO Journal — Russell Bigler

D. Show the Board a List of the Districts That Have Returned the GASB-45 Letter of Intent Form — Russell Bigler

E. Show the Board What TMJ Covers — Russell Bigler

F. Comments from the Board of Directors Will Be Heard

G. Adjournment

H. Next Meeting: Wednesday, June 21, 2006
1:00 p.m.
SISC Board Room - City Centre

DIRECTIONS TO MANDALAY BEACH RESORT:

I-5 to 126; 126 to Victoria; Left on Victoria to Channel Island Boulevard; Right on Channel Island Boulevard - Cross Over the Bridge - Channel Island Boulevard becomes Harbor Boulevard; take Harbor Boulevard to Costa de Oro; Left on Costa de Oro to the hotel

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, APRIL 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 1:10 p.m. on Wednesday, April 19, 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:	**ALTERNATES PRESENT:**	**OTHERS PRESENT:**
Russell Bigler	Paul Baxter	Cindy Sproles
Ken Hochnadel	Richard Graham	Bonnie Bowles
Doug Miller	Judy Marty	Lynn LaValley
Dan Munis	John Stenerson	Nancy Russo
Dennis Scott		Mary Bouchard – Kaiser Permanente
John Von Flue		Carolyn Temple – Kern Foundation
Michael Rucks		Steve Beargeon – Tulare Foundation
		Judy Fussel, Buckman-Mitchell
		JoeAnna Reynoso, Buckman-Mitchell
		Heather Clark
		Lori Brackett
		Jennifer Bennett
		Cherie Payne
		Kim Oliver

CONSENT CALENDAR

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

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

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

DELTA DENTAL	Claims	$ 5,745,770.93	
SISC ASO		377,497.13	
DENTAL COALITION	Claims	1,327,972.35	
DENTAL COALITION ASO		87,247.79	
DELTACARE/PMI PREMIUM		4,787.68	
TOTAL			$7,543,275.88

VISION SERVICE	Claims	$ 754,141.43	
ASO		82,422.90	
MES CLAIMS –		$ 17,692.44	
ASO –		2,781.10	
TOTAL			$ 857,037.87
PACIFICARE/BEHAV HEALTH		$ 405,102.38	
CIGNA BEHAV. HEALTH (MCC SELECT)		$ 10,082.34	
SECURE HORIZON PREMIUM (PACIFICARE)		$ 10,082.34	
SENIOR ADVANTAGE PREMIUM (KAISER)		$ 33,462.00	
SENIORITY PLUS PREMIUM (HEALATHNET)		$ 88,437.08	
BLUE SHIELD HMO PREMIUM		$1,641,805.13	
HEALTH NET PREMIUM		$ 812,516.65	
CALIFORNIA CARE PREMIUM		$ 697,369.52	
KAISER PREMIUM		$2,161,668.81	
PACIFIC CARE PREMIUM		$ 3,383.19	
PACIFIC UNION DENTAL PREMIUM		$ 2,412.19	
UNITED HEALTHCARE (LIFE INSURANCE)		$ 151,503.04	
NAT'L BENEFIT RESOURCES (Stop Loss)		$ 65,007.36	
BLUE CROSS HEALTH CLAIMS		$30,409,864.41	
BLUE SHIELD HEALTH CLAIMS		$ 1,473,320.58	
BEHAVIORAL HEALTH CLAIMS		$ 255,493.33	
ITS CLAIMS		$ 945,713.79	
COMPANION CARE CLAIMS		$ 120,026.25	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS			$33,204,418.36
BLUE CROSS NETWORK ASO		$ 909,732.10	
FOUNDATION ADJUDICATION ASO		$ 463,910.37	
BLUE SHIELD ASO		$ 87,529.61	
BEHAVIORAL HEALTH ASO		$ 133,161.68	
ITS ASO		$ 1,472.85	
TOTAL BLUE CROSS AND BLUE SHIELD ADMIN.			$ 1,620,054.71
TOTAL BLUE CROSS AND BLUE SHIELD			$34,824,473.07
MERCK CLAIMS		$ 8,367,363.19	
ASO-COPAY		$ 326,120.35	
M/O - DISCOUNT CARD		89,461.40	
ASO - DISCOUNT CARD		3,446.46	
TOTAL MERCK CLAIMS			8,786,391.40
TOTAL BC, BSC AND MERCK			$43,610,864.47

PUBLIC COMMENT

ACTION ITEMS

Financial Report. Cindy Sproles reviewed with the Board the Financial Report for the period ending March 31, 2006. After discussion, motion was made by Director Doug Miller seconded by Dennis Scott and carried approving the Financial Report as presented. Revolving Fund Expenditures for the period October 2006-March 2006 were reviewed.

Request The Board Approve Covering Temporomandibular Joint Disorder. Director Bigler advised the Board that two years ago we requested the Board increase the frame allowance for our vision plan because the current one had fallen behind. Last year we requested that the Board increase the PPO lifetime maximum from $2 million to $5 million. To stay competitive we need to continue to constatly make changes to our products and the way we do business. With the above as background, Director Bigler advised the Board that we need to cover Temporomandibular Joint Disorders. He advised that we get this thrown in our face when we are marketing and when we are servicing member districts. It will only cost a fraction of a percent. After discussion, motion was made by Director Doug Miller, seconded by Director Scott and carried with Director Hochnadel voting in the negative, authorizing covering Temporomandibular Joint Disorder starting with the 2006-2007 contract year. Director Hochnadel requested a copy of the plan.

Request the Board Approve Covering Hearing Aids. Director Bigler further advised the Board that two years ago we requested that they increase the frame allowance for our vision plan because the current one had fallen behind. Last hear we requested that the Board increase the PPO lifetime maximum from $2 milliion to $5 million. To stay competitive we need to continue to constantly make changes to our products and the way we do business. With the above as background, Director Bigler advised the Board that we need to cover hearing aids. He advised that we get this thrown in our face when we are marketing and when we are servicing member districts. It will only cost a fraction of a percent. After discussion, motion was made by Director Scott, seconded by Director Miller and carried, 8 for and 1 against, approving coverage of hearing aids up to $1000.00 every 36 months starting with the 2006-2007 contract year.

INFORMATION AND DISCUSSION ITEMS

Kaiser Permanente Staff Will Discuss Childhood Obesity Program. Mary Bouchard, Kaiser Permanente, presented information on Childhood Obesity and programs being instituted by Kaiser Permanente to combat the problem.

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

Show the Board a Copy of the Customer Service Memorandum. Director Bigler advised the Board that we have discussed sending several different customer service items to the members. He reviewed with the Board a Customer Service Memorandum dated March 2006.

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

Show the Board a Copy of the Draft Press Release Concerning Prilosec OTC. Director Bigler reviewed with the Board a draft of a press release concerning Prilosec OTC.

1. If a doctor writes Prilosec OTC they can get it for no co-payment at any RX.

    - Before, the pharmacist would go into the computer, see that it isn't covered and tell the person to go get it over on aisle 24 at a cost of $17±

2. We will be sending a letter to each member explaining what we are doing.

3. The firm we are working with to put this together is going to:

    - Have representatives visit a third of the doctors' offices in Bakersfield and Visalia as a pilot. We will use the heads of the two Foundations to pinpoint the visits.

    - Send a package explaining what is going on to one third of the pilot group doctors.

    - Not send a packet to one third of the pilot group doctors.

    Then compare results.

John Stenerson Will Discuss Health Trends. Director Bigler advised the Board that John recently made a presentation at the Central Section CASBO Mid-Year Conference. John discussed a couple of pages from his presentation.

Show the Board an Article From the Palm Beach Post. Director Bigler reviewed with the Board an interesting article from the Palm Beach Post on the relationship between Medicare Part D and buying drugs from Canada.

Show the Board a Copy of the Prescription Drug Benefit Annual Statement. Director Bigler reviewed with the Board a sample of the Prescription Drug Benefit Annual Statement sent out by Medco. It is a real eye opener for most members.

Show the Board an Article from School Services of California. Director Bigler reviewed with the Board an article which talks about health care benefits provided to retired public employees. It also talks about the difference in funding health care benefits vs. funding pension benefits. It showed that pension benefits are fairly well funded but health care benefits are not.

CSEA Handout. A letter dated April 5, 2006 from the California School Employees Association re SB-840/Single Payer Cost Savings Calculation Request was distributed and discussed. SISC III will oppose this bill.

Comments from the Board of Directors Will Be Heard 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 Chapman, seconded by Director Rucks and carried adjourning the meeting at 2:20 p.m.

NEXT MEETING

The next meeting of the Board of Directors will be held **Thursday, May 18, 2006,** at 3:30 p.m.at Mandalay Beach Resort Embassy Suites in Oxnard, California.

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DOUG MILLER, Secretary

May 18, 2006

TO: SISC III Board of Directors

FROM: Russell E. Bigler, Chief Executive Officer

SUBJECT; Request Approval to Assist Driver Alliant in Administering the CSAC EIA JPA

Background Information

SISC III – The purpose for doing this is to produce revenue, increase bargaining power with our providers, increased stability and increase marketing of the SISC III JPA.

California State Association of Counties and Cities Excess Insurance Authority (CSAC-EIA) – The purpose for doing this is to take advantage of SISC's bargaining power with the providers, increase stability and earn more interest on their reserves.

As you recall, for those of you that have been on the Board for several years, several years ago when it looked like the County of Kern would be willing to pay SISC III to help administer their health (not dental, vision or life) benefits, I asked you if you were willing to allow the SISC III Administration to do this if we could put together a contract that made sense to SISC III and you said we could. However, we were never able to put it together.

The SISC III JPA works with ten (10) Brokerage Firms that assist us in providing benefits for 91 separate school entities throughout the state. One of these firms is Driver Alliant.

Driver Alliant is also the Broker for the California State Association of Counties and Cities (CSAC), JPA. About a year ago they mentioned they would like to have the CSAC-EIA JPA, which has a little over 8,000 medical contracts, contract with SISC III, which has about 60,000 medical contracts. It was just a topic of discussion until about December. Since, at about that time, it looked like it could really happen, I put it on the January Agenda as an Information Item. See attached information Item #J.

Since January, Frank Fekete and Jim Jett have worked, and signed off on, a contract between SISC III and the CSAC-EIA JPA that would provide each party with the points I mentioned in the beginning.

Additional points are:

- CSAC-EIA would not be a SISC III member district. This is strictly a contract between two parties just like we contract with Blue Cross, Delta, AIG, etc.
- Present CSAC-EIA members are:
    - Amador, Calaveras, Merced Counties
    - Merced, Visalia, and Santa Rosa Cities

- CSAC-EIA will continue to be responsible for maintaining their own billing and eligibility. CSAC-EIA will maintain its contractual relationship with Blue Cross, Medco and Employee Benefits Specialists. This is where the time consuming work is and they will maintain this.

- The Non-Compete Clause says that school-related districts cannot join the EIA Health Program but must access the SISC III medical pool as a member of SISC III. SISC III cannot access cities and counties but that's okay, we don't want to. This contract is for the sole purpose of strengthening SISC III via the points I mentioned at the beginning.

- Each JPA indemnifies, defends and holds each other harmless.

- The agreement would take effect on July 1, 2006.

    - Either party may terminate this contract with six months notice and the contract would terminate at the end of the calendar year following the six month notice.

- This contract is just for providing selected medical administration and it does not include dental, vision or life.

- CSAC-EIA will pay SISC III $3.50 per contract per month. For 8,000 contracts this would be over $300,000 a year. This could grow if the CSAC-EIA JPA grows or we provide more services.

As a staff we have discussed this and determined that the time commitments vs. the tremendous upside for the SISC III members represent a unique opportunity to provide SISC III with the points I mentioned at the beginning of this Background Information. We have worked with CSAC-EIA and Driver Alliant officials and everybody is ready to implement it on July 1st.

In summary, you know we are always looking at ways to make all of the SISC JPA's distance themselves from our competition. All of our research tells us that the signing of this contract will allow us to further distance SISC III from the competition just like the putting together of the GASB-45 contracting, the Defined Benefit and the SISC Flex Programs have done.

Administrative Recommendation

It is respectfully requested that the Board approve contracting between SISC III and CSAC-EIA with the understanding that the SISC III administration will report back to the Board within the next six months on the time commitments of the SISC III staff in assisting Driver Alliant in administering the CSAC-EIA JPA.

REB:wkc

SISC III
INFORMATION ITEMS

A. **Monthly Blue Cross/SISC PPO Trend History Through April 2006.** John Stenerson will report on this.

B. **Show the Board a Copy of the Cover Letter and Policy Number 10000.8 That Was Mailed to Member Districts**.

C. **Show the Board a Copy of the Ad in the CASBO Journal.** Enclosed is a copy of the ad. It's one of those protect your turf type of communication. As you can see the other JPA's, trusts, Keenan, etc., have ads in the magazine. It looks a lot better in color.

D. **Show the Board a List of the Districts That Have Returned the GASB-45 Letter of Intent Form.** The following districts have returned their GASB-45 Letter of Intent Form. Although it is non-binding, they have expressed a desire to participate.

1. Antelope Valley Schools Transportation Agency
2. Barstow Unified School District
3. Buttonwillow Unified School District
4. Fairfax School District
5. General Shafter School District
6. Inyo County Office of Education
7. Kings River Union Elementary
8. Lakeside Union School District
9. Lamont School District
10. Lindsay Unified School District
11. Livingston Union School District
12. McSwain Union Elementary
13. Sanger Unified School District
14. Wasco Union High School District

E. **Show the Board What TMJ Covers.** At the last meeting you requested information showing what TMJ covers. I have enclosed a page showing what TMJ covers and in which program it is covered.

F. **Comments from the Board of Directors Will Be Heard**