SISC
Self-Insured Schools of California
Schools Helping Schools

HEALTH BENEFITS
BOARD OF DIRECTORS MEETING
AUGUST 21, 2025
1:00 P.M.

AGENDA

I. Consent Agenda

A. Approval of Minutes for July 2025 Board of Directors Meeting — Dave Ostash

B. Report of Activity for the Month of July 2025 and the Ratification of Payment as follows: — Dave Ostash

DELTA DENTAL CLAIMS		16,820,227.87	
DELTA DENTAL ASO		982,205.18	
ANTHEM DENTAL CLAIMS		420,327.00	
ANTHEM DENTAL ASO		13,393.80	
		TOTAL DENTAL	18,236,153.85
VSP CLAIMS		1,988,672.91	

EYE MED CLAIMS		127,865.18	
VSP ASO		125,505.74	
EYEMED ASO		11,566.40	
		TOTAL VISION	2,253,610.23
ANTHEM BLUE CROSS HEALTH CLAIMS		119,248,199.10	
BLUE SHIELD HEALTH CLAIMS		44,958,738.75	
ANTHEM BC COMPANION CARE RETIREE CLAIMS		709,825.16	
	TOTAL HEALTH CLAIMS	164,916,763.01	
ANTHEM BLUE CROSS ASO		5,503,199.36	
BLUE SHIELD PPO ASO		708,742.36	
AMERIBEN PPO ASO		22,865.00	
ANTHEM BC COMPANION CARE RETIREE ASO		130,210.37	
FOUNDATION CLMS PROCESSING ASO		689,641.58	
	TOTAL HEALTH ASO	7,054,658.67	
		TOTAL HEALTH	171,971,421.68
EXPRESS SCRIPTS CLAIMS		14,369,853.92	
NAVITUS RX CLAIMS		53,530,303.51	
EXPRESS SCRIPTS ASO		730,155.85	
NAVITUS RX ASO		627,969.31	
RX N GO		107,988.01	
		TOTAL RX	69,366,270.60
INSURED PRODUCTS			
ANTHEM BC HMO CLAIMS		8,336,557.73	
ANTHEM BC HMO ADMIN FEE		965,323.42	
ANTHEM BC EAP		342,936.00	
ANTHEM VIVITY		2,414,064.87	
ANTHEM HMO CAPITATION		7,566,064.50	
BLUE SHIELD HMO CLAIMS		3,102,624.06	
BLUE SHIELD HMO ADMIN FEE		5,800,162.92	
KAISER HMO		71,841,047.83	
SIMNSA		670,023.00	

DELTACARE/PMI DENTAL		30,417.67	
EYEMED-FULLY INSURED		77,707.12	
BLUE SHIELD MEDICARE ADVANTAGE		16,298.90	
LINCOLN FINANCIAL LIFE INSURANCE		422,529.26	
		TOTAL INSURED	101,585,757.28
WELLNESS			333,499.45
ALL OTHER			6,567,429.37
		TOTAL III PAYMENTS	370,314,142.46

Moved_____2nd_____

Yes_____No_____Abstain_____Roll Call Vote_____

II. Public Comment

III. Action Items

A. Financial Report – Presentation of Financial Statements for the Month of July 2025 Will Be Submitted for Approval — Kim Sloan

Moved_____2nd_____

Yes_____No_____Abstain_____Roll Call Vote_____

IV. Information and Discussion Items

A. Review Monthly Budget-to-Actual through July 2025 — John Stenerson

B. Background on and Impact of the Withdrawal of the Public Risk Innovation, Solutions and Management (PRISM) JPA from SISC — John Stenerson

C. XP Health and Proactive Care Plan Update — Nicole Mata

D. Hinge Select Program — Nicole Mata

E. Comments from the Board of Directors Will Be Heard — Dave Ostash

F. Next Meeting: — Dave Ostash
Thursday, September 25, 2025
1:00 p.m.
SISC Board Room, 4th Floor – Larry E. Reider Education Center
2000 K Street, Bakersfield, CA 93301

G. Adjournment Dave Ostash

Moved_____2nd_____

Yes_____No_____Abstain_____Roll Call Vote_____

Any materials required by law to be made available to the public prior to a meeting of the Governing Board of the SISC III JPA can be inspected at the following address during normal business hours at:
2000 K Street, Bakersfield, CA. 93301
For more information regarding how, to whom, and when a request for disability-related modification or accommodation, including auxiliary aids or services, may be made by a person with a disability who requires a modification or accommodation to participate in the public meeting, please contact Kristy Comstock at 661-636-4682 or krcomstock@siscschools.org

*The number of Board Members needed to form a quorum for this meeting is eight

HEALTH BENEFITS TERMINOLOGY

Adjudication: Refers to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

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: The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider and the fee for the particular service exceeds the allowable charge.

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 Medical Excellence (CME): Health care providers designated as a selected facility for specified medical services. Providers participating in a CME network have an agreement to accept an agreed upon amount as payment in full for covered services.

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.

Coordination of Benefits: This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy.

Co-Payment: A specific charge that a health plan may require a member to pay for a specific medical service or supply, after which the insurance company pays the remainder of the charge.

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 program that is designed to provide employees and their dependents with access to resources to support various life situations. It also provides confidential, short-term counseling by qualified practitioners, in person or virtually.

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: Financial account that allows employees to set aside pre-tax money from their paycheck toward premiums or costs not covered by their health plan, such as co-payments. Generally, all the money must be used within the plan year or it is lost.

Health Assessment: A health screening that provides participants with basic health results and actionable steps for improving them.

Health Insurance Portability and Accountability Act (HIPAA): A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, protects the privacy rights of heath plan participants.

Health Maintenance Organization (HMO): A plan that offers a wide range of health care services through a network of providers who agree to provide services to members at a pre-negotiated rate. Members of an HMO choose a primary care physician who manages all healthcare and refers to specialists as needed.

Health Savings Account: A tax advantaged savings account to be used in conjunction with certain high-deductible (low premium) health insurance plans to pay for qualifying medical expenses, such as deductibles. Contributions may be made to the account on a tax-free basis. Funds remain in the account from year to year and may be invested at the discretion of the individual owning the account. Interest or investment returns accrue tax-free. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses. Employers can also fund such plans.

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.

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.

Medical Tourism: To have medical care outside the United States.

Medigap: Refers to various private health insurance plans sold to supplement 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: A time period during which eligible employees can select among the plans offered by their employer as well as make any other dependent changes.

Out-Of-Network: The use of health care providers who have not contracted with the carrier to provide services. Members are generally not reimbursed if they go out-of-network except in emergency situations.

Out-Of-Pocket: The most a member would pay for covered medical expenses in a plan year through copays, deductibles and coinsurance before your insurance plan begins to pay 100 percent of the covered medical expense.

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: This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area. Also known as Usual, Customary and Reasonable (UCR).

Skilled Nursing Facility: An inpatient healthcare facility with the staff and equipment to provide skilled care, rehabilitation and other related health services to patients who need nursing care, but do not require hospitalization.

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

Transparency: 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.