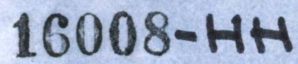


CITY OF LONG BEACH

CONTRACTS

PLAN YEAR 2006 - 2007

NEW IDEAS FROM THE FRONTIER OF HEALTH CARE℠

Great-West℠
HEALTHCARE

Great-West
LIFE & ANNUITY INSURANCE COMPANY

8515 East Orchard Road
Greenwood Village, CO 80111
(303) 737-3000
Mailing Address: PO Box 1700, Denver, CO 80201
www.greatwest.com

August 31, 2006

16008-HH

To Whom It May Concern:

Under authority vested in me as Vice President and Actuary of the Company under Board Resolution approved November 3, 1993, the following person is authorized to sign "For the Actuary" as indicated below:

Craig Davies
Group Life and Group Health Contracts
and Commission Agreements

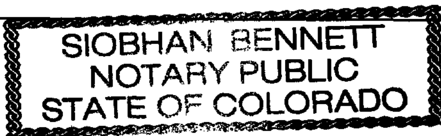
Yours truly

James L. McCallen, F.S.A., M.A.A.A.
Senior Vice President and Actuary

JLM/nrm

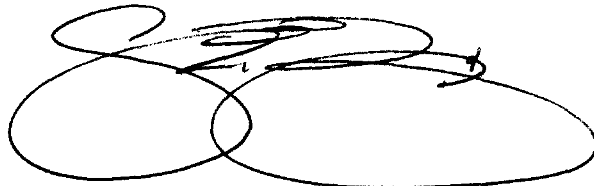
Craig Davies

My Commission Expires:



MY COMMISSION EXPIRES 6/6/2009

Dated: 22 January 2007



Great-West℠
HEALTHCARE

8505 East Orchard Road
Greenwood Village, CO 80111

January 23, 2007

City of Long Beach
Department of Human Resources
and Affirmative Action
333 West Ocean Blvd.
Long Beach, CA 90802

Ladies and Gentlemen:

This contract includes the following:

1) Rate Confirmation;

2) Administrative Services Contract;

3) Plan Document;

4) Excess Loss Contract;

5) Letter Agreements
   - Claims Fluctuation Reserve
   - Terminal Liability Fund
   - Benefit Payment Funding Account

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY RATE CONFIRMATION
For City of Long Beach Plan No. 24968/050703

The information below confirms the monthly rates for active employees for the period December 1, 2006 – November 30, 2007 and for retired employees for the period February 1, 2007 – January 31, 2008

Schedule of Service Fees							
Class 1	**Class 2**	**Class 3**	**Class 4**	**Class 5**	**Class 6**	**Class 7**	**Class 8**
$49.39	$51.90	$51.90	$38.90	$37.22	$41.23	$41.23	$29.97
Class 9	**Class 10**						
$8.60	$24.72						

Minimum Funding Requirement							
Class 1	**Class 2**	**Class 3**	**Class 4**	**Class 5**	**Class 6**	**Class 7**	**Class 8**
$766.35	$841.86	$690.02	$439.29	$603.38	$675.04	$553.56	$351.99
Class 9	**Class 10**						
$386.81	$774.51						

Schedule of Excess Loss Factors
Aggregate Limitation Factor – 10%

Monthly Attachment Factors – Medical and Prescription Drug Coverages							
Class 1	**Class 2**	**Class 3**	**Class 4**	**Class 5**	**Class 6**	**Class 7**	**Class 8**
$759.06	$834.57	$682.73	$432.00	$596.09	$667.75	$546.27	$344.70
Class 9	**Class 10**						
$386.81	$774.51						

Monthly Attachment Factors – Vision (MES) Coverage							
Class 1	**Class 2**	**Class 3**	**Class 4**	**Class 5**	**Class 6**	**Class 7**	**Class 8**
$7.29	$7.29	$7.29	$7.29	$7.29	$7.29	$7.29	$7.29
Class 9	**Class 10**						
N/A	N/A						

Schedule of Excess Loss Premium							
Class 1	**Class 2**	**Class 3**	**Class 4**	**Class 5**	**Class 6**	**Class 7**	**Class 8**
$9.16	$8.79	$8.79	$10.43	$7.29	$6.94	$6.94	$8.26
Class 9	**Class 10**						
$4.68	$9.41						

Schedule of Terminal Attachment Factors							
Class 1	**Class 2**	**Class 3**	**Class 4**	**Class 5**	**Class 6**	**Class 7**	**Class 8**
$1,411.90	$1,407.38	$1 ,148.53	$608.65	$1,083.17	$1,109.05	$904.78	$477.26
Class 9	**Class 10**						
$656.21	$1,312.40						

Schedule of Terminal Premium Factors							
Class 1	**Class 2**	**Class 3**	**Class 4**	**Class 5**	**Class 6**	**Class 7**	**Class 8**
$155.52	$164.95	$164.95	$127.85	$121.41	$135.68	$135.68	$101.38
Class 9	**Class 10**						
$37.80	$75.61						

Class 1 Active and Retired employees (not eligible for Medicare) and their eligible dependents who are covered under the PPO plan.

Class 2 Active and Retired employees (not eligible for Medicare) and their eligible dependents who are covered under the POS 100 plan.

Class 3 Active and Retired employees (not eligible for Medicare) and their eligible dependents who are covered under the POS 90 plan.

Class 4 Active and Retired employees (not eligible for Medicare) and their eligible dependents who are covered under the PPO Thrift plan.

Class 5 Dependents (under age 65) of Retired employees covered under the Medicare Supplement Benefit (MSB) plan who are covered under the PPO plan.

Class 6 Dependents (under age 65) of Retired employees covered under the Medicare Supplement Benefit (MSB) plan who are covered under the POS 100 plan.

Class 7 Dependents (under age 65) of Retired employees covered under the Medicare Supplement Benefit (MSB) plan who are covered under the POS 90 plan.

Class 8 Dependents (under age 65) of Retired employees covered under the Medicare Supplement Benefit (MSB) plan who are covered under the PPO Thrift plan.

Class 9 Retired employees eligible for Medicare who are covered under the Medicare Supplement Benefit (MSB) plan for themselves only.

Class 10 Retired employees eligible for Medicare who are covered under the Medicare Supplement Benefit (MSB) plan for themselves and their spouses.

ADMINISTRATIVE SERVICES CONTRACT

BY AND BETWEEN

City of Long Beach

(Herein called the Client)

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY
(Herein called the Service Contractor)

Whereas, the Client desires to provide benefits for certain classes of individuals (hereinafter called "Members") in accordance with a written employee welfare benefit plan established by the Client as described in the Plan Document Appendix;

Whereas, under said plan the Client will bear all liabilities, except as otherwise specifically provided for herein, but desires that the Service Contractor provide certain services in connection with the administration and operation of the plan (hereinafter called "the Plan");

Whereas, the Plan is an employee welfare benefit plan and the Client, who is both the fiduciary of the Plan, except as otherwise set forth in the Claim Appeal Fiduciary Appendix; and the Plan Administrator, hereby retains the Service Contractor to provide services for the Plan in accordance with the following terms and conditions;

Now, therefore, in consideration of the payments to the Service Contractor as provided in the Payment Schedule Appendix and subject to the terms and conditions contained herein, it is hereby agreed as follows:

Section 1. Definitions

As used in this Contract, its Appendices and Attachments:

a. "Affiliate" means a person or entity within the same common control group as determined under Internal Revenue Code section 414(c) and the regulations thereunder, and for Service Contractor includes a person or entity with whom the Service Contractor operates under a joint marketing or joint venture contract.

b. "Health Information" means any information related to health care treatment, payment or operations that identifies or could reasonably be used to identify a member.

c. "Plan Administrator" shall have the meaning ascribed to the term "administrator" as defined in ERISA and shall have a comparable meaning for non-ERISA plans.

d. "Plan Month" shall mean a calendar month.

e. "Plan Quarter" shall mean a three calendar months period, with the first Plan Quarter beginning on the first day of the first Plan Year.

f. The first "Plan Year" shall begin on December 1, 2006 and shall continue until the beginning of the second Plan Year. The second Plan Year shall begin on December 1, 2007 and successive Plan Years shall begin with the anniversary of such date.

Section 2. Services

The Service Contractor will provide the services listed in the Services to be Provided by the Service Contractor Appendix through the Claim Appeal Fiduciary Appendix subject to modification as provided herein, for the administration and operation of the Plan; such services will be coordinated by a representative of the Service Contractor to assure effective and efficient operation of the Plan.

It is understood, except as otherwise set forth in the Claim Appeal Fiduciary Appendix, that the Service Contractor performs purely non-discretionary and ministerial functions for the Client within a framework of policies, interpretations, rules, practices and procedures made by the Client. The Service Contractor shall perform Services in accordance with the terms of the Plan, including but not limited to the terms of the summary plan description (SPD).

If the Client has not adopted a final SPD, the Service Contractor will process benefit payments in accordance with its standard policies and procedures for the benefits selected by the Client as set forth on the magnetic or computer readable records of Client's information maintained by the Service Contractor or prior carrier booklet with appropriate modifications. When following such standard policies and procedures, the Service Contractor will not be responsible for any act taken that may conflict with the terms of the SPD that is ultimately adopted. However, in the event that the Client amends its Plan to include items that the Service Contractor either cannot or will not administer, nothing herein shall be construed to require the Service Contractor to so administer said amendments but, rather, this Contract shall remain in full force and effect as if said amendments had not been made.

Section 3. Banking Arrangements

3.1 Establishment of a Benefit Payment Funding Account. The Service Contractor agrees to establish an account for the purpose of paying benefits under the Plan. The Client agrees to remit monthly to the Service Contractor amounts which are adequate to maintain an amount in the Benefit Payment Funding Account which is at least equal to the Minimum Funding Requirement described in 3.2.

3.2 Minimum Funding Requirement. The Service Contractor will determine the amount required to fund the Benefit Payment Funding Account for the payment of benefits under the plans at the beginning of each contract month. The amount so determined shall be paid by the Client to the Service Contractor for deposit in the Benefit Payment Funding Account. Such amount shall be equal to the product of the number of employees covered for the current contract month and the Minimum Funding Requirement factors shown in the Rate Confirmation Schedule.

3.3 Maintenance of Benefit Payment Funding Account After Termination of Contract. The Service Contractor shall continue to transfer from the Client's Benefit Funding Payment Account pursuant to the terms of this Section 3 for 12 months after the termination of this Contract in order for Service Contractor to process claims that were incurred prior to the termination of the Contract.

The Client agrees to remit to the Service Contractor monthly the Monthly Terminal Attachment limit as defined in the Excess Loss contract.

Section 4. Payments to the Service Contractor

4.1 Service Fees. The Client shall make payments to the Service Contractor of amounts due for monthly service fees and other service fees and expenses as set forth in the Payment Schedule Appendix.

Charges for hourly services will be determined in accordance with the Service Contractor's established time allocation procedures, and those of other organizations from whom hourly services are purchased. These charges will be made only if both parties agree on the Service Contractor's providing any hourly services.

Printed material created at the Client's request and not listed in the Payment Schedule Appendix will be billed for separately when furnished.

4.1.1 The Client acknowledges that the Payment Schedule is based on information provided by the Client including but not limited to the number of employees and dependents that the Plan will

cover. The Service Contractor has the right to revise any Payment Schedule retroactively to the effective date or the anniversary date, as applicable, to reflect actual participation in the Plan. Any difference between payments made under the Payment Schedule and the Revised Payment Schedule will be collected from or credited to the Client.

4.1.2 Any proposed Payment Schedule will become final when the Service Contractor delivers a final *written schedule, signed by its officer, to the Client.*

4.2 Amendment of Fees.

4.2.1 The Service Contractor may propose changes to the fees under this Contract:

a. if the Client amends its Plan to modify benefits; or

b. upon modification of the Service Contractor's administrative duties; or

c. if the Service Contractor's cost of operation is increased by virtue of a change in charges to the Service Contractor by a governmental unit, but such adjustment shall be limited to the amount of the change; or

d. on the annual anniversary of the Plan Year and annually thereafter; or

e. on any Plan Month subsequent to a Plan Year anniversary, provided that either no renewal was presented to the Client or no required renewal adjustments were made at the time of such anniversary; or

f. upon addition or deletion of coverage for any subsidiary or Affiliate or corporate division of Client; or

g. if the excess loss policy or stop-loss contract, if any, between the Service Contractor and Client is terminated; or

h. if there is a change in the number of employees and/or dependents covered under the Client's Plan for any benefit coverage provided under the Client's Plan which equals or exceeds:

i. 10% in any Plan Month when compared to the previous Plan Month; or

ii. 25% during any period of three consecutive Plan Months.

The Client agrees to make available to the Service Contractor all information necessary to determine whether the changes set forth in i. or ii. above have occurred. If the change in the number of employees and/or dependents covered under the Plan is such that a change in fees results, then the Service Contractor will advise the Client of its intention to change the fees.

The effective date of the change in fees under subsections a. through h. above will be the effective date of the event that causes such change.

4.2.2 Modification of fees may be made by written notice to the Client by the Service Contractor. If the Client pays such revised fees or fails to object to such revision in writing within 15 calendar days of receipt, this Contract shall be deemed modified to reflect the fees as communicated by the Service Contractor.

Section 5. Client Responsibilities

5.1 Payments to Service Contractor. The Client shall make all payments as set forth in this Contract.

5.2 Enrollment and Determination of Eligibility.

5.2.1 The Client shall:

a. handle routine inquiries from Members and prospective Members, including inquiries concerning enrollment in the Plan; and

b. handle enrollment activity; and

c. notify prospective Members of their right to enroll in the Plan.

5.2.2 In determining any person's right to benefits under the Plan, the Service Contractor shall rely on eligibility information consistent with the description in the Plan and information provided by the Client. It is mutually understood that the effective performance of this Contract by the Service Contractor will require that it be advised on a timely basis by the Client of the identity of persons covered under the Plan, and the effective date or the termination date of their coverage. For the purpose of determining fees under this Contract, a Member shall be considered to be:

a. enrolled on the first day of the first month following the month in which the Member is eligible to receive benefits under the Plan or on the first day of the first month in which the Member is eligible to receive benefits under the Plan if the Member is first eligible to receive benefits on such day; and

b. terminated on the last day of the last month in which the Member is eligible to receive benefits under the Plan.

Retroactive adjustments for Member enrollment or termination will be allowed for periods not exceeding sixty (60) days unless approved by the Service Contractor. Retroactive adjustments for termination are limited to Basic ASO Service Fees as set forth in the Payment Appendix.

5.3 Plan Benefits. Except as otherwise explicitly provided in this Contract, the Client shall retain the responsibility for all Plan benefit claims and all expenses incident to the Plan. The Client shall be responsible for:

a. Any state premium or similar tax, however denominated, including any penalties and interest payable with respect thereto, assessed against the Service Contractor on the basis of and/or measured by the amount of Plan benefits administered by the Service Contractor pursuant to this Contract;

b. The consequence of any acts or omissions, except those related to the handling of claim appeals as set forth in the Claim Appeal Fiduciary Appendix, occurring during the operation of this Contract alleged to be a breach of fiduciary duty under ERISA if applicable, or a breach of duty or trust, or other contractual duty regardless of the source of law serving as a basis for such allegation; and

c. Any amounts determined to be Service Contractor's liability arising from any legal action or proceeding to recover benefits under the Plan.

d. Reimbursing any health care service provider with whom Service Contractor has entered into a provider agreement that has provided covered services to a Member if Service Contractor is unable to or otherwise does not reimburse such provider as a result of Client failure to fulfill its obligations under this Contract, including but not limited to funding the Benefit Payment Funding Account for payment of claims. Client further acknowledges that it is responsible, and is a guarantor of payment, for covered benefits under the Plan. Client acknowledges that, through provider contracts negotiated by Service Contractor, Client, as the party responsible for payment, has certain obligations

not inconsistent with the terms of this Contract, even though it is not a party to such provider agreements. As such, any contracted provider may bring a cause of action or assert a lien against Client for payment of any unpaid claims for covered services rendered by such provider to a Member.

5.4 COBRA. If COBRA is applicable to the Client, the Client is responsible for performing the duties required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), including but not limited to:

a. notifying employees and covered spouses and dependents at their last known address of their rights under COBRA when they first become covered under the Plan;

b. notifying qualified beneficiaries of their continuation rights upon occurrence of qualifying events;

c. notifying Service Contractor of COBRA-related eligibility changes as they occur. This includes but is not limited to termination of coverage under the Plan as a result of a qualifying event, subsequent election of coverage and payment of premiums and reinstatement of coverage;

d. processing elections from continuants; and

e. billing and collection.

At the Clients' option and for a fee payable to the Service Contractor, the Service Contractor will arrange to perform some or all of the required duties, as set forth in a separate Continuation of Coverage (COBRA) Premium Collection Service Contract. Whether the Client or the Service Contractor performs COBRA administration, the Service Contractor shall have no liability resulting from the failure of the Client, including its employees, directors, or officers, or a third party administrator to fulfill any obligations under COBRA or this Contract.

5.5 Delays. It is mutually agreed that the Service Contractor shall not be responsible for delay in the performance of its duties under this Contract or for non-performance hereunder, if such delay or non-performance is caused or contributed to in whole or in part by the failure of the Client to promptly furnish any required information.

5.6 5500 Forms. The Client shall be solely responsible for the submission of 5500 Forms. However, the Service Contractor shall be responsible for providing the Client with any applicable Schedule A and Schedule C information necessary to submit said forms.

5.7 Furnishing of Information. The Client shall furnish the Service Contractor with correct and complete information required by the Service Contractor to provide services in accordance with this Contract, including, but not limited to, eligibility information, identity of agents and brokers, and information to verify contribution and participation requirements with respect to insurance policies issued by the Service Contractor. The information will be furnished at the times and in such manner as the Service Contractor may request. The Service Contractor will assume that all such information is complete and accurate and will be under no duty to question the accuracy of such information. The Service Contractor, at its discretion, may charge additional reasonable fees to the extent additional services are required because information is not furnished, is incomplete or inaccurate or is not furnished at the time or in the manner as requested.

5.8 Disclosure to Members. The Client will distribute SPDs to all Members as required by law. The Client will make all disclosures to employees and dependents under its Plan as required by applicable law including but not limited to the Health Insurance Portability and Accountability Act, the Newborn's And Mother's Health Protections Act, the Women's Health and Cancer Rights Act, ERISA and COBRA.

5.9 Legal Proceedings. The Service Contractor shall consult with the Client or legal counsel designated by the Client in claim matters that are beyond the ordinary and that are not part of claims appeals. As a fiduciary for the handling of claim appeals, as set forth in the Claim Appeal Fiduciary Appendix, the

Service Contractor will have complete authority and discretion to determine all matters related to the claim appeals. Client shall be responsible for its own defense of any legal action brought by a third party related to the Plan. Nothing herein shall require the Client to defend the Service Contractor in an action in which the Service Contractor is a named party. Nothing herein shall require the Service Contractor to defend the Client. The Service Contractor and the Client shall cooperate in the defense of any legal proceeding and each party will furnish the other and its legal counsel with all pertinent information regarding the proceeding.

5.10 Special Payments. To the extent that the federal or state government, through Medicare, Medicaid, the Veterans Administration or any other agency or entity asserts a reimbursement right against the Client, or against the Service Contractor, pursuant to that agency's or entity's rights under applicable law (for example, Medicare Secondary Payor rules), with respect to claims processed by the Service Contractor under this Contract, the Client shall be responsible for reimbursing any such amounts determined to be owed. Any such reimbursements requested of the Service Contractor during the currency of this Contract prior to its termination shall be processed by the Service Contractor in the same manner as any other claim and the Service Contractor shall be responsible for asserting any applicable defenses to such request. Any such reimbursements requested of the Service Contractor after the termination of this Contract shall be forwarded to the Client for resolution. The Service Contractor will work with the Client to determine whether and to what extent such request must be honored and the Client shall promptly make any necessary payment. This provision shall survive the termination of this Contract.

Section 6. Indemnification and Limitation of Liability

6.1 Client's Indemnification. The Client shall indemnify, protect and hold the Service Contractor harmless from any and all loss, liability, claim, damage or expense (including reasonable attorney's fees, court costs and expenses of litigation) arising out of any act or omission of the Client, its Affiliates or subcontractors in connection with the Plan or in connection with this Contract, including compensatory, punitive, or other damages. The Client shall also indemnify, protect and hold the Service Contractor harmless from any and all loss, liability, claim, damage or expense (including reasonable attorney's fees, court costs and expenses of litigation) arising out of or in any way related to a breach of duty by the Plan Administrator or the named fiduciary of the Plan.

6.2 Service Contractor's Indemnification. The Service Contractor will not be liable for any act or failure to act on the part of itself or any of its Affiliates in the performance of its duties hereunder, if such act or failure to act is performed in good faith and is not a result of the Service Contractor's breach of its duty as claim appeal fiduciary. The Service Contractor agrees to indemnify, protect and hold the Client harmless from any and all extra-contractual (non-benefit) costs, loss, liability, claim, damage or expense (including reasonable attorneys' fees, court costs and expenses of litigation) arising out of gross negligence, dishonest, fraudulent or criminal acts of the Service Contractor's employees and Affiliates acting alone or in collusion with others, or out of the Service Contractor's breach of its duty as claim appeal fiduciary. The Service Contractor's duty to indemnify and hold the Client harmless shall not extend to acts or omissions of providers who render health care services with respect to Members.

6.3 Exclusion from Indemnification. The Service Contractor shall not be responsible for Client's lost profits, exemplary, special, punitive or consequential damages or be liable to the Client for the same.

6.4 Survival. The terms of this Section shall survive the termination of this Contract.

Section 7. Authority to Control and Manage the Plan

7.1 Service Contractor's Control and Authority.

7.1.1 The Service Contractor and the Client agree that while this Contract is in effect the Service Contractor and its delegates shall have exclusive authority to provide the Plan with the services listed in the attached Appendices, and that during such time the Client shall not undertake on its own nor shall it authorize or allow any other person or entity to provide any of those services without the prior written consent of the Service Contractor.

7.1.2 The Service Contractor and the Client agree that the Service Contractor shall have no liability under this or any other agreement between the said parties with respect to any payment of benefits or other act that violates the provisions of subsection 7.1.1 above.

7.2 Client's Control and Authority. The parties acknowledge that the Client and the Plan Administrator have the exclusive authority to control and manage the Plan. The Client expressly agrees that the Service Contractor is not the Plan Administrator. The Client expressly agrees that the Service Contractor is not the named fiduciary or a fiduciary of the Plan, except for the limited purpose described in the Claim Appeal Fiduciary Appendix, and that neither the Client nor the Plan Administrator will designate the Service Contractor as the named fiduciary or a fiduciary of the Plan for any other purpose.

Except as set forth in the Claim Appeal Fiduciary Appendix, the Service Contractor shall have no power, discretion or authority or control over the Plan or Plan assets or responsibility for the terms or validity of the Plan or to alter, modify, or waive any terms or conditions of the Plan, or to waive any breach of any such terms or conditions, or to bind the Client, or to waive any of its rights, by making any statement or by receiving at any time any notice or information.

The Service Contractor shall have no power, discretion or authority to act for or on behalf of the Client other than as herein expressly granted, and no other or greater power or authority shall be implied by the grant or denial of power or authority specifically mentioned herein.

7.3 Plan Documents. The Client acknowledges that the Plan Administrator has the responsibility to provide Members with a summary plan description ("SPD") and to make available to Members certain other materials and information. To the extent that the Client uses documents, including but not limited to the SPD, or other materials or information provided to the Client by the Service Contractor for the purpose of satisfying the Plan Administrator's obligations, the Client acknowledges that it adopts such documents and other material and information as its own as if they were drafted and made available to Members solely by the Client and under the authority of the Plan Administrator. The fact that the Service Contractor has drafted or assisted in drafting any document, including but not limited to the SPD, or provided any other materials or information to the Client, shall not be construed as the exercise of any discretion, authority or control by the Service Contractor with respect to the Plan, and shall not be construed as establishing any fiduciary, agency, trust, or other similar relationship whatsoever between the Service Contractor and any Member.

7.4 Relationship to Members. Nothing herein will be deemed to impose upon the Service Contractor any obligation to any Member under the Plan.

Section 8. Right to Audit

Upon providing forty-five (45) days advance written notice to the other, each Party shall have the right to inspect and copy the records of the other that are pertinent to the operation of the Plan. The rights set forth in this Section will continue for the five (5) years immediately following each Plan Year. Any inspection shall take place only during regular business hours and only in accordance with a reasonable written agreement that sets forth the scope of the audit. The auditing Party shall prepare an audit report within thirty days after the completion of the audit and the Party being audited shall be given a copy of the report and have the right to review and provide comments on the audit report. The Parties shall maintain information reviewed or generated related to the audit, the results of the audit, the audit report and all materials related thereto as confidential and shall not release the information, results or report to any third party, except for Company or the Client, without the consent of the other Party. The parties agree that no proprietary materials may be copied or removed from the audit site. The auditing party shall not contact the other Party's customers, Members, contractors, sub-contractors or vendors. Any costs of such inspection shall be borne by the inspecting Party. The Parties shall cooperate with each other and make all reasonable efforts to confine any audit to a reasonable length of time, not to exceed five (5) business days during any twelve-month period.

Section 9. Service Contractor's Use and Disclosure of Records

9.1 Confidentiality. The Service Contractor shall maintain the confidentiality of Health Information in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy and Security Contract Appendix.

9.2 Custody of Records. Subject to Section 9.1 above, the original files and other records in the possession of the Service Contractor will be maintained in accordance with the Service Contractor's corporate record retention policy. Copies of such files and records may be made available, upon request and to the extent needed, to the Client.

Section 10. Term and Termination of Contract

10.1 Contract Term. This Contract shall be effective on December 1, 2006 (the "Effective Date"), and shall continue in force for one year (the "Initial Term"), unless terminated earlier pursuant to this Section. This Contract shall expire at the end of the Initial Term, subject to the right of the parties to renew the Contract as set forth herein, in which case, the Contract shall remain in force until the expiration of the period for which the Contract was renewed (the "Renewal Term"), unless terminated earlier pursuant to this Section.

10.2 Contract Renewal. The Service Contractor shall submit to the Client, not later than 60 days prior to the expiration of the Initial Term and any Renewal Term, the Service Contractor's proposed terms and conditions for the renewal of the Contract (the "Renewal Proposal"). If prior to the expiration of the Contract, the parties do not agree on the terms and conditions under which the Contract will be renewed, unless expressly directed by the Client to discontinue service as of the expiration date, the Service Contractor may elect to continue providing Services beyond the expiration date in order to facilitate continuity of service for Members. In that case, this Contract shall be deemed to have been renewed under the terms and conditions of the Renewal Proposal as if the Client had affirmatively assented to the Renewal Proposal and this Contract shall be deemed to have been renewed. Notwithstanding anything above to the contrary, the Service Contractor shall not be obligated to provide services after the expiration of this Contract, except to the extent expressly required to do so under another provision of this Contract. Once this Contract is renewed, whether by express agreement or deemed renewal, this Contract may be terminated only as set forth below in this Section. In the event Service Contractor does not provide Client with a timely Renewal Proposal, the current Contract terms shall apply until 30 days after such Renewal Proposal is sent.

10.3 Termination Upon Notice. This Contract may be terminated:

a. at any time by either the Service Contractor or the Client, provided written notice of such termination is given at least thirty (30) days in advance of the effective date of the termination;

b. upon amendment of the Plan in a manner deemed unsatisfactory by the Service Contractor, and on notice to the Client, such termination shall be effective on the effective date of such amendment.

10.4 Immediate Termination. This Contract shall terminate immediately and without notice:

a. at the option of the Service Contractor upon termination of the excess loss policy or stop-loss contract, if any, between the Service Contractor and the Client;

b. upon failure of the Client to comply with any material term or condition of this Contract such as but not limited to, failure to:

i. make the payments as specified in Section 4 of this Contract, entitled "Payments to the Service Contractor"; or

ii. fund the Benefit Funding Payment Account.

10.5 Reinstatement after Termination. If the Service Contractor terminates this Contract under Section 10.3 or 10.4, and the Client desires to reinstate this Contract, it will be reinstated only if:

a. the Service Contractor agrees; and

b. the Client pays all outstanding amounts plus interest accruing from the date of termination at the rate of the lesser of one and one-half percent (1.5%) per month or the maximum allowed pursuant to state law; and

c. the Client reimburses the Service Contractor for any network access fees required to be paid by the Service Contractor on behalf of the Client following termination of this Contract.

10.6 Termination by Law. If any state or other jurisdiction enacts a law which prohibits or effectively prevents the continuance of this Contract, or the existing law is interpreted to so prohibit or effectively prevent the continuance of this Contract, the Contract shall terminate automatically as to such time or jurisdiction on the effective date of such law or interpretation.

10.7 Termination for Breach. In addition to the foregoing, if one party has materially breached this Contract (the "Breaching Party") and the other party (the "Nonbreaching Party") desires to terminate this Contract, the Nonbreaching Party shall give the Breaching Party specific written notice of the nature of the breach. The Breaching Party shall have 30 days to cure such breach. If the breach remains uncured 30 days following the notice of breach, this Contract shall terminate as of the end of such 30-day cure period. This section shall not apply to immediate breaches as set forth in section 10.4 above.

10.8 Effect of Termination.

10.8.1 If on the date this Contract terminates the Client has not made all payments then due under this Contract, the Service Contractor will have the right to immediately stop providing the Services, including but not limited to processing claims, on the effective date of such termination. In this case, information regarding all outstanding claims which are unpaid (regardless of when the claim was incurred and regardless of when the Service Contractor received the claim) or received after such date will be returned by the Service Contractor to the Client. In addition, the Client will notify each Member covered under the Plan of such termination.

10.8.2 With respect to claims incurred prior to and not processed before termination of this Contract, the Service Contractor shall not be responsible for adjudicating the claims unless Service Contractor agrees in writing to do so and the Client pays the terminal fee either set forth in the Payment Schedule Appendix or mutually agreed upon by the Client and the Service Contractor. Such adjudication shall be limited to claims incurred prior to the termination of this Contract and submitted for consideration within the 12-month period immediately following the termination date. If the Service Contractor does not process such claims, the Service Contractor will send the claims to the Client or to Client's designated representative upon request.

Section 11. Subcontracting

The Service Contractor's duties under this Contract may be performed directly, wholly or in part, by an organization or organizations under contract with the Service Contractor. The Service Contractor may, at its discretion, enter into subcontracting agreements with any organization of its choosing.

Section 12. Compensation to Agents or Brokers

The Client acknowledges that Service Contractor may pay reasonable compensation to the agent or broker of record. Any and all agents and brokers are hereby declared to be an agent(s) of the Client and not of the Service Contractor. An agent or broker is not a trustee of the Plan, a Plan Administrator, a named fiduciary of the Plan (within the meaning of ERISA Sec. 402(a)(2)), or a fiduciary who is expressly authorized in writing to manage, acquire, or dispose of the assets of the Plan on a discretionary basis. The Client shall notify the Service Contractor, in writing, if the Client changes its agent or broker. Changes shall be effective on the first day of the month following thirty (30) days after receipt of the notice of change. The Service Contractor shall not be responsible for recovering any payments made to the prior agent or broker and will not be responsible for any amount asserted to be owed to the new agent or broker that accrues prior to the receipt by the Service Contractor at its Group Office and at its Executive Office in Greenwood Village, Colorado of the written notice from the Client. For the purpose of this Section, delivery of notice to any location other than the Service Contractor's Group Office and its Executive Office in Greenwood Village, Colorado shall not constitute valid or effective delivery unless and until said notice is physically received in the Service Contractor's Group Office and in its Executive Office in Greenwood Village, Colorado.

Section 13. Advertising

The Client will not use Service Contractor's name in any release or printed forms unless approved in advance by the Service Contractor.

Section 14. Other Financial Provisions

14.1 Savings Initiatives. In its sole discretion, Service Contractor may undertake initiatives in addition to the services described in this Contract for the purpose of saving additional money for the Plan. Examples of such initiatives might include, but are not limited to, subrogation and right of recovery, and provider bill/fee negotiation and discounts on claims from providers outside of the Service Contractor's primary network of providers.

14.1.1 For purposes of pursuing savings under this provision, the Service Contractor may retain third party vendors.

14.1.2 For its services in obtaining savings for the Plan, Service Contractor shall be entitled to retain 33.33% of the savings realized.

14.2 Compensation and Financial Arrangements with Third Parties. The Client acknowledges that the fees charged to the Client under this Contract are calculated on the basis that the Service Contractor may receive compensation from third parties with which the Service Contractor contracts or has other arrangements. For example, the Service Contractor maintains contracts with providers such as, but not limited to, hospitals, physician groups, individual physicians, labs and clinics; and with vendors that assist the Service Contractor with certain services, such as, but not limited to, pharmacy benefit management, disease management, claims negotiation and claims audit vendors. Some of Service Contractor's contracts with providers and vendors provide compensation to the Service Contractor in the form of discounts, rebates, allowances, rate differentials, commissions, administrative fees, distribution or marketing fees, incentives, adjustments, settlements, minimum guaranteed payments, or other financial arrangements. Such compensation is for the sole benefit of the Service Contractor. The Service Contractor may retain such compensation, regardless of the form or manner in which it is received, to defray expenses of the Service Contractor and to provide for a profit.

14.3 Access Fees. The Service Contractor may negotiate arrangements with third parties to provide Members services and benefits that are not otherwise covered under the Plan. The Service Contractor may retain any fees received from the third parties pursuant to their contractual arrangements.

14.4 Surcharges. For any state that assesses a surcharge to fund medical care for uninsured populations, finance the operation of risk pools or for any other purposes required by the state, the Service Contractor shall render such payments pursuant to the payment method elected or deemed elected by the Client and in accordance with that state's requirements. The Service Contractor shall draw such funds from the Client's Benefits Payment Account. Upon termination, Client agrees to allow Service Contractor to access the Transfer Account for a period of 12 months following the last day on which the Service Contract is responsible for claims payment, so that Service Contractor has continued access to Client's funds in order to meet all surcharge obligations. In the event Service Contractor processes any claims following the twelve-month post-termination period for which Client is responsible, Service Contractor shall calculate the surcharge due and send that amount, along with any requisite report, to Client for payment and submission to the state.

Section 15. Miscellaneous

15.1 Reliance. The Service Contractor shall be entitled to rely upon any communication believed by the Service Contractor to be genuine and to have been signed or presented by the proper party or parties. For verification of persons eligible for the coverages provided under the Plan, the Service Contractor will rely solely upon information in its computer records at the time eligibility verification is requested. These records will be based upon eligibility information provided to the Service Contractor by the Client.

15.2 Notices. Any notice which may be given under this Contract shall be in writing and may either be personally delivered, sent by registered or certified mail through the United States Postal Service, return

receipt requested, or by reputable overnight carrier, delivered prepaid, addressed as follows. A notice so delivered shall be deemed given on the date of delivery if personally delivered or delivered by overnight carrier, and on the date indicated on the return receipt if delivered by the United States Postal Service.

15.2.1 To the Service Contractor:

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY
Greenwood Village Administrative Office
Attn: Plan Services, 4T1
8505 East Orchard Road
Greenwood Village, Colorado 80111

15.2.2 To the Client:

Dora Hogan, Human Resources Officer
City of Long Beach
333 West Ocean Blvd. 13th Floor
Long Beach, CA 90802
Facsimile number: 562-570-5985

15.2.3 A party's address may be changed by notice to the other in accordance with this section.

15.2.4 Delivery of notices to the Client's broker shall constitute delivery to the Client unless the Client instructs the Service Contractor otherwise in writing.

15.3 Waiver. Failure by the Client or the Service Contractor to insist upon compliance with any provision of this Contract at any given time or under any given set of circumstances shall not operate to waive or modify such provision or in any manner render it unenforceable, as to any other time or as to any other occurrence, and no waiver of any of the terms or conditions of this Contract shall be valid or of any force or effect unless contained in a written instrument specifically expressing such waiver and signed by a person duly authorized to sign such waiver.

15.4 Amendments. Except with respect to modification of fees as described in Section 4 of this Contract, no alteration or modification of the terms and conditions of this Contract shall be valid or of any force or effect unless in each instance it is contained in a written instrument expressing such alteration or modification and executed for the Client and the Service Contractor by their officers duly authorized to execute such alteration or modification.

15.5 Assignment. Either party may assign the right to receive money. The Client shall not transfer its rights or delegate its duties under the Contract, except as permitted elsewhere in this Contract, without the express written consent of the Service Contractor. The Client's reorganization, any merger in which the Client is not the surviving company, and any transfer of the Client's assets whether by bulk sale or otherwise, shall be deemed to be a transfer or delegation by Client. Any transfer or delegation by a party in violation of this Section shall be void and of no force or effect and shall entitle the other party to immediately terminate this Contract.

15.6 Inurement. This Contract shall be binding upon and shall inure to the benefit of the parties hereto and their permitted respective successors and permitted assigns and delegates.

15.7 Force Majeure. In the event that either party is unable to perform under this Contract on account of strikes, accidents, acts of Nature, severe weather conditions, fire, governmental restrictions, computer system failure or any other reason which is beyond the reasonable control of the parties, then performance under this Contract shall be excused for a reasonable period of time to enable the parties to resume performance. If a party is unable to resume its performance within such reasonable period of time, the other party may terminate this Contract as provided herein.

15.8 Entire Contract. This Contract, including any schedules, appendices or supplements thereto, shall constitute the entire contract between the parties and shall govern the rights, liabilities and obligations of the parties hereto, except as it may be modified in accordance with the provisions of this Contract. This

Contract supersedes all prior proposals, representations, communications, negotiations and Contracts between the parties, whether oral or written.

15.9 Controlling Law. This Contract shall be construed and enforced according to the laws of the state of California to the extent that such laws are not preempted by ERISA.

15.10 Provisions Separable. The provisions of this Contract are independent of and separable from each other. In the event any provision of this Contract shall be held illegal, invalid or unenforceable in whole or in part, for any reason by law or a court of competent jurisdiction, said illegality or invalidity shall not affect the remaining parts of this Contract, but it shall be construed and enforced as if said illegal or invalid provisions had not been included herein either initially, or beyond the date it is first held to be illegal or invalid if after the effective date of this Contract, provided the basic purposes hereof can be effectuated through the remaining valid and legal provisions.

15.11 Gender and Number. Any reference in the masculine gender herein shall be deemed to also include the feminine gender, unless expressly provided otherwise. Wherever appropriate, any reference in this Contract in the singular shall include the plural, and any references in the plural shall include the singular.

15.12 Counterparts. This Contract may be executed in any number of counterparts, each of which shall be deemed an original, and said counterparts shall constitute but one and the same instrument.

15.13 Currency and Place of Payments. All sums payable to, or payable by, the Service Contractor pursuant to this Contract shall be payable in the lawful currency of the United States of America at its Greenwood Village office.

15.14 Headings. Section, sub-section or paragraph headings contained in this Contract are for reference purposes only and shall not affect the meaning or interpretation of this Contract.

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed by their respective officers duly authorized to do so, to be effective as of December 1, 2006.

Dated at Long Beach (City), CA (State), this 26 (Date)

day of July (Month), 2007 (Year).

City of Long Beach

By:

(Signature of Authorized Representative)

City Manager

(Official Title)

APPROVED AS TO FORM

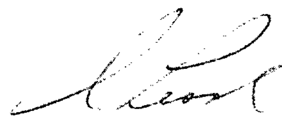
July 19, 2007

ROBERT E. SHANNON, City Attorney

BY ____________

DEPUTY CITY ATTORNEY

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

By: 

(Signature of Authorized Representative)

Vice President

(Official Title)

September 19, 2006

(Date)

Payment Schedule Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

Services Provided:

Includes:
Basic Claims Adjudication Services
and Direct Claim and Verification Service
("Basic ASO Service Fee")
Actuarial and Underwriting Services
Care Management (includes Utilization Management
and Case Management)
Utilization Management
Case Management
Disease Management
Maternity Support Program
Access to Managed Health Care Network
Document Preparation
Electronic Services
I.D. Cards
Prescription Drug Card Service

Service Fees Schedule.

The Service Contractor shall have the right to adjust the fees listed below as specified under Section 4 of the Contract.

A. The Client shall make payments to the Service Contractor in advance for service fees listed below by the first day of each Plan month in which the Service Contractor performs the listed services. A grace period of 30 days is granted after such monthly payment due date. The amount due will be determined as follows:

	Monthly Amount per Active Employee And Retired Employee Covered under the Plan
Class 1	$49.39
Class 2	$51.90
Class 3	$51.90
Class 4	$38.90
Class 5	$37.22
Class 6	$41.23
Class 7	$41.23
Class 8	$29.97
Class 9	$ 8.60
Class 10	$24.72

B. The Client agrees to compensate the Service Contractor for services listed below as follows:

	Amount Due
1. Subrogation and Recovery	33.33% of all recovered amounts

The Service Contractor reserves the right to offset the amount due for this service against recovery amounts.

2. Claim Reduction Negotiation 2nd Tier Network Discounts and Negotiations	33.33% of all amounts saved

The Service Contractor reserves the right to charge the amount due for this service as part of the benefit payment under the Plan.

3. Hospital Bill and Credit Balance Audits Service	33.33% of audit savings amounts

The Service Contractor reserves the right to offset the amount due for this service against audit savings amounts.

4. The cost of customized or bulk printing will be billed as charged to the Service Contractor for any documents not specifically listed in the Services to be Provided by the Service Contractor Appendix.

5. The cost of any mass mailings to plan participants will be billed separately.

6. Medical Care Conversion Privilege	$10,000 except for Covered Persons who reside in New York and Florida, where the charge shall be $15,000 per conversion. This is not available for Covered Persons in Louisiana.

C. For any services not historically and periodically performed by the Service Contractor, a rate of $87.00 per hour shall apply.

D. For the adjudication of claims incurred prior to the termination of this Contract and submitted for consideration within the 12-month period immediately following the termination date, the Client shall pay to the Service Contractor an administrative fee as specified in the Rate Confirmation Table per employee covered on the first day of the last Plan month prior to the end of this Contract.

Services to be Provided by the Service Contractor Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

The Service Contractor will perform the following services:

Basic Claims Adjudication Services and Direct Claim and Verification Service

These Basic Services provide for the processing of all claims incurred and received while this Contract is in force. The services to be performed by the Service Contractor are:

1. Preparation of claim checks and Explanation of Benefit forms on a universal check form to be mailed by the Service Contractor on a daily basis or on the following business day if the day is a holiday;
2. Claims and inquiries come directly to the Service Contractor; claim checks and correspondence are mailed directly to employees and/or assignees; copies of Explanation of Benefit forms are sent to the Client if desired; copies of declination letters are sent to the Client;
3. Maintenance of individual benefit records for determination of plan benefits and satisfaction of deductibles;
4. Request additional medical or service information from provider;
5. Coordinate benefit payments with other employee plans;
6. Maintenance of records for determination of overutilization or plan abuse by users and providers;
7. Preparation of annual statistical claim reports for valuation of "Incurred but not Received";
8. Preparation of IRS Reports (1099) Medical Provider Fees;
9. Claim control practices; and
10. Verification of employee eligibility as to coverage and benefits.

Actuarial and Underwriting Services

This includes those services which concern the pricing of benefit types and the actuarial estimate of the incurred but unreported claim reserve. Such services include:

1. Benefit design advice;
2. Annual re-rating of the existing plan;
3. Pricing proposed benefit plan alternatives; and
4. Advice on the expected financial results of plan changes.

Services provided under this Section do not include actuarial consulting services, such as the issuance of actuarial opinions or certifications.

Document Preparation

Document Preparation includes assistance with contractual drafting which consists of review of the employee Summary Plan Description as provided by the Client.

The cost of printing the Summary Plan Description and other documents is not included.

I.D. Cards

Identification cards will be prepared for enrolled employees based on eligibility information provided by the Client.

Electronic Services

Electronic Services are available as described in the Electronic Services Appendix.

Claims Processing and Payment Services Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

The Service Contractor shall accept for processing and payment or denial, all claims presented under the Plan. The examination, investigation, review, calculation, approval and disapproval of all such claims by the Service Contractor shall be in accordance with the Service Contractor's claim cost control standards, audit procedures, and claim practices, as agreed to by the Client.

The Service Contractor shall investigate the validity of each claim and each recurring benefit payment and shall compute the benefits payable, if any, on each such claim.

The Service Contractor shall pay all claims which it has determined to be payable under the Contract, except the following:

a. All contested or doubtful claims or benefit amounts, that are not part of a claim appeal covered by the Claim Appeal Fiduciary Appendix, shall be referred to the Client for its determination of liability and instruction to the Service Contractor. Claims, except appeals covered by the Claim Appeal Fiduciary Appendix, with respect to which there is legal action against the proceeds, such as suit, attachment, or restraining order; on such claims the Service Contractor will consult with the Counsel of the Client and shall proceed to pay or deny the claim or turn the file over to the Client for further processing, as set forth in written advice from the Client's Counsel.

b. To the extent that the following are not superceded by the provisions of the Claim Appeal Fiduciary Appendix, the Service Contractor will take appropriate action, such as denial, holding in pending, or turning over to the Client if the claim becomes involved in legal action or proceedings; such instances would include but not be limited to where the claimant or his representative has filed a claim or an appeal under any law applicable to benefit entitlement, including but not limited to workmen's compensation, unemployment compensation, disability or cash sickness law of any state.

It is understood that the duties of the Service Contractor under this Contract shall not involve insurance department proceedings, tax proceedings, proceedings before quasijudicial boards, medical proceedings, the furnishing of legal advice, or participation in any function or activity prohibited to the Service Contractor; provided, however, the Service Contractor will provide to the Client its files and any other records of action that it has taken with respect to any claim.

Subject to and except as otherwise provided in any set of rules of administrative procedure agreed to in writing by the Client and the Service Contractor with respect to the administration of benefits pursuant to this Contract, each individual administrative act, decision and interpretation by the Service Contractor (including any errors, clerical or otherwise) shall be binding upon the Client with respect to past performance or completed action. In addition, the Service Contractor shall not be responsible for errors in eligibility information and COBRA qualified beneficiaries information provided to it by the Client or the Client's agent.

If after any payment has been made hereunder (i) to or on behalf of an ineligible individual, or (ii) it is determined that more or less than the correct amount has been paid by the Service Contractor, the Service Contractor will attempt to recover the payment made to an ineligible person, or the overpayment, or will adjust the underpayment, but the Service Contractor will not be required to initiate court proceedings for any such recovery. If the Service Contractor is unsuccessful, the Service Contractor shall so notify the Client in order that the Client

may take such action as may be available to it. This paragraph is modified to the extent as provided for in the Collection of and Liability for Claim Overpayment Section, if any, contained in the Contract.

Claim Appeals

The appeal of any denied claims shall be handled in accordance with the provisions of the Claim Appeal Fiduciary Appendix.

Accounting for Claim Payment

During the continuance of the Service Contractor's claims processing and payment of benefits pursuant to this Contract, the Service Contractor shall render an accounting monthly unless otherwise agreed upon by the Service Contractor and the Client in writing. Such accounting details may be set forth in a separate written statement.

Monthly Accounting

Within 30 days following the end of a Plan month, the Service Contractor will furnish to the Client a list of claims paid, showing the coverage(s) under which the claim was paid and the amount paid on each claim, the totals paid under each coverage, and the grand total of payments for the month.

Collection of and Liability for Claim Overpayments

a. Procedure. The Service Contractor shall take appropriate steps as it would for its own business under similar circumstances to collect Claim Overpayments. The Service Contractor shall not be required to initiate court proceedings to recover an overpayment(s) but is expressly authorized to take all actions to pursue recovery, including retaining counsel, setting and compromising claims, and delegating recovery to a third party vendor to assist it in its overpayment collection efforts. In such instances, the amount of money returned to the Plan will be net of any fees charged by such vendor or counsel. In pursuing recovery of Claim Overpayments identified by the Service Contractor, the Service Contractor initially attempts to recover the overpayments itself. If the Service Contractor is unable to recover Claim Overpayments, it may retain third party vendors to assist with recovery. The Service Contractor's decision to retain third party vendors to assist with recovery may be based upon the amount of the Claim Overpayments or other factors as determined by Service Contractor. The Service Contractor currently retains third party vendors to assist with recovery for Claim Overpayments that are in excess of specified minimum amounts. That threshold may change from time to time in the Service Contractor's sole discretion. For further information on the Service Contractor's current practices, please contact the your account representative.

b. Responsibility. The Service Contractor will not be responsible for Claim Overpayments that are caused directly or indirectly by the Client, its agents or employees, or providers. For this type of overpayment(s), the Service Contractor retains the sole right to determine whether to seek repayment from the payee. For any Claim Overpayment first identified by a vendor, regardless of the cause, if the Service Contractor uses the services of a vendor to recover the Claim Overpayment, the Client agrees to reimburse the Service Contractor 33.33% of the returned overpayment for collection costs.

c. Returns. The Service Contractor shall return to the Client any refund of an overpayment of Plan monies that it receives from a third party on behalf of a specific Covered Person's account. The Service Contractor shall have the right to retain any returned overpayments that are received more than 12 months following the termination of this Contract.

Services After Contract Termination

The Service Contractor agrees to adjudicate the claims incurred prior to the termination of this Contract and submitted for consideration within the 12-month period immediately following the termination date. The administrative fee for this service is as provided in the Rate Confirmation Schedule.

Subrogation and Recovery Services Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

1. The Service Contractor agrees to provide, on behalf of and as agent of the Client, subrogation and recovery services to the Client's Plan. Such services are limited to those cases in which the Service Contractor has identified the Client's possible rights of subrogation, reimbursement or recovery (hereafter, "Claim"). The Service Contractor will use its good faith efforts to recover Claims for the Plan, arising out of or in connection with health care benefit payments for injuries or illness of any Covered Person, against tort-feasors, their insurers or any other sources of payment liable or responsible for such injuries or sickness, or for the treatment or service costs thereof. Claims subject to this subrogation and right of recovery section include, but are not limited to, recovery of medical expenses incurred by a Covered Person as the result of injuries or illness caused by a third party, recovery of medical expenses incurred by a Covered Person due to a work-related injury or illness, and recovery of medical expenses through class action lawsuits.

   The Service Contractor will not be required to pursue any subrogation or recovery that is reasonably expected to result in a recovery of $1,000 or less.

   The Service Contractor is given full, exclusive and discretionary authority to settle any Claim that could reasonably result in: (i) a maximum recovery of $5,000 or less; or (ii) a maximum recovery of more than $5,000, provided that the settlement offered represents at least 70% of the maximum possible recovery of such Claim.

2. The Service Contractor is expressly authorized to take all actions contemplated herein, including, but not limited to, the authority to pursue subrogation, reimbursement, recovery and other related rights through any legal means, to retain counsel on behalf of the Client, to settle and compromise Claims, and to delegate and subcontract the responsibilities of such subrogation and recovery services to third party vendors.

3. Subject to the Client's payment of compensation as provided in 4 below, the Service Contractor shall be responsible for all ordinary and necessary expenses of recovery incurred by it or its delegate in connection with the performance of its duties, as set forth in Exhibit 1, attached hereto.

4. The Client agrees to pay the Service Contractor, as compensation for services, fees equal to 33.33% of all Claims recovered following the commencement of any collection or recovery effort taken by the Service Contractor, whether such Claims are paid to or recovered by the Service Contractor, its delegate, the Client, or its delegate or assignee. The Service Contractor has the right to offset any fees owed to it against any recovery amounts belonging to the Client. The Service Contractor reserves the right to change the rate of the fees charged by giving the Client at least four months advance notice. If the Client does not exercise its right to terminate this Appendix within 20 days after the notice of changes in the fees, the new fees as changed shall become effective as of the date stated in the advance notice.

5. Upon termination of this Contract or Appendix, for any reason other than breach, the Service Contractor shall continue to be authorized to pursue recovery of Claims unrecovered, in whole or in part, on the termination date, and shall be entitled to be compensated for the recovery pursuant to the fees in effect as of the termination date.

EXHIBIT 1
Ordinary and Necessary Expenses

I. Ordinary and Necessary Expenses include costs for the following:

A File Handling Costs;

B. Outside Copy Services;

C. Outside Investigations;

D. Expert Witness Evaluations; and

E. Legal Services necessary to make recovery on the Claims.

II. Not included as Ordinary and Necessary Expenses are, but not limited to:

A. Any commitments by the Client or Plan to pay fees and expenses to attorneys representing Beneficiaries; and

B. Any payments that are required by any federal, state or local law to be paid to attorneys representing Beneficiaries.

Attorneys' fees and expenses described in paragraphs II.A. and B. shall be paid solely from the case recoveries, and the amount of recovery for purpose of computing the Service Contractor's service fees will be net of any payments of such amounts.

The Service Contractor will comply with any withholding requirements on any applicable sales and use taxes, and will withhold such amounts from cash recoveries, as required, and in addition to Fees due to the Service Contractor.

Medical Care Conversion Privilege Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

If a Member's coverage with the Plan ends because employment ends, personal coverage may be purchased ("conversion coverage") for such Member and each of his/her covered dependents, provided:

1. the Member (and his/her dependents) were covered by the Plan (and under any group plan providing similar benefits which it replaces) for at least three months prior to the date employment ends; and

2. the Member (and his/her dependents) are not eligible for Medicare.

A Member (or his/her dependents) have thirty-one (31) days from the date his coverage ends to submit a written application and the first premium for conversion coverage. Such Member (or covered dependents) are solely responsible for contacting the Service Contractor to obtain this coverage. Premium will be based on the type of coverage, relationship to the Member, age and state of residence of the person purchasing the coverage and effective date of the conversion. Coverages will become effective on the date group coverage under the Plan ends.

If the purchase of conversion coverage will result in over-insurance, as determined by the Service Contractor, the Service Contractor reserves the right to deny such coverage.

This privilege is also available to

a. covered dependents of a Member who dies; or
b. to a dependent child who reaches the limiting age; or
c. to the ex-spouse of a Member on the date a valid decree of divorce is issued, if exercised within thirty-one (31) days of the date coverage ends.

The conversion coverage will not exceed the minimum conversion plan requirements, if any, of the state in which it is issued.

If a Member or his/her dependents' coverage with the Plan has been continued according to federally mandated standards, such Member or covered dependents may still be able to exercise this conversion right. **The full term of the available federal continuation coverage must have been exhausted to receive this conversion privilege.**

Managed Care Services Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

1. Managed Care

Programs. The Service Contractor agrees to provide services to allow the Client to establish the following programs under its Plan:

a. Provider Network. A Provider Network consisting of participating hospitals, physicians, other health care professionals and other types of providers as appropriate (collectively called "Providers"). A higher level of benefits is typically paid when the Member receives covered health care services from the Provider Network or as otherwise set forth in the Plan.

b. Medical Management. A medical management program known as Care Management ("CM"). A care manager will assess the health care needs of a Member with a long-term and/or complex illness or injury, develop appropriate discharge plans, and coordinate needed medical services. A care manager will also review medical necessity and appropriateness of care through pre-treatment authorization of inpatient hospitalization and certain outpatient procedures, review of continuing hospital stays, and an appeal process. Written notice will be promptly provided to the Member, the hospital where appropriate, and the treating physician of the status of each authorization.

c. Subcontractors. The Service Contractor may occasionally utilize services of subcontractors to assist with assessment of the case. Payment of said subcontractor fees will be the responsibility of the Client.

   The Service Contractor will develop mechanisms for early identification of potential cases to benefit from the CM Program. In the CM Program, the Members' individual needs are assessed with both the Member and the attending physician. An alternative treatment plan to traditional care is developed and presented to the Member and family members and the physician for approval. The alternative treatment plan is implemented via coordination by the CM medical professionals. Claims reflective of the alternative treatment plan are submitted and reviewed by the CM Program. The CM Program monitors the medical necessity of the care until case closure.

   The Service Contractor is not required to seek Client's approval prior to the implementation of any alternative treatment plan where:

   i. all expenses to be payable under the alternative treatment plan are normally covered under the Client's Plan; or

   ii. with respect to the Client who has a separate stop-loss or excess loss policy in effect with the Service Contractor covering its excess loss under the Plan, expected benefits payable outside or within the alternative treatment plan exceed the applicable stop-loss or excess loss protection point.

   In all cases, the Client agrees that expenses for the alternative treatment plan shall be included as eligible expenses even if they are not included as such under the Client's Plan.

d. Adverse Determination/Additional Review. If a Member receives an adverse determination under one of these programs and seeks additional review (as entitled by law or by the terms of the Plan), by a third party or an independent utilization review organization, any cost or fee for such additional review shall be billed to the Client or charged against the Client's Benefit Plan Account.

2. Provider Network Product(s)

a. Networks. The Service Contractor shall contract with one or more networks of Providers to furnish health care services in conjunction with the Provider Network Product.

b. Availability and Incentives to Members. The Service Contractor shall offer and the Client shall make the Networks available to Members. It is the duty and responsibility of the Client to include in the Plan incentives and/or disincentives to Members to encourage use of the services of the Networks.

c. Provider Network Directories. The Service Contractor shall provide the Client with access to a directory listing of Network Providers and shall provide periodic updates of same. The Service Contractor reserves the right to revise the directory at least once a year to reflect changes in the participation of Providers.

d. Standard and Character of Performance. The Service Contractor, through its contracts with Networks, shall use customary and reasonable care and proper diligence in the performance of its services under this Appendix.

3. Disease Management

a. The Service Contractor, through its own employees, Affiliates and/or employees of contracted third-party vendor(s), will provide Disease Management (the "Program") which delivers services and/or supplies to Members and consists of, but is not limited to, disease and pain management.

b. The Service Contractor, through its own employees, Affiliates and/or employees of contracted third-party vendor(s), will perform an initial identification of Members meeting predetermined medical criteria indicating the potential to be service and/or supply recipients. This identification process will be based on information legally obtained through claims, Members' self-referral or other valid sources.

c. A Member who is accepted into the program ("Participant") will receive services and/or supplies consisting of assessment and education for targeted diseases or chronic conditions (including but not limited to pain, diabetes, asthma, and renal failure). The services and/or supplies are designed to enable the Participant to gain knowledge and skills necessary to prevent severe chronic medical conditions, manage his or her life-long condition and/or improve the quality of his or her life. The program neither warrants nor guarantees the well-being or improvement of the Participant's chronic medical condition or disease.

d. The Service Contractor shall cover the Program's costs by treating program services and/or supplies similarly to a claim and billing the Client similarly to the billing and claim process for Plan covered benefits. Features of the Program may be added, expanded or deleted at any time by the Service Contractor without the prior consent of the client. Nothing herein shall negate the Service Contractor's rights pursuant to Section 14 hereof.

e. The Client agrees to provide 100% benefit reimbursement under its Plan, without application of the deductible or copayment, for all Program services and/or supplies received. The benefit reimbursement amount shall apply to the Member's lifetime maximum.

4. Maternity Support Program

This program monitors the health and well-being of pregnant mothers. The program neither warrants nor guarantees a normal or safe pregnancy or delivery. Nor does it guarantee the health or well-being of pregnant mothers or their newborn child(ren).

The Client agrees to provide 100% benefit reimbursement under its Plan, without application of the deductible or copayment, for all Program services and/or supplies received. The benefit reimbursement amount shall apply to the member's lifetime maximum.

Hospital Bill and Credit Balance Audits Services Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

1. The Service Contractor agrees to provide, on behalf of and as agent of the Client, through its employees and/or subcontractor(s), hospital bill audits and credit balance account audits for the Client's Plan. Such services are limited to those inpatient, outpatient, emergency and trauma hospitalization claims which the Service Contractor has identified as meeting its auditing guidelines (hereafter, "Claim").

   Each hospital bill audit entails a comparison of billed services to services ordered and/or documented in the medical record. Upon conclusion of each hospital bill audit, the Service Contractor will present the applicable medical provider with a billing listing the net overcharges due and will employ commercially reasonable efforts to recover the overcharges from the provider.

2. As compensation for services, the Client agrees to the following terms regarding the rate of service fees and its payment to the Service Contractor of such fees:

   a. Fees equal to 33.33% of all audit savings which are recovered following the commencement of any hospital bill audit, or credit balance account audit undertaken by the Service Contractor, whether such savings are paid to or recovered by the Service Contractor, its subcontractor(s), the Client, or its delegate or assignee. The Service Contractor has the right to offset any fees owed to it against any audit savings recovery amounts.

   b. Fees equal to 33.33% of the identified audit savings should the Client request the Service Contractor to forego recovery of a specific overpayment or positive balance after the audit process is complete.

   c. The Service Contractor reserves the right to change the rate of the fees by giving the Client at least 60 day advance notice. If the Client does not exercise its right to terminate this Appendix within 30 days after the notice of changes in the fee rate, the new fee rate shall become effective as of the Client's ASO Service Contract anniversary date following the advance notice.

   The fees stated above are inclusive of the Service Contractor's handling and transactional charges and subcontractors' fees.

   "Audit Savings" means the net dollar amount of the overcharges less the undercharges as identified in the final audit summary report with respect to a hospital bill audit, or a dollar amount consented by a hospital as a positive balance at the conclusion of a credit balance account audit.

3. Upon termination of this Contract or Appendix, for any reason other than the Service Contractor's breach, the Service Contractor shall continue to be authorized to provide auditing services with respect to all Claims in process on the termination date. Claims are considered in process if the Service Contractor or its subcontractor has evaluated, screened, audited or in any way processed, including all Claims inventoried in auditing database.

License Agreement Appendix
for
BENLink Services

Effective Date: December 1, 2006

To be attached to and made a part of the Administrative Services Contract

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

For Clients using BENLink online services, the following provisions shall apply:

The Service Contractor grants the Client the non-exclusive, non-transferable right to use BENLink in accordance with this Contract while this Contract is in effect.

The Client is responsible for performing all BENLink functions in order to administer the Plan, including but not limited to the following:

1) Acquisition and maintenance of completed, executed and accurate enrollment applications for every eligible employee or dependent;

2) Updating information regarding all Members including, but not limited to, recording changes for name, beneficiary, benefits or primary care physicians, within 10 working days of the Client's receipt of notice or change.

The Client shall be responsible for reimbursing the Service Contractor for any claims paid on behalf of a terminated Member where the Client failed to timely update BENLink and remove the Member therefrom. Such payments shall be funded through the Benefit Funding Payment Account as set forth in Section 3 of the Contract.

If a new Member has properly enrolled and has coverage and the Client fails to enter the new Member in BENLink, then the Client shall be responsible for the lesser of one thousand dollars ($1,000.00) or fifty percent (50%) of the claim amount for any claims received by the Service Contractor during the time before which BENLink is updated. Such payments shall be funded through the Benefit Funding Payment Account as set forth in Section 3 of the Contract.

The Service Contractor is relieved of any duties imposed upon it under other terms of this contract to the extent those duties can be performed by the Client using BENLink.

BENLink may be used only to administer the Plan. With the Service Contractor's prior consent, the Client may subcontract, delegate or assign its rights or duties related to BENLink, or allow a third party "read only access" to the Client's data on BENLink. In this event, the following terms apply:

1) The Client shall retain ultimate responsibility for all duties and obligations under the Contract. Any third party shall be subject to such duties and obligations. The Client shall be responsible for monitoring and overseeing the third party's performance pursuant to said subcontract, delegation, or assignment and shall remain fully responsible as stated herein notwithstanding said delegation. The Client shall be responsible for any breach by a third party of such duties and obligations, and the Client indemnification provisions under the Contract shall apply to any such breach by a third party.

2) The Service Contractor shall have no obligations to any third party, nor any liability for the BENLink services performed by any third party.

3) The Client shall abide by the Privacy of Health Information requirements set forth in Section 5.5 of the Contract.

BENLink must not be used in any manner not expressly allowed by this Contract.

Client acknowledges that Service Contractor is under no obligation to provide support for BENLink, except for basic technical assistance via telephone, facsimile and electronic mail during the Service Contractor's regular business hours. The Client shall be responsible for all Internet service provider charges, and all related long distance charges, if any.

The Service Contractor shall have no liability with respect to the Client's use of BENLink, and further, makes no representations or warranties with respect to BENLink. The Service Contractor is not responsible for mistakes made by the Client in its use of BENLink.

BENLink online services will terminate immediately upon misuse of BENLink by the Client or its subcontractors, delegates or assigns and may terminate, in the sole discretion of the Service Contractor, upon discontinuation of the BENLink product.

Pharmacy Benefit Manager Service Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

by and between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

1. Services to be provided by the PBM

The Service Contractor shall arrange for services to be provided by the pharmacy benefit manager (PBM) identified in this Appendix in support of the prescription drug benefit provided under the Client's Plan as follows:

a. The PBM services shall be provided by Express Scripts Inc.

b. The PBM shall perform pharmacy services for Members through its network of participating pharmacies.

c. The PBM shall adjudicate claims for prescription drugs covered under the Plan submitted by participating pharmacies using the PBM's electronic on-line claim adjudication system. The PBM's claim adjudication system will include all Plan information regarding deductibles, copayments, coinsurance, Member out-of-pocket maximums, benefit maximums and any other features of the Plan to be used in processing claims. Participating pharmacies may collect from Members at point of sale the amount specified in the Plan. The PBM shall reimburse participating pharmacies for such claims according to the terms of the PBM's contract with the participating pharmacy.

d. The PBM shall accept claims submitted by Members directly to the PBM on the PBM's standard claim form, or otherwise agreed upon form, together with proof of payment. The PBM shall process such claims and produce and mail to the Member an explanation of benefits and, if any payment is due the Member, a check for the reimbursement amount specified in the Plan.

e. The PBM shall make available to Members a toll free telephone number during the PBM's hours of operation. The PBM's staff shall be available to answer Members' questions about Plan prescription drug benefits, deductibles, copayments, coinsurance, maximum benefits, instructions for completing a standard claim form, and status of Member-submitted claims.

2. Services to be provided by Service Contractor

The Service Contractor shall provide the following support for the prescription drug benefit provided under the Client's Plan:

a. Based on information it receives from Client, timely notify PBM of the identity of each Member eligible for prescription drug benefits under the Plan, the date the Member becomes eligible, and the date the Member's eligibility ends.

b. Reimburse PBM for the total of (i) the amount of all payments due pursuant to Payment Section of this Appendix for drugs provided to Members during the preceding billing period, plus (ii) dispensing fees PBM charged for prescriptions filled for Members by participating and mail order pharmacies during the preceding billing period. Within five (5) working days after the date on which it reimburses PBM, Service Contractor shall be entitled to initiate recovery to its own account from Client's claim account the full amount of its reimbursement to PBM.

c. Support Client's efforts to improve the cost-benefit relationship of its prescription drug benefit plan through regular consultation with Client and PBM.

d. Make available to Client the advisory and consulting services of Service Contractor's pharmacy services support unit.

e. Provide Client with standard reports consisting of data provided by the PBM describing claims, utilization, and other pertinent information.

f. Through Service Contractor's medical management unit support the prior authorization provisions of the Plan.

3. Third-Party Litigation

Neither the Service Contractor nor the PBM shall have any duty on Client's behalf to participate in or in any way pursue any claim in any class action or other litigation commenced by a third-party to recover damages of any type whatsoever in connection with drugs provided to Members.

4. Mail Service Program

The PBM shall administer the Plan's provisions whereby certain prescription drugs may be provided through the PBM's mail order pharmacy service.

a. The PBM shall provide Client with appropriate numbers of its standard information material explaining its mail service and the forms necessary for Members to utilize the service. The PBM shall make available to Members toll-free telephone access to a pharmacist and customer service representative. Access to a pharmacist shall be available 24 hours per day, seven days per week.

b. Subject to and in accordance with the Plan and applicable law, the PBM shall dispense through its mail service pharmacy new or refill prescription drug orders upon receipt from a Member of a valid prescription order or a completed refill order form, and the applicable copayment or coinsurance amount. The PBM shall cause the filled prescriptions to be mailed to each Member via common carrier at the address shown on the PBM's records, so long as such address is in the United States. Neither Service Contractor nor the PBM shall have any liability to Client or any Member for any delay in delivery due to circumstances beyond the PBM's control.

c. PBM shall at all times while this Appendix is in effect operate its mail service pharmacy in compliance with all applicable state and federal laws and regulations, and shall dispense only those prescription drugs which, in its sole discretion, fulfill requirements of the prescription writer and comply with such laws. The PBM shall have the right to refuse to fill or renew a prescription for any Member when, in the participating pharmacist's professional judgment, the filling or renewing of such prescription is not in the best interest of the Member, or the pharmacist has reason to doubt the authenticity of the prescription. The PBM may from time to time implement programs through its mail service pharmacy to promote certain prescription drugs.

d. Client acknowledges that the PBM's mail service pharmacy may from time to time engage in therapeutic interchanges.

e. The PBM's mail service pharmacy may dispense drugs to Members even if the prescription is not accompanied by the correct copayment, coinsurance or deductible amount. If Service Contractor is charged for any uncollectible copayment, coinsurance or deductible amount, Client shall be liable to Service Contractor for such amount if reasonable collection efforts by the PBM fail.

5. Plan Changes

If Client elects to change the prescription drug benefits of the Plan, including but not limited to covered drugs, copayment, coinsurance or deductible amounts, or prior authorization Client shall advise Service Contractor in writing, and Service Contractor shall inform PBM. Whether the changes can be implemented, and/or implemented by the date Client requests, will be determined at least in part by the PBM.

6. Proprietary Rights

The format of all reports, printouts and copies therefrom, and any prior and future versions thereof by any name, are the property of the PBM and are protected by copyright which the PBM owns.

7. **Limitations**

The Service Contractor does not direct or exercise any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or providing pharmaceutical-related services at a PBM participating pharmacy. Participating pharmacies are independent contractors, not subcontractors or agents of the Service Contractor, and the Service Contractor shall not have any liability to Client or any Member for any loss or damage related to or in any way growing out of any act or omission of any PBM participating pharmacy or its agent or employee.

8. **Payments**

For the PBM's services, Client shall pay Service Contractor:

The amounts Service Contractor bills for (i) drugs provided to Members during the preceding billing period, plus (ii) dispensing fees PBM charged for prescriptions filled for Members by participating and mail order pharmacies during the preceding billing period.

Charges for drugs provided to Members may be based on the average wholesale price of a prescription drug as calculated by the PBM using a variety of factors, including but not limited to the First DataBank National Drug Data File or other nationally recognized pricing source. The PBM's method of calculating the average wholesale price of a prescription drug may change from time to time, as the PBM shall determine. Service Contractor shall have no duty to notify Client of any such change.

Client acknowledges that the Service Contractor's net cost to provide the pharmacy benefit management services described in this Appendix might be more or less than the payments called for by this section, and Client agrees that the Service Contractor is at risk for such difference.

9. **Termination**

a. This Appendix may be terminated at any time upon thirty (30) days prior written notice by either party to the other. In addition, this Appendix shall terminate automatically when the first of the following events occurs:

   (i) the Administrative Services Contract ends;

   (ii) the Plan terminates;

   (iii) the Service Contractor no longer administers the Plan;

   (iv) the Plan no longer includes a prescription drug benefit that utilizes a PBM;

   (v) Client commits a material breach of this Appendix or defaults in the performance of any of its duties or obligations under this Appendix and such breach or default continues for a period of fifteen (15) days after Service Contractor gives Client written notice specifying the nature of the breach or default.

b. Termination of this Appendix while the Administrative Service Contract continues in effect shall be a modification of the Service Contractor's administrative duties for purposes of Section 4.2.1.b of the Contract.

Claim Appeal Fiduciary Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

1. Client agrees that Service Contractor will serve as a fiduciary solely with respect to the handling of claims appeals as set forth below. Nothing in this Appendix, or in the Contract, shall be construed to establish Service Contractor as a fiduciary for any purpose whatsoever other than as expressly stated herein. Service Contractor is not, and shall not be, the Plan Administrator of the Plan. Further, nothing in this Appendix, or in the Contract, shall be construed to establish Service Contractor as the Plan Administrator. Service Contractor's sole fiduciary obligation with respect to the Plan will be to handle claims appeals. Service Contractor will have no fiduciary responsibility with respect to:

   a. establishing or determining the eligibility of Members, except to the extent that such eligibility may be relevant in the conduct of processing an appeal; or

   b. establishing, adopting or amending the terms of the Plan; or

   c. providing disclosures or notices to Members including, but not limited to, summary plan descriptions, notices of amendments to the Plan, annual reports, or COBRA notices, except notices of Service Contractor's decision on review of an appeal of a denied claim; or

   d. the funding methodology of benefits under the Plan; or

   e. the availability of funds to pay for claims and expenses of the Plan, or the payment of any such claims or expenses; or

   f. the establishment or maintenance of stop-loss or excess loss insurance; or

   g. any aspect of the Plan other than the processing of appeals of denied claims as set forth below.

2. Service Contractor will require Members to exhaust two (2) levels of claim appeal to, or arranged by, the Service Contractor, prior to pursuing a civil action under ERISA.

3. With respect to claims that do not require medical review, Service Contractor will permit Members to undertake one or more additional appeals ("voluntary appeal") after the exhaustion of the first two appeals, provided that any Member who wishes to undertake such a voluntary appeal must present new and relevant information that was not considered, or available for consideration, in a previous appeal.

4. With respect to the appeal process, Service Contractor will have complete authority and full discretion to:

   a. interpret the Plan, and

   b. resolve any ambiguities in the Plan documents, and

   c. determine whether an appealed claim was properly paid or denied, either in whole or in part, and

   d. cause the Plan to pay a claim that had been previously denied, either in whole or in part, or to disapprove a claim that had been previously approved, either in whole or in part.

5. All appeals shall be conducted in accordance with policies and procedures established by Service Contractor (which may be changed from time to time at the discretion of Service Contractor), the plan documents, and the appeals provisions of the United States Department of Labor claims regulations.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA")
Privacy and Security Contract Appendix

To be attached to and made a part of the Administrative Services Contract

Effective Date: December 1, 2006

By and Between

City of Long Beach

AND

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

The Service Contractor and the Client agree as follows:

1. **Definitions**. The following terms shall have the meaning ascribed to them in this Appendix.

   a. "Applicable Law" shall mean any such item listed below in this sub-section A as it may apply to any particular Protected Information, including any amendments to any such item as such may become effective;

      i. the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");
      ii. the federal regulations regarding privacy and security promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164, and
      iii. any state statute or regulation or other bulletin or document that has the force of law that has been issued by a state in furtherance of that state's protection of the privacy or security of an individual's health information to the extent that such statute or regulation or other bulletin or document that has the force of law is not otherwise pre-empted by any federal law; and
      iv. any statute or regulation or other bulletin or document that has the force of law that has been issued in furtherance of a governmental entity's ability to obtain health information for health oversight purposes, investigatory, administrative, judicial or law enforcement proceedings or other lawful purpose.

   b. "Contract" shall refer to this Appendix.

   c. "Individual" shall mean the person who is the subject of the Protected Information or a person who qualifies as the personal representative of the individual.

   d. "Protected Information" shall mean any information, in any form, including electronic information that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, including demographic information collected from an individual, that is created by a health care provider, health plan, employer or health care clearing house, or by a Party and that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual, and that is obtained, created, received, maintained or transmitted on behalf of the other Party.

   e. "Party" or "Parties" shall mean the Service Contractor and the Client.

   f. "Secretary" shall mean the Secretary of the Department of Health and Human Services ("HHS") and any other officer or employee of HHS to whom the authority involved has been delegated.

   g. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification or destruction of electronic Protected Information or interference with the operation of an information system.

2. <u>Term and Termination</u>. The term of this Contract shall commence as of the Effective Date, and shall terminate when all of the Protected Information made available and/or transferred or caused to be transferred

to a Party, or obtained, accessed by, or received by a Party from or at the direction of or on behalf of the other Party or a customer of either Party is destroyed, rendered inaccessible, or returned to the appropriate Party.

3. Limits on Use and Disclosure Established by Terms of Contract. The Parties shall be prohibited from using or disclosing the Protected Information for any purpose other than as expressly permitted or required by this Contract.

4. Permitted and Required Uses and Disclosures. Except as otherwise set forth in this Contract, the Parties shall be permitted to use and/or disclose Protected Information only for the purpose of conducting the transactions contemplated under this Contract and only for purposes within the scope of that Party's representation of, or work conducted on behalf of the other Party or a customer of the other Party.

5. Use of Protected Information for Management, Administration and Legal Responsibilities. The Parties are permitted to use Protected Information if necessary for the proper management and administration of their respective businesses and to carry out their respective legal responsibilities.

6. Disclosure of Protected Information for Management, Administration and Legal Responsibilities. The Parties are permitted to disclose Protected Information for the proper management and administration of their respective businesses and to carry out their respective legal responsibilities, provided:

   a. The disclosure is required by Applicable Law; or

   b. The disclosing Party obtains reasonable assurances from the person to whom the Protected Information is disclosed that it will be held confidentially and used or further disclosed only as required by Applicable Law or for the purposes for which it was disclosed to the person, the person will use appropriate safeguards to prevent use or disclosure of the Protected Information, and the person will immediately notify the disclosing Party of any instance of which it is aware in which the confidentiality of the Protected Information has been breached.

7. Data Aggregation Services. Each Party is permitted to use or disclose Protected Information to provide data aggregation services, as that term is defined by 45 C.F.R. 164.501, relating to the health care operations of that Party.

8. Obligations of Party Receiving Protected Information:

   a. Limits on Use and Further Disclosure Established by Contract and Law. The Parties hereby agree that the Protected Information shall not be further used or disclosed other than as permitted or required by this Contract or as required by Applicable Law.

   b. Appropriate Safeguards. The Parties will establish and maintain appropriate safeguards to prevent any use or disclosure of the Protected Information other than as provided for by this Contract. The Parties shall also establish and maintain administrative, physical and technical safeguards to reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Information.

   c. Reports of Disclosures. The Parties shall maintain information related to its disclosures of Protected Information sufficient to provide each other with any necessary accounting of such disclosures and shall promptly notify the other of any such disclosures in a manner acceptable to the Parties.

   d. Reports of Improper Use or Disclosure. The Parties hereby agree that they shall promptly report to each other any use or disclosure of Protected Information not provided for or allowed by this Contract including any Security Incident related to electronic Protected Information.

   e. Public Statements. The Parties agree that any public statements regarding the other Party's information security program must be approved by the other Party, in advance, to protect the confidentiality, integrity and availability of the security program.

   f. Subcontractors and Agents. The Parties hereby agree that anytime Protected Information is provided or made available to any subcontractors or agents, the disclosing Party must enter into a subcontract with the subcontractor or agent that contains the same terms, conditions and restrictions as contained in this Contract, including reasonable and appropriate safeguards for electronic Protected Information.

g. Right of Access to Protected Information. To the extent required by the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts160 and 164, the Parties hereby agree to make available and provide a right of access to Protected Information by an Individual. This right of access shall conform with and meet all of the requirements of 45 C.F.R. 164.524 to the same extent as if the Party were directly subject to 45 C.F.R. 164.524.

h. Amendment and Incorporation of Amendments. To the extent required by the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164, the Parties agree to make Protected Information available for amendment and to incorporate any amendments to Protected Information in accordance with 45 C.F.R.164.526 to the same extent as if the Party were directly subject to 45 C.F.R. 164.526.

i. Provide Accounting. To the extent required by the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164, the Parties agree to make Protected Information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528 to the same extent as if the Party were directly subject to 45 C.F.R. 164.528.

j. Access to Books and Records. The Parties hereby agree to make their respective internal practices, books, and records relating to the use or disclosure of Protected Information available to the Secretary or the Secretary's designee for purposes of determining compliance with the HHS Privacy Regulations. The Parties hereby agree to make their internal practices, books, and records relating to the use or disclosure of Protected Information and the security of electronic Protected Information reasonably available to each other.

k. Return or Destruction of Protected Information. At termination of this Contract each Party hereby agrees to return or destroy all Protected Information received from, or created or received by the other, and not to retain any copies of the Protected Information after termination of this Contract, if reasonably feasible. If return or destruction of the Protected Information is not feasible, the Parties agree to extend the protections of this Contract for as long as necessary to safeguard the Protected Information and to limit any further use or disclosure consistently with the intent of this Contract. If a Party elects to destroy the Protected Information, it shall certify to the other Party that the Protected Information has been destroyed.

l. Mitigation Procedures. The Parties agree to have procedures in place, and to implement those procedures as necessary, for mitigating, to the extent practicable, any deleterious effect from the use or disclosure of Protected Information in a manner not consistent with this Contract. The Parties also agree to mitigate, to the extent practicable, any deleterious effects from a Security Incident involving electronic Protected Information.

m. Minimum Necessary. When using or disclosing Protected Information under this Contract, or when requesting Protected Information from another party for purposes related to this Contract, a Party shall make reasonable efforts to limit Protected Information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

n. Notice of Restriction. The Parties agree to notify each other of requests for restriction or confidential communications, submitted in accordance with 45 C.F.R. 164.522, which may affect the performance of the other Party. Notification shall be provided in advance of any agreement to such restriction or confidential communication.

o. Training. The Parties agree to maintain diligent hiring practices and train individuals granted access to Protected Information about their privacy and security responsibilities.

p. Survival. The rights and obligations pursuant to this Contract shall survive termination of the Administrative Service Contract.

PLAN DOCUMENT

PLAN DOCUMENT

Article I. Establishment of the Plan

1.1 **The Plan.** CITY OF LONG BEACH (the Employer) hereby establishes a Plan of Medical and Prescription Drug benefits for its Employees. This plan will be known as the CITY OF LONG BEACH Health Care Payment Plan (the Plan) and is effective as of December 1, 2006 for active Employees, as of January 1, 2007 for retired Employees who are eligible for Medicare, and as of February 1, 2007 for retired Employees not eligible for Medicare in replacement of the Plan Document which was effective December 1, 2005. This Plan is designed to provide Employees and their Eligible Dependents with significant financial protection against the economic strain that might result from Illness or Injury.

Only the terms and provisions relating to the Medical and Prescription Drug Benefits, as described in the Summary Plan Descriptions listed below, form a part of the Plan:

a. Great-West PPO Plan;

b. Great-West POS 100 Plan;

c. Great-West POS 90 Plan;

d. Great-West PPO Thrift Plan;

e. Great-West Medicare Supplement (MSB) Plan

1.2 **Plan Document**. The plan document consists of two parts: Part One includes Articles I through V; the "APPLICABILITY OF COVERAGE DOCUMENT" page, the "ELIGIBLE CLASS OR CLASSES" page; Part Two includes the attached Summary Plan Descriptions of Medical and Prescription Drug Benefits.

Article II. Definitions

2.1 Employee means any individual employed by the Employer and to the extent necessary, a retired or terminated employee entitled to receive Benefit payments under this Plan.

2.2 Participant means an employee who has elected to participate in the Plan.

2.3 Eligible dependent means an individual defined under the Plan as an eligible dependent.

2.4 Plan Claim Administrator means the entity designated by the Employer to pay claims for Benefits.

2.5 Plan Administrator means the Employer.

Article III. Funding

3.1 **Source of Funds**. The funding medium for the Plan is funds contributed by the Employer from its general assets and by Participants. The amount of Participant contributions shall be as determined by the Employer from time to time.

Article IV. Payment of Claims

4.1 **Submission of Claims**. Claims for benefits under the Plan shall be submitted to the Plan Claim Administrator and in accordance with the procedures described in the Summary Plan Description in effect at the time claim is submitted.

4.2 **Appeal of Denied Claim**. An employee or eligible dependent whose claim is denied in whole or in part may appeal such denial in accordance with the claim review procedures described in the Summary Plan Description.

Article V. General Provisions

5.1 **Plan Administrator**. The Plan shall be administered by the Employer, which shall have the authority to construe and interpret the terms of the Plan, and resolve any disputes which may arise with regard to the rights of persons covered under the Plan, including but not limited to eligibility for participation and claims for benefits. The Administrator shall be responsible for maintaining all records relating to the administration of the Plan and for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service and Department of Labor applicable to Employee Welfare Benefit Plans.

5.2 **Rules and Decisions**. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Plan Claim Administrator, or legal counsel.

5.3 **Nonalienation of Benefits**. Benefits payable under this Plan shall not be assigned, transferred, or pledged as collateral prior to their actual receipt by the person entitled thereto under the terms of the Plan.

5.4 **Termination and Amendments**. The Employer intends that this Plan will continue in effect indefinitely, but reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed by its duly authorized officers on this

____________ day of ______________, 20___.

____

Title:____

PLAN OF

MEDICAL AND PRESCRIPTION DRUG BENEFITS
(herein called the Plan)

FOR

EMPLOYEES OF

CITY OF LONG BEACH
(herein called the Employer)

Effective: December 1, 2006

APPLICABILITY OF COVERAGE DOCUMENT

Only the terms and provisions relating to the Medical and Prescription Drug as described in of the Summary Plan Descriptions listed below, form a part of the Plan:

a. Great-West PPO Plan;

b. Great-West POS 100 Plan;

c. Great-West POS 90 Plan;

d. Great-West PPO Thrift Plan;

e. Great-West Medicare Supplement (MSB) Plan

ELIGIBLE CLASS OR CLASSES

Eligible Class or Classes of Employees

Eligible employees are all employees of the Employer if they are hired to do work on a Permanent Full-Time basis.

A Retired Employee and his or her eligible dependents are included in an Eligible Class for Medical Care and Prescription Drug Benefit coverages.

"Retired Employee" means a person who meets the rules and regulations of the Employer's pension benefits program at the time of the retirement on or after August 1, 1982.

If an employee elects coverage through a Health Maintenance Organization (HMO), the employee and his or her dependents will not be eligible for the Prescription Drug Benefits of the Plan.

PROVISIONS RELATING TO INDIVIDUAL COVERAGE

Contribution Basis

1. For Employee's Coverage:

   Contributions are required from employees for personal coverage in accordance with rules established by the Employer for the Great-West PPO Plan, Great-West POS 100 Plan, Great-West POS 90, Great-West PPO Thrift Plan and Medicare Supplement Plan.

2. For Dependent's Coverage:

   Contributions are required from employees for dependent coverage in accordance with the rules established by the Employer for the Great-West PPO Plan, Great-West POS 100 Plan, Great-West POS 90 Plan, Great-West PPO Thrift Plan and Medicare Supplement Plan.

Employee Eligibility Date

Each employee who is in an Eligible Class on the effective date of the Plan will be eligible on that date.

Each employee who later enters an Eligible Class shall be eligible for Medical and Prescription Drug benefits as follows:

1. New employees hired on the first through the fourth of the month are eligible on the first of the following month.

2. New employees hired on or following the fifth of the month are eligible on the first of the following or coinciding with one full month of employment.

Termination of Coverage

Part 1. of the "When Coverage Ends" provision is expanded to read:

1. the end of the month in which the employee ceases Active Work on a Permanent Full-Time Basis in an Eligible Class unless one of the following events occurs:

   a. if the employee ceases Active Work due to Injury or Illness, the Employer will continue his or her Medical Care coverage subject to payment of any Contribution. Such coverage will continue only while the employee is unable to return to work because of the Injury or Illness. Such continuance will be on a basis precluding individual selection;

   b. if the employee stops Active Work to take a qualified military leave of absence (pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994) he or she may elect to continue coverage subject to payment of Contributions. Such coverage will continue only while he or she is unable to return to work because of the qualified military leave of absence. Such continuance will be on a basis precluding individual selection;

   c. if the employee ceases Active Work to take a Qualified Leave of Absence (pursuant to the Family and Medical Leave Act of 1993) for reasons other than personal Illness or Injury, the Employer will continue his or her coverage subject to payment. Such coverage will continue only while the employee is unable to return to work because of the Qualified Leave of Absence. Such continuance will be on a basis precluding individual selection;

   d. if the employee ceases Active Work due to other leave of absence, or due to temporary layoff, the Employer may elect to continue coverage subject to payment. Such coverage may be continued until the earlier of the date on which he/she becomes engaged in any occupation or employment for pay or profit or the date which is 90 days after the date of termination. This coverage continuance will be on a basis precluding individual selection.

INSERT SUMMARY PLAN DESCRIPTIONS (SPD'S) HERE

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY
Greenwood Village Administrative Office:
8505 East Orchard Road
Greenwood Village, Colorado 80111
(303) 737-3000

APPLICATION FOR EXCESS LOSS INSURANCE

City of Long Beach

(the Applicant) hereby applies to Great-West Life & Annuity Insurance Company for Excess Loss Insurance Policy No. 024968 in the form attached hereto. This Policy has been approved and its terms accepted by the Applicant.

Dated ___________________, 200__
City of Long Beach

Witness: ____________________________ By: ____________________________

Licensed Resident Agent: ____________________________ Title: ____________________________

Excess Loss Insurance Policy
(Non-Dividend Participation)

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GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

SCHEDULE OF EXCESS LOSS INSURANCE

This Schedule is applicable only to the Excess Loss Insurance Policy issued to the Policyholder whose name is specified below.

Each category, coverage basis, and optional feature of the Excess Loss Insurance described herein and in each of the attached Riders (hereafter, collectively referred to as "Categorized Coverage") applies to the Policyholder only when the appropriate selection of such Categorized Coverage is indicated by the Company in the appropriate space provided. The data in this Schedule is applicable only to the First Policy Term (commencing on the Effective Date through the Expiration Date of the Policy). This Excess Loss Insurance Policy may be renewed pursuant to provisions of Article VIII, Section A "Renewal", contained herein.

A. POLICYHOLDER'S AND PLAN'S INFORMATION, POLICY'S IMPORTANT DATES AND COVERAGE PERIODS

1. Policyholder's Control Number:

0024968

Full Legal Name of Policyholder ("Policyholder" and/or "You"):

City of Long Beach

Address:

333 West Ocean Boulevard, 13th Floor
Long Beach, CA 90802

Full Legal Names of Associated Companies included, if any:

Not Applicable

2. Policy's Important Dates & Renewal Term:

The Initial Effective Date of this Policy: December 1, 2006

The Expiration Date of this Policy: November 30, 2007

The Anniversary Date of this Policy: December 1

Renewal Term of this Policy: At the end of the Expiration Date, renewable for a one-year term

3. Policy Period and Coverage Periods:

Policy Year: 12 months

Expense Incurral Period:

Aggregate: The Policy Year December 2005 – November 30, 2006.

Expense Payment Period:

a) While the Policy is in effect:
Aggregate: The Policy Year

b) After the Policy ends for any reason except the Policyholder's insolvency or failure to pay premium on time:
Aggregate: 12 Months

B. AGGREGATE EXCESS LOSS INSURANCE

You are insured for the Aggregate Excess Loss Insurance.

Monthly Attachment Points are provided in the Rate Confirmation Table.

Covered Benefits:
Medical, outpatient prescription drugs (through a third party vendor plan), vision (through a third party vendor plan).

Optional Feature for Aggregate Loss Insurance included in the Policy:

Rider #D2: Monthly Accommodation and Terminal Protection with Deficit Carryforward Type B

Number of consecutive calendar months included as Policy Months after the Policy ends: 12 months

Terminal Attachment Points:

As provided in the Rate Confirmation Table.

C. PREMIUMS

Monthly premium for each Categorized Coverage is determined for the Premium Unit method by multiplying the applicable premium rate (expressed as a dollar amount) by the applicable number of the specified Premium Units covered under the Plan on the first day of each Policy Month. If more than one type of Premium Unit is utilized as indicated below, add all products of the multiplications for all identified types of the Premium Unit together to arrive at the total monthly premium for such Categorized Coverage.

As used throughout the Premiums section of this Schedule, the term Covered Benefits includes only those amounts that meet the definition of Covered Benefits of Article II – Definition but which are not reimbursable by the Company because, with respect to the Aggregate Excess Loss portion, they do not exceed the Cumulative Attachment Limit or the Annual Attachment Limit, whichever is applicable.

1. **Aggregate Excess Loss Premium:** Provided in the Rate Confirmation Table.

2. **Rider Premium:**

   Premiums for Riders listed above have been included in the Aggregate Premium Rates.

D. BANKING OPTIONS (identifies the frequency of your withdrawals from Your Bank Account for claims payments): Monthly

E. NAME OF THIRD PARTY PLAN ADMINISTRATOR (TPA):

Great-West Life & Annuity Insurance Company

ARTICLE II. DEFINITIONS

As used in this Policy, its attached Riders, Amendments, Addenda, and Appendices, unless the context specifically indicates otherwise, the following terms shall have the following meanings:

ANNUAL ATTACHMENT LIMIT
means the annual deductible amount for the Aggregate Excess Loss Insurance which is the financial responsibility of the Policyholder. This amount is the Cumulative Attachment Limit for the last Policy Month of the Policy Year.

COBRA PARTICIPANT
if specified in the Schedule as applicable to You, means a person who is covered under Your Plan by virtue of that person's status as a COBRA qualified beneficiary who validly and timely elects to continue coverage pursuant to the federal health continuation coverage law under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. The term COBRA Participant does not include any person covered under the Plan whose continued coverage is not mandated by such law.

COMPANY
means Great-West Life & Annuity Insurance Company.

COVERED BENEFITS
for purposes of Excess Loss Insurance coverage under this Policy:

1. to the extent not being limited further under Section 2. immediately below, are limited to expenses incurred by a Covered Person which are:

   a. **included** in the class or classes of Covered Benefits shown in the Schedule; and

   b. **covered** under the terms of the Plan, taking into account all of the exclusions and limitations in the Plan; and

   c. incurred:

      i. during the Expense Incurral Period shown in the Schedule; and

      ii. prior to the date this Policy ends; and

   d. **paid** during the Expense Payment Period, shown in the Schedule.

   Covered Benefits do not include: 1) any amount that is excluded from coverage under this Policy pursuant to Article IV - Limitations and Exclusions of Coverage; or 2) with respect to any Policy Year, any amount that qualifies as Covered Benefits for any previous Policy Year.

COVERED PERSON
means a person who is in a class or classes of persons included under Your Excess Loss Insurance Policy as specified in the Schedule who is enrolled for coverage and meets the eligibility requirements set forth under the Plan.

CUMULATIVE ATTACHMENT LIMIT

1. During the Policy Year while the Policy remains in effect, means:

   a. For each Policy Month, the sum of the Monthly Attachment Limit for the current Policy Month plus the Monthly Attachment Limit for each of the previous Policy Months in the then current Policy Year.

2. After the Policy ends for any reason except the Policyholder's insolvency or failure to pay premium on time, means:

   a. For the first Policy Month after the Policy ends, the sum of the Terminal Attachment Limit for such Policy Month plus the Cumulative Attachment Limit for the last Policy Month prior to the end of this Policy.

b. For the second Policy Month after the Policy ends, the sum of the Terminal Attachment Limit for such Policy Month plus the Cumulative Attachment Limit for the prior Policy Month.

c. For subsequent months after the Policy ends, the Cumulative Attachment Limit will be equal to the Cumulative Attachment Limit of the second month after the Policy ends.

EXPENSE INCURRAL PERIOD
as shown in the Schedule, means the period of time during which an expense covered under Your Plan must be incurred by a Covered Person to count as a Covered Benefit under this Policy.

In no event shall the Expense Incurral Period extend beyond the date the Policy ends.

Unless specifically stated otherwise, an expense is considered incurred on the date the service, treatment or supply is provided to a Covered Person.

EXPENSE PAYMENT PERIOD
as shown in the Schedule, means the period of time during which the Plan must actually make payment for expenses covered under Your Plan in order to count as a Covered Benefit under this Policy.

Unless specifically stated otherwise, an expense is considered paid on the date a check or draft of the Policyholder is issued for payment, provided sufficient funds are then available to cover such payment, and it is:

1. placed in the United States mail or other means of delivery to the payee; and

2. paid upon presentation.

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN
means care and treatment for which the Company determines that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications.

2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.
   The Company determines if this item 2 is true based on:

   a. published reports in authoritative medical literature; and

   b. regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, the federal Food and Drug Administration (FDA), the Health Care Financing Administration (HCFA), or any other appropriate technological assessment body.

3. In the case of a drug, a device or other supply that is subject to FDA approval:

   a. it does not have FDA approval;

   b. it has FDA approval only under its Treatment Investigational New Drug regulation or similar regulation; or

   c. it has FDA approval, but it is being used for an indication or at a dosage that is not an Accepted Off-Label Use. An "Accepted Off-Label Use" is a use that is:

      i. included and favorably recognized for treatment of the indication in one or more of the following medical compendia: The American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and The United States Pharmacopoeia Information; or

      ii. established based on supportive clinical evidence in peer - reviewed medical publications.

4. The providers institutional review board acknowledges that the use of the service or supply is Experimental, Investigational, or Unproven and subject to that board's approval.

5. Research protocols indicate that the service or supply is Experimental, Investigational, or Unproven. This item 5 applies for protocol used by the Covered Person's provider as well as for protocols used by other providers studying substantially the same service or supply.

FAMILY MEMBER
if specified as applicable to Your Excess Loss Insurance Policy, means each Covered Person in the same Family Unit other than a Participant.

FAMILY UNIT,
if specified as applicable to Your Excess Loss Insurance Policy, means a Participant and all of such Participant's eligible dependents who are Covered Persons under Your Plan.

MONTHLY ATTACHMENT LIMIT
means the Aggregate Excess Loss Insurance monthly deductible amount which is the financial responsibility of the Policyholder and is to be calculated by multiplying the appropriate Monthly Attachment Point (as shown in the Schedule) by the appropriate number of the Attachment Units at the beginning of such Policy Month.

If more than one type of the Attachment Unit is utilized as stated in the Schedule, add all products of the multiplications for all identified types of the Attachment Unit together to arrive at the total amount of the Monthly Attachment Limit for such Policy Month.

PARTICIPANT
means a Covered Person who is covered under the Plan as an eligible employee, retirees, or COBRA qualified beneficiary, or under other coverage status (but only if such other coverage status is specifically approved to be included in this Policy in writing in advance by the Company).

PLAN
means the self-funded employee health benefit plan or plans established and maintained by You and approved by You and the Company for purposes of this Excess Loss Insurance Policy. If so approved by the Company, the term "Plan" shall, during the period immediately prior to the date on which the self-funded plan as described in the first sentence is approved by both parties, mean either:

1. a draft Summary Plan Description(s), or a Brief Outline of Plan Benefit Design(s), or a copy(ies) of Your plan's prior benefit booklets or certificates (with modifications, if any, as so specified), whichever being attached to the end of this Policy; or

2. if the Company is appointed as the Policyholder's TPA, magnetic or computer-readable records of plan's information maintained by the Company, which are used by the Company as a source of information to provide claim payment and other administrative services to the Policyholder's Plan.

POLICY
means the Excess Loss Insurance Policy issued to the Policyholder. This Policy contains the Aggregate Excess Loss Insurance coverage as specified in the Schedule to be applicable to the Policyholder.

POLICY MONTH
means a calendar month during a Policy Year.

POLICY QUARTER
means a period of three consecutive Policy Months during a Policy Year, with the first Policy Quarter beginning on the Effective Date of this Policy.

POLICY YEAR
means the Policy Period which is a period beginning on the Effective Date or the most current Renewal Date of the Policy and, except for the first Policy Year which may contain any number of Policy Months (if so indicated in the Schedule), consists of 12 consecutive Policy Months. For purposes of this Policy, the Policyholder's Final Active Policy Year will end on the date the Policy ends, even if this occurs prior to the Expiration Date and/or results in a Policy Year consisting of less than 12 Policy Months.

SCHEDULE
means the Schedule of Excess Loss Insurance coverage included and specified under Article I as applicable to You, or such Schedule as amended or supplemented by the Renewal Schedule of Excess Loss Insurance issued specifically to You, or any Amendments thereto, showing the category, coverage basis, feature and applicable rates, factors and points of Your Excess Loss Insurance coverage under the Policy.

TERMINAL ATTACHMENT LIMIT
applies exclusively to the Aggregate Excess Loss Insurance Policy with a Rider providing Terminal Protection, and means part of the Aggregate Excess Loss Insurance deductible amount which is the financial responsibility of the Policyholder and is to be calculated monthly after the Policy ends as follows:

1. For each of the first two Policy Months after this Policy ends, multiply the appropriate Terminal Attachment Point by the appropriate number of the Attachment Units on the first day of the second prior Policy Month.

2. For the third and each subsequent Policy Months after this Policy ends, the Terminal Attachment Limit for such Policy Month is zero.

If more than one type of the Attachment Unit is utilized as stated in the applicable Rider information section of the Schedule (or an amendment), add all products of the multiplications for all identified types of the Attachment Unit together to arrive at the total amount of the Terminal Attachment Limit for such Policy Month.

YOU, YOUR, POLICYHOLDER or POLICYHOLDER'S
means the Policyholder whose name is shown in the Schedule.

ARTICLE III. AGGREGATE EXCESS LOSS INSURANCE

The provisions under this Article III apply to You only if You are insured for the Aggregate Excess Loss Insurance.

A. While the Policyholder's Aggregate Excess Loss Insurance remains in effect, the Company will pay to the Policyholder, subject to the terms, conditions and limitations of the Policy, the Aggregate Excess Loss Insurance reimbursement due, if any pursuant to Article VIII – Claims Provisions.

B. After the end of each Policy Year the Company will reimburse the Policyholder the amount by which the Plan's total paid Covered Benefits during the Policy Year exceed the Annual Attachment Limit for such Policy Year.

ARTICLE IV. LIMITATIONS & EXCLUSIONS OF COVERAGE

A. The Company shall have no obligation under this Policy to directly pay any Covered Person or provider of professional or medical services or supplies for any benefit which the Policyholder has agreed to provide under the terms of the Plan. This Policy is solely between the Company and the Policyholder, and shall not create any rights or legal relationship between the Company and any Covered Person or agent, assignee or beneficiary thereof. The Company's sole liability hereunder is to the Policyholder, subject to the terms, conditions and limitations of this Policy.

B. Expenses incurred for or in connection with the following, as reasonably determined by the Company, will not be considered Covered Benefits under this Policy and the Company shall not be liable to reimburse the Policyholder or any person for any such expenses:

1. For expenses incurred while the Plan's coverage is not in force with respect to the Covered Person.

2. For expenses which are not covered, or are in excess of the amount payable, under the terms and provisions of the Plan.

3. For or in connection with any managed care or catastrophic case management programs not specifically contained in the Plan, unless provided otherwise in a Rider or unless the Company has agreed in writing in advance to cover such specific payment.

4. For expenses to the extent the Policyholder or Plan receives any payment or receives a reduction in charges because of a PPO, EPO, other managed care arrangement, claims reduction negotiation program, a coordination of benefits provision in the Plan or any right of recovery or subrogation.

5. For or in connection with procedures, drugs or treatment methods that are deemed Experimental, Investigational or Unproven, except to the extent agreed to otherwise in writing in advance by the Company.

6. For any liability due to war, declared or undeclared, or riots.

7. For any liability or obligations assumed by the Policyholder under any contract or service agreement other than the Plan.

8. For cost of the administration of claims payments or expense of litigation with individual claimants, service or professional providers relating or unrelating to benefits under the Plan including, but not limited to, costs of defense and liability for punitive or exemplary or extracontractual damages.

9. For liabilities, expenses, losses or fines which are based upon noncompliance or violation of any court judgment or order, any federal or state statute, rule, or regulation.

10. For premium or surcharge taxes, other assessments, or similar payment obligations regardless of what their title is and regardless of who or what entity the designated payee is, as levied by any local, state or other governmental unit against the Plan, Policyholder or Company, unless the Company has agreed in writing in advance to cover such specific payment.

11. For expenses in excess of the usual and customary charges for the locality where administered.

12. For expenses or losses that were caused by a wrongful, criminal or tortious act of any person or entity and for which the Policyholder or Plan released such person or entity from its legal liability without just compensation to the Plan.

13. For liabilities which are non-pecuniary in nature (not having a monetary value).

14. For expenses or claims paid by any person or entity other than the Company, unless the Company has agreed in writing in advance to cover such specific payment.

C. Subject to the provisions of any Rider that provides Terminal Protection, after the termination of this Policy, the Company will not be liable for any further payments under this Policy regardless of the date that the underlying benefit claim was incurred or submitted to the company, provided that the company has not intentionally delayed processing the claim.

ARTICLE V. TERMINATION OF POLICY

The Policy and all coverages hereunder will terminate upon the earliest of the following dates.

A. Except as provided under the Grace Period Section under Article VI, at the end of any period for which the last premium is paid.

B. Except to the extent of coverage provided under the Terminal Aggregate Liability Protection feature as described in the appropriate Rider, if such Rider applies to You, the date the Policy ends.

C. The date of termination of the Plan.

D. The Expiration Date of the Policy unless the Policy is renewed pursuant to the Renewal Section under Article VII.

E. The date of cancellation of the administrative services agreement between the Policyholder and the Company.

F. If any state or other jurisdiction enacts a law which prohibits the continuance of this Policy, or the existing law is interpreted to so prohibit the continuance of this Policy, as reasonably determined by the Company, the Policy shall terminate automatically as to such time or jurisdiction on the effective date of such law or interpretation.

G. The Policyholder may terminate this Policy at any time by giving written notice to the Company at least 30 days in advance of such date.

H. The Company may terminate this Policy:

1. On any Expiration Date of the Policy, by giving written notice to the Policyholder at least 45 days prior to such date;

2. Immediately upon written notice to the Policyholder in the event the Policyholder files a petition for bankruptcy or for voluntary reorganization for the benefit of creditors, or is the subject of an involuntary petition for bankruptcy. However, such termination will not relieve the Company from its liability existing prior to the date of termination;

3. Immediately upon written notice to the Policyholder of the discovery of the Policyholder's material misrepresentation which affects the insurability of the risk;

4. Retroactively to the Policy Effective Date or the latest Renewal Date as applicable, upon written notice to the Policyholder, if it is discovered that the Policy was obtained or was renewed through fraudulent statements, omissions or concealment of facts material to the acceptance of the risk assumed by the Company

5. Immediately and without notice upon failure of the Policyholder to comply with any material term of this Policy; and

6. Immediately and without notice upon Company's receipt of information that the Policyholder has failed to fund its Benefit Payment Funding Account established to pay benefits under the Plan. This provision shall survive the termination of this Policy.

If this Policy terminates for any reason, the Policyholder shall remain liable for any unpaid amounts that have accrued under this Policy including amounts accrued during the grace period.

ARTICLE VI. PREMIUM PROVISIONS

A. PREMIUM DUE DATE AND PAYMENT: The first premium is due on the Effective Date of this Policy. Future premiums are due on the first day of each Policy Month. All premiums shall be paid in U.S. currency to the Company at its Greenwood Village Administrative Office. Premiums are not considered paid until the full premium payment is received by the Company.

B. GRACE PERIOD: A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect provided that the premium is paid before the end of the Grace Period. If the Policyholder does not pay the premium during the Grace Period, this Policy will terminate without further notice retroactively to the date for which premiums were last paid.

C. COMPUTATION OF PREMIUMS: Monthly premium for each Categorized Coverage will be computed as stated in the Schedule. Add all monthly premiums for all Categorized Coverages together, as applicable to the Policyholder, to arrive at the total monthly premiums for the Policyholder.

D. PREMIUM REFUNDS: Any error or correction to any premium paid for the preceding Policy Year must be reported to the Company within 60 days after the end of such preceding Policy Year. No premium refunds will be owed or made to the Policyholder or any person if an error or a correction in paid premium is failed to be reported to the Company within this time limit.

E. CHANGES IN RATES, FACTORS, CALCULATION OF MONTHLY ATTACHMENT LIMIT AND POINTS: The Company reserves the right to change any premium rates, factors, Monthly Attachment Limit calculation, and points and Specific Deductible Amount(s) on any of the following dates:

1. On the date when the terms of this Policy are changed

2. On any Anniversary Date of the Policy (however, any such change which represents an increase in rates, factors, points, or Specific Deductible Amount(s), will not become effective until after the date which is 30 days after the Company has given written notice to the Policyholder informing the Policyholder about the increase);

3. On the effective date of any change to the Plan having material effects on benefits provided under the Plan;

4. On the first day of a Policy Month following a change in Policyholder's primary business or in Policyholder's geographical location;

5. On the date the Policyholder adds or deletes subsidiary or affiliated companies or divisions with the Company's approval;

6. On the first day of a Policy Month following a change in the number of Covered Persons under the Plan if such change exceeds 10% in any Policy Month or 25% over any period of three consecutive Policy Months; and

7. On any date that the Policyholder requests the addition of a Covered Person who should have been included as a Covered Person earlier, such change to be retroactive to the date the Covered Person should have been included; provided, however, that Company reserves the right to consider that such Covered Person shall be included under this Policy no earlier than 60 days prior to the Policyholder's request to add the person(s).

ARTICLE VII. MISCELLANEOUS PROVISIONS

A. RENEWAL: On each Policy Anniversary Date, this Policy may be renewed by the mutual agreement of the Company and Policyholder, under the terms agreed to by the Company for a further term of the number of years as specified in the Schedule. The terms of such renewal shall be as set forth:

1. in the Schedule as modified or supplemented by the Renewal Schedule then issued by the Company to the Policyholder; or

2. if no new Renewal Schedule is issued, in the most recently-issued Schedule or Renewal Schedule, as the case may be, with appropriate adjustments to be made regarding the Effective Date, the Expiration Date, and the Policy Year period of the Policy.

B. ENTIRE CONTRACT: This Policy together with the Policyholder's applications, if any, attached hereto and the Policyholder's Plan, a copy of which is attached hereto or on file, or details of such being kept in records with the Company or, if so approved by the Company, with the Policyholder's designated TPA, and any Renewal Schedule, Riders, amendments, addenda, appendices and supplements attached hereto constitute the entire contract regarding the Excess Loss Insurance between the parties.

In the event of a conflict between the provisions of the Plan and the provisions of this Policy, the latter shall prevail. The Company has relied upon the underwriting information provided by the Policyholder or its authorized representative in the issuance of this Policy and the Policyholder represents such information as accurate. Should subsequent information become known which, if known prior to the issuance of this Policy, would affect the rate(s), attachment point(s), deductible(s), attachment limit(s), claim limit(s) or terms and conditions for coverage hereunder, the Company shall have the right to revise the rate(s), attachment point(s), deductible(s), attachment limit(s), claim limit(s), or terms or conditions as of the effective date of issuance of this Policy or, at the option of the Company as of the next premium due date, by providing written notice to the Policyholder.

C. DATA REQUIRED: The Policyholder shall maintain adequate records regarding administration of the Plan covered under this Excess Loss Insurance Policy. The Policyholder must maintain records of all Covered Persons under the Plan during the period the Policy is in effect and for a period of seven years after the end of the Policy. Upon request by the Company, the Policyholder shall make available to the Company any such records and information deemed necessary for the Company's administration of this Excess Loss Insurance Policy. The Company may periodically examine any of the Policyholder's records relating to the coverage under this Policy and any claims filed under the Plan, and as a result of any examination of the Policyholder's records shall be entitled to readjust premiums, attachment points, deductibles, attachment limits, claim limits or reimbursements paid as may be necessary to reflect the true intent of this Policy. This provision shall survive the termination of this Policy.

D. CLERICAL ERROR: Clerical error whether by the Policyholder or by the Company in keeping any records pertaining to the coverage will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, but no such error shall expand the Company's obligations under this Policy.

E. NOTICE: All notices and communications required under the terms of this Policy shall be given in writing by one party addressed to the other as follows:

1. Notices to the Company, to the following address, or other address as the Company may from time to time specify to the Policyholder in a written notice:

   Great-West Life & Annuity Insurance Company
   Greenwood Village Administrative Office
   8505 East Orchard Road
   Greenwood Village, Colorado 80111

2. Notices to the Policyholder, to the Policyholder's address specified in the Schedule, or other address as the Policyholder may from time to time specify to the Company in a written notice.

F. HOLD HARMLESS: It is understood that the only parties to this Policy are the Company and the Policyholder. No express or implied interest or rights are created under this Policy for any other persons

or entities, whether they are the Policyholder's employees, former employees, providers, their dependents, heirs or assignees; and no third-party beneficiary status is conferred upon such persons or entities.

Based on the above understanding, except for a claim, demand or lawsuit arising out of the Company's tortious or wrongful act committed directly against the Policyholder's employees or their dependents, the Company shall have no liability under this Policy, and the Policyholder agrees to hold harmless and indemnify the Company against any and all such loss, damage, and expense including court costs and attorney's fees, resulting from or arising out of claims, demands, or lawsuits brought against the Company by such employees, their dependents, heirs or assignees, and to claims for paid claim or surcharge taxes by any local, state or other governmental unit or other assessments (except for taxes on insurance premiums received under this Policy as described in Article VI) made against the Company by any governmental unit.

G. AMENDMENT TO THE PLAN: The Plan shall not be amended while this Policy is in force without the prior written consent of the Company. Notice of any amendment to the Plan must be given to the Company in writing at least 30 days prior to the effective date of the amendment. No change in benefits payable under the Plan or any amendment to the Plan will be binding on the Company until such change or amendment is approved in writing by the Company. In the event that such advance written notice is not received by the Company in accordance with this provision, the Company's reimbursement liability will be limited to the Plan provisions in effect prior to the change or amendment. The Company may, in its sole discretion and at the written request of the Policyholder, approve a Plan amendment retroactively to the date requested by the Policyholder, but the Company shall have no obligation to do so.

H. POLICYHOLDER'S THIRD PARTY ADMINISTRATORS (collectively "TPA"): Without waiving any of its rights or remedies under this Policy, the Company agrees to accept the Policyholder's request that the Company recognize the Policyholder's TPA, whose name(s) are indicated in the Schedule, as agents of the Policyholder for purposes of this Policy. Duties that the TPA is authorized and assigned to perform, on behalf of the Policyholder, include, but are not limited to, submitting proofs of loss, warranting the payment of prior claims, transmitting payment of premiums due the Company and receiving payments from the Company. Any payments by the Company to the TPA shall be construed as payments to the Policyholder. The Policyholder hereby holds the Company harmless from any liability arising from or related to any negligence, error, omission or defalcation by the TPA.

Unless the Company is appointed the Policyholder's TPA, the TPA shall not be considered an agent of the Company.

I. CONFORMITY WITH THE LAW: If any provision of this Policy at time of issue is contrary to any law to which it is subject, that provision is changed to meet the law's minimum requirements.

J. LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

K. AMENDMENTS TO THE POLICY: Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company have the authority to alter this Policy, or to waive any of the Company's rights or requirements and then only in writing. No such alteration to this Policy shall be valid unless amended on or attached to this Policy. Notwithstanding anything in this Policy to the contrary, Company reserves the right to amend the Policy at any time on 90 days advance written notice, such amendment to be effective at the expiration of said 90 days.

L. OFFSET: The Company shall be entitled to offset payments due to the Policyholder under this Policy against premiums due and unpaid by the Policyholder to the Company.

M. ASSIGNMENT: Except as authorized under Section H of Article VIII, any assignments of this Policy or of any rights hereunder shall be void and of no force or effect.

N. NOT WORKERS' COMPENSATION: The coverage provided under this Policy applies only to benefits under Your Plan of benefits for non-occupational accidents or illnesses. It is not the intent of this Policy to provide benefits or coverage under any Plan in lieu of Worker's Compensation Insurance.

O. NON-PARTICIPATION IN DIVISIBLE SURPLUS: This Policy does not provide for any Policyholder 's right to participate in the Company's divisible surplus.

ARTICLE VIII. CLAIMS PROVISIONS

A. NOTICE OF CLAIM: The Policyholder shall give written notice of claims to the Company in a form satisfactory to the Company within 30 days of the date the Policyholder becomes aware of the existence of facts that would reasonably suggest the possibility that Covered Benefits will be incurred which are covered by this Policy.

If the Policyholder designates the Company as TPA, as specified in the Schedule, the Policyholder's notice and proof of claim submission duty is considered to have been delegated to the Company. The Policyholder's such duty is thereby waived.

Failure of the Policyholder to furnish written notice within 30 days will not invalidate or reduce any claim if it was not reasonably possible to give such written notice within such time; provided that written proof of loss is furnished timely as prescribed in the paragraph immediately below.

The Policyholder shall submit on a timely basis, but not later than one year after the date that written notice of claims is otherwise required, all proofs, reports and documents supporting a claim as requested by the Company, including but not limited to, periodic estimates of claims pending under the Plan.

B. PAYMENT OF CLAIMS: Contingent upon the Company's receipt of the Policyholder's timely submitted notice and satisfactory proof of claim as described in Section A. above, the Company will thereafter pay to the Policyholder any Excess Loss Insurance reimbursement due within a reasonable time, but not to exceed 60 working days.

C. ADJUDICATION OF CLAIMS: Notwithstanding anything in this Policy to the contrary, the Company shall have no obligation for the settlement or adjustment of claims filed by Covered Persons under the Policyholder's Plan. Any determination by the Company as to the availability or extent of coverage with respect to any claim for reimbursement under this Policy shall not be deemed binding or conclusive on the underlying claim filed by Covered Persons against the Plan. The Policyholder shall always have the final right to determine the availability or extent of benefits payable under its Plan and the Company shall always have the final right to determine the availability and extent of coverage to the Policyholder under this Policy.

D. WARRANTY: The Policyholder warrants that upon presentation of a Proof of Loss to the Company all monies necessary to pay for services and supplies covered under the Plan have been paid to the respective providers of medical services or supplies to which the claim for reimbursement relates.

E. AUDITS: The Company or its authorized representative shall have the right to inspect and audit all records and procedures of the Policyholder and to require, upon request, proofs of records satisfactory to the Company that payment has been made to the Covered Person or the provider of such services or benefits which are the basis for any claim by the Policyholder under this Policy.

F. REIMBURSEMENT RECOVERY RIGHTS: If, prior to or after the Company reimbursed You under this Policy, You or Your Plan had received or receives payment, from a third-party tortfeasor, insurer thereof, or any other source, for medical or health expenses that are otherwise part of the Policy's Covered Benefits contributory to the reimbursement You received, the Company shall have the right to recover from You the amount of such reimbursement. The reimbursement that the Company is entitled to recover under this Section will not exceed the amount of the payment You or Your Plan had received or receives from such other sources, less any documented reasonable expenses and fees You incurred to obtain such payment. The Company will also have the right to offset this reimbursement recovery amount against any other reimbursement otherwise due and payable to You.

This provision in this Section F shall survive beyond the termination of this Policy.

G. RECOVERY OF OVERPAYMENT: If the Company reimbursed You more than it should have, the Company has the right to recover the excess amount directly from You.

The provisions in this Section G shall survive beyond the termination of this Policy.

H. INSOLVENCY: In the event of the insolvency or bankruptcy of the Policyholder, all reimbursements made or becoming due after the effective date of this Policy shall be payable by the Company on the basis of the amount of liability of the Plan under the terms and conditions of this Policy as finally determined in the liquidation or receivership proceeding without diminution because of the insolvency or bankruptcy of the Policyholder. Such amount shall be paid directly to the Policyholder or its liquidators, receiver, or other statutory successor. The Company shall be discharged from its obligations under this Policy to the extent of such payments.

Nothing in this Section shall increase the Company's liability beyond that which would have existed had the Policyholder not become insolvent or bankrupt.

INTRODUCTORY PAGE TO THE ATTACHED RIDER(S)

The Excess Loss Insurance Policy number 0024968, as issued to City of Long Beach ("Policyholder" and/or "You"), contains the following Rider(s), which are designed to expand, limit and/or change certain Policy's terms and provisions:

Rider #D.1.2: Aggregate Excess Loss Insurance with Monthly Accommodation (With Deficit Carryforward Type A.2 & Terminal Protection) 2

RIDER #D.1.2: AGGREGATE EXCESS LOSS INSURANCE WITH MONTHLY ACCOMMODATION
(With Deficit Carryforward Type A.2 & Terminal Protection)

This Rider applies to You only if it is so specified in the Schedule or otherwise added by Amendment.

This Rider forms a part of Excess Loss Insurance Policy number: 0024968 to which it is attached and modifies the Policy to the extent provided below. All the terms and conditions of the Policy, not in conflict with this Rider, remain in effect. The provisions and terms of this Rider shall survive beyond the date the Policy ends.

Article III - Aggregate Excess Loss Insurance, Section B is superseded by the following provisions:

A. Definitions:
As used in this Rider, the following terms shall have the following meanings:

1. "Deficit" for any Policy Year shall mean the amount of the Aggregate Excess Loss Insurance Reimbursement that the Company pays or is liable to pay to the Policyholder which equals the result of the Plan's total paid Covered Benefits during the Policy Year minus the Cumulative Attachment Limit of the last Policy Month of the Policy Year. Subject to A.2. below, a Deficit occurring during any Policy Year will be carried forward for recovery from the Policyholder by the Company in any subsequent Policy Year in which there is a Surplus.

2. "Recoverable Deficit" shall mean the limited amount of a Deficit, from that Policy Year, that can be carried forward from one Policy Year to any following Policy Year for recovery. The Recoverable Deficit for a Policy Year will not exceed 10% of the Cumulative Attachment Limit of the last Policy Month of the Policy Year for which such Deficit is being carried forward. However, if the Policy ends on a date other than the Policy Expiration Date, there will be no limit on the amount of the Recoverable Deficit, which was incurred in a Policy Year prior to the final Active Policy Year.

3. "Active Policy Year" shall mean any Policy Year prior to the date this Policy ends.

4. If this Policy ends for any reason except the Policyholder's insolvency or failure to pay premium on time, this Rider shall include the "Policy Year After the Policy Ends," which shall contain the consecutive number of calendar months (which shall be deemed Policy Months) as specified in the Schedule's section with information designed for this Rider or in an amendment, and shall begin on the date immediately after the final Active Policy Year ends.

B. During the Active Policy Year:

1. After the end of each Policy Month, except for the Policy Month specified in B.2. below:

   a. The Company will reimburse the Policyholder the amount by which (i) the result of the Plan's total paid Covered Benefits for the Policy Year to date minus the amount of any reimbursement previously paid to the Policyholder during the Policy Year and which the Policyholder has not repaid, exceeds (ii) the Cumulative Attachment Limit for such Policy Month.

   b. If the amount calculated pursuant to B.1.a. above is less than zero, the Policyholder shall pay the Company the sum of (i) the total reimbursement previously paid to the Policyholder during the Policy Year less any amount the Policyholder has repaid, plus (ii) the Recoverable Deficit from all previous Policy Years which the Policyholder has not repaid.

   c. In no event shall the amount the Policyholder is required to pay the Company in B.1.b. above exceed the amount by which the amount in B.1.a.(ii) is greater than the resultant amount in B.1.a.(i).

2. If the date the Policy ends coincides with the Policy Expiration Date, after the end of the Policy Month in which the Policy ends:

   a. The Company will reimburse the Policyholder the amount by which (i) the result of the Plan's total paid Covered Benefits for the final Active Policy Year to date minus the amount of any

reimbursement previously paid to the Policyholder during the final Active Policy Year and which the Policyholder has not repaid, exceeds (ii) the Cumulative Attachment Limit for such Policy Month plus the Cumulative Attachment Limit for the last Policy Month of the Policy Year prior to the final Active Policy Year.

b. If the amount calculated pursuant to B.2.a. above is less than zero, the Policyholder shall pay the Company the sum of (i) the total reimbursement previously paid to the Policyholder during the final Active Policy Year less any amount the Policyholder has repaid, plus (ii) the Recoverable Deficit from all previous Policy Years which the Policyholder has not repaid.

c. In no event shall the amount the Policyholder is required to pay the Company in B.2.b. above exceed the amount by which the amount in B.2.a.(ii) is greater than the resultant amount in B.2.a.(i).

C. During the Policy Year After the Policy Ends:

1. If the date the Policy ends coincides with the Policy Expiration Date:

After the end of the second Policy Month of the Policy Year After the Policy Ends and any subsequent Policy Month thereafter:

a. The Company will reimburse the Policyholder the amount by which (i) the result of the Plan's total paid Covered Benefits during the final Active Policy Year and the Policy Year After the Policy Ends to date minus the amount of any reimbursement previously paid to the Policyholder during the final Active Policy Year and the Policy Year After the Policy Ends and which the Policyholder has not repaid, exceeds (ii) the Cumulative Attachment Limit for such Policy Month.

b. If the result as calculated pursuant to C.1.a. above is less than zero, the Policyholder shall pay the Company the sum of (i) the total reimbursement previously paid to the Policyholder during the final Active Policy Year and the Policy Year After the Policy Ends less any amount the Policyholder has repaid, plus (ii) the Recoverable Deficit from all previous Policy Years which the Policyholder has not repaid.

c. In no event shall the amount the Policyholder is required to pay the Company in C.1.b. above exceed the amount by which the amount in C.1.a.(ii) is greater than the resultant amount in C.1.a.(i).

2. If the date the Policy ends does not coincide with the Policy Expiration Date:

After the end of the second Policy Month of the Policy Year After the Policy Ends and any subsequent Policy Month thereafter:

a. The Company will reimburse the Policyholder the amount by which (i) the result of the Plan's total paid Covered Benefits during the final Active Policy Year and the Policy Year After the Policy Ends to date minus the amount of any reimbursement previously paid to the Policyholder during the final Active Policy Year and the Policy Year After the Policy Ends and which the Policyholder has not repaid, exceeds (ii) the sum of the Cumulative Attachment Limit for such Policy Month plus the Cumulative Attachment Limit for the last Policy Month of the Policy Year prior to the final Active Policy Year.

b. If the result as calculated pursuant to C.2.a. above is less than zero, the Policyholder shall pay the Company the sum of (i) the total reimbursement previously paid to the Policyholder during the final Active Policy Year and the Policy Year After the Policy Ends less any amount the Policyholder has repaid, plus (ii) the Recoverable Deficit from all previous Policy Years which the Policyholder has not repaid.

c. In no event shall the amount the Policyholder is required to pay the Company in C.2.b. above exceed the amount by which the sum in C.2.a.(ii) is greater than the resultant amount in C.2.a.(i).

D. The Policyholder agrees to repay the amount as calculated pursuant to B.1.b. & B.1.c., B.2.b. & B.2.c., C.1.b & C.1.c. and C.2.b. & C.2.c. above within ten days of written notice from the Company of the amount due. If repayment is not made within such period, interest at an annual percentage rate equal to the prime rate plus one percentage point will be added to the amount due and must be paid to the Company. The Company, at its option, may, in lieu of requesting repayment, reduce the repayment amount from subsequent reimbursements under the Aggregate Excess Loss Insurance.

Great-West℠
HEALTHCARE

8505 East Orchard Road
Greenwood Village, CO 80111

January 23, 2007

City of Long Beach
Department of Human Resources
and Affirmative Action
333 West Ocean Blvd.
Long Beach, CA 90802

Ladies and Gentlemen:

Re: Claims Fluctuation Reserve Agreement
Group Contract No. 24968GSL (herein called the Group Contract)
Self Insured Payment Plans (herein called the ASO Plans)

The purpose of this letter is to set forth the terms of an agreement between Great-West Life & Annuity Insurance Company (herein called the Company) and City of Long Beach (herein called the Group Contractholder) whereby the Company shall establish and maintain a special contingency reserve for stabilization of the Group Contractholder's ongoing claim liability funds. This shall be designated as the Claims Fluctuation Reserve.

This agreement is effective as of December 1, 2006.

It is hereby provided that

(1) the Company shall subsequently credit to the Claims Fluctuation Reserve

(a) all or a portion of any experience surplus declared by the Company with respect to the Group Contract, such proportion being mutually agreed upon by the Company and the Group Contractholder, and

(b) interest annually on the balance of the Claims Fluctuation Reserve at the then current interest rate determined each calendar quarter and shall be based on the 13-week United States Treasury Bill note as listed on the federal government web-site for the first Friday of such quarter.

(2) the Company shall subsequently debit to the Claims Fluctuation Reserve any accumulated experience deficit declared by the Company with respect to the Group Contract, up to the balance of the Claims Fluctuation Reserve. Any remaining deficit shall be carried forward and shall be recovered by reducing the amount of any future experience surpluses declared by the Company.

This agreement shall terminate automatically on the following date:

(a) the date of termination of the Group Contract, if the Group Contractholder decides that the Company will not administer run-out claims; or

(b) 12 months following the date of termination of the Group Contract, if the Company is administering run-out claims.

After termination of this agreement, the Company shall pay to the Group Contractholder the balance, if any, of the Claims Fluctuation Reserve, including interest up to the date such payment is made, less any amount owed to the Company by the Group Contractholder.

Dated at Greenwood Village, Colorado this 23rd day of January 2007.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

D. C. [signature]

Senior Vice President
General Counsel and Secretary

[signature]

President/CEO

[signature]
For the Actuary

The terms of this agreement are accepted by the City of Long Beach this 26th day of July, 2007.

CITY OF LONG BEACH

By: [signature]

Title: City Manager

APPROVED AS TO FORM

JULY 19, 2007
ROBERT E. SHANNON, City Attorney

BY [signature]
DEPUTY CITY ATTORNEY

Great-West[SM]
HEALTHCARE

8505 East Orchard Road
Greenwood Village, CO 80111

January 23, 2007

City of Long Beach
Department of Human Resources
and Affirmative Action
333 West Ocean Blvd.
Long Beach, CA 90802

Ladies and Gentlemen:

Re: Terminal Funding Agreement (herein called the Agreement)
Group Contract No. 24968GSL (herein call the Group Contract)
Funds Held at US Bank Institutional Trust & Custody, Portland, Oregon
Trust Account No. 89577500

This Agreement sets out the terms of an agreement between Great-West Life & Annuity Insurance Company (herein called Great-West) and the City of Long Beach (herein called the Contractholder), whereby the Contractholder agrees to maintain sufficient monies to cover its Terminal Liability Fund (hereinafter referred to as the Fund).

1. Effective Date

   This agreement is effective as of December 1, 2006.

2. Definitions

   For the purposes of this Agreement, the term

   (a) "Contract months" and "contract years" shall be calculated from the effective date of this Agreement. A contract year shall mean a period of 12 consecutive months except that the last contract year and the last contract month shall terminate upon termination of this Agreement.
   (b) "Terminal Liability" shall mean the sum of (i) and (ii) below, where:
       (i) is the sum of the Terminal Attachment Levels for the first 2 months after the termination of the Group Contract; and
       (ii) is the product of the Terminal Premium Factor and the number of employees in the Employees Classes shown in the Schedule of Fees for the contract month immediately preceding termination of the Group Contract.

3. Funding Requirement

The Contractholder agrees to maintain funds equal to at least 110% of the estimated Terminal Liability as determined by Great-West on each December 1 prior to the date of termination of this Agreement. The estimated Terminal Liability on any December 1 shall be the sum of (a) and (b) below where:

(a) is the product of
    (i) the Terminal Attachment Factor, and
    (ii) the number of employees for the most recent month of December which precedes the date of termination of this Agreement, and
    (iii) 2.
(b) is the product of
    (i) the Terminal Premium Factor, and
    (ii) the number of employees for the most recent month of December which precedes the date of Termination of this Agreement.

The Amount of such funds shall be evidenced by United States Treasury Notes, or any other form of security which is acceptable to Great-West – to which the rights have been irrevocably assigned to Great-West as security only. Additional amounts of security shall be required at any time the amount of security currently irrevocably assigned to Great-West is less than 110% of the Terminal Liability as estimated by Great-West. Such additional amounts of security shall be irrevocably assigned to Great-West within 31 days of the date on which such notification of the change in Terminal Liability is sent to the Contractholder by Great-West. Notification occurs each April when the renewal is presented.

If the Contractholder does not comply with this requirement within the time specified, then it is understood that the Contractholder will maintain the balance of the funding requirement as reserves within their budget.

4. Credits to the Fund

Great-West shall credit to the Fund:

(a) payments made by the Contractholder from time to time, and
(b) interest as of the end of the contract year at the interest rate determined each calendar quarter and shall be based on the 13-week United States Treasury Bill note as listed on the federal government web-site for the first Friday of such quarter.

5. Debits to the Fund

If the Contractholder fails to fulfill its obligations to transfer or remit monies to Great-West, Great-West shall have the right to withdraw from the Fund:

(a) any amount required to fund the Contractholder's obligations under the Group Contract; and
(b) any other amounts owed to Great-West by the Contractholder for any period prior to or after termination.

6. Termination

This Agreement shall terminate on the earliest of the following dates:

(a) the date which is 12 months after the date on which the Group Contract terminates;
(b) any other date which is mutually agreed upon by Great-West and the Contractholder; or

(c) the date which is 12 months after the date on which either Great-West or the Contractholder gives written notice to the other party of its intent to terminate this Agreement.

After termination of the Group Contract, Great-West will continue to transfer from the Contractholder's Benefit Payment Funding Account any amounts required to fund the Contractholder's liability under the Group Contract. Great-West will cease administrative services if the appropriate monies are not available for disbursement to fund the Contractholder's liability. Monies to fund the Contractholder's liability may be drawn from the Contractholder's Benefit Payment Funding Account, the Claims Fluctuation Reserve and/or from the Terminal Liability Fund.

7. Disposition of Fund upon Termination of the Group Contract

The Fund balance shall be reviewed and any surpluses will be returned to the Contractholder according to the schedule set out below. Each such payment, less any monies owed to Great-West by the Contractholder, shall be made following the end of the month specified in the schedule.

Month Following Termination of the Group Contract	***Percentage of Fund Balance***
Sixth Month	25%
Ninth Month	25%
Twelfth Month	Balance, less any monies owed to Great-West

Dated at Greenwood Village, Colorado this 23rd day of January, 2007.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

D. C. [signature]

Senior Vice President
General Counsel and Secretary

[signature]

President/CEO

[signature]
For the Actuary

The terms of this agreement are accepted by the City of Long Beach this 26th day of July, 2007

CITY OF LONG BEACH

By: [signature]

Title: City Manager

APPROVED AS TO FORM

July 19, 2007
ROBERT E. SHANNON, City Attorney

BY [signature]
DEPUTY CITY ATTORNEY

Great-West[SM]
HEALTHCARE

8505 East Orchard Road
Greenwood Village, CO 80111

January 23, 2007

City of Long Beach
Department of Human Resources
and Affirmative Action
333 West Ocean Blvd.
Long Beach, CA 90802

Ladies and Gentlemen:

Re: Benefit Payment Funding Account (BPFA) Agreement
Group Contract No. 24968GSL (herein called the Group Contract)
Self Insured Payment Plans (herein called the ASO Plan)
Services Agreement between Great-West and the Contractholder (herein called the Services Agreement)

This Benefit Payment Funding Account Agreement (herein called the BPFA Agreement) sets out the terms of an agreement between Great-West Life & Annuity Insurance Company (herein called Great-West) and the City of Long Beach (herein called the Contractholder), whereby:

(A) Great-West agrees to establish an account for the purpose of paying benefits under the ASO Plan; and

(B) the Contractholder agrees to remit monthly to Great-West amounts which are adequate to maintain an amount in the Benefit Payment Funding Account which is at least equal to the Minimum Funding Requirement described below:

1. <u>Effective Date</u>

This BPFA Agreement is effective as of December 1, 2006 for active employees and February 1, 2007 for retired employees.

2. <u>Minimum Funding Requirement</u>

The amount required to fund for the payment of benefits under the ASO plan for any contract month shall be determined by Great-West at the beginning of that contract month. The amount so determined shall be paid by the Contractholder to Great-West for deposit in the Benefit Payment Funding Account. The term "contract month" is defined in the Group Contract.

Such amount shall be equal to the product of (a) and (b) below, where:
(a) is the number of Employees covered for the current month; and
(b) is the factor shown below for the employee's class and ASO plan:

1. for employees in Employee Class 1, $ 766.35
2. for employees in Employee Class 2, $ 841.86
3. for employees in Employee Class 3, $ 690.02
4. for employees in Employee Class 4, $ 439.29
5. for employees in Employee Class 5, $ 603.38
6. for employees in Employee Class 6, $ 675.04
7. for employees in Employee Class 7, $ 553.56
8. for employees in Employee Class 8, $ 351.99
9. for employees in Employee Class 9, $ 386.81
10. for employees in Employee Class 10, $ 774.51

The above factors are effective from December 1, 2006 for active employees and February 1, 2007 for retired employees.

Payment of the amount described above shall be due on the 8th working day of each month throughout the period during which this BPFA Agreement is in force. If payment is not made by the due date, this BPFA Agreement shall terminate. Any payment may be made in advance of the date it would otherwise be due.

3. Retention

Retention is the amount paid to Great-West for ongoing administration and aggregate stop loss policy premiums.

The amount required to fund for retention for any contract month shall be determined by Great-West at the beginning of that contract month. The amount so determined shall be paid by the Contractholder to Great-West.

The term "contract month" is defined in the Group Contract.

Such amount shall be equal to the product of (a) and (b) below, where:
(a) is the number of Employees covered for the current month; and
(b) is the factor shown below for the employee's class and ASO plan:

1. for employees in Employee Class 1, $ 49.39
2. for employees in Employee Class 2, $ 51.90
3. for employees in Employee Class 3, $ 51.90
4. for employees in Employee Class 4, $ 38.90
5. for employees in Employee Class 5, $ 37.22
6. for employees in Employee Class 6, $ 41.23
7. for employees in Employee Class 7, $ 41.23
8. for employees in Employee Class 8, $ 29.97
9. for employees in Employee Class 9, $ 8.60
10. for employees in Employee Class 10, $ 24.72

The above factors are effective from December 1, 2006 for active employees and February 1, 2007 for retired employees.

4. Billed Rates

Billed rates are determined by adding the Minimum Funding Requirement to the Retention for any given class. Billed Rates are as follows:

1. for employees in Employee Class 1, $ 815.74
2. for employees in Employee Class 2, $ 893.76
3. for employees in Employee Class 3, $ 741.92
4. for employees in Employee Class 4, $ 478.19
5. for employees in Employee Class 5, $ 640.60
6. for employees in Employee Class 6, $ 716.27
7. for employees in Employee Class 7, $ 594.79
8. for employees in Employee Class 8, $ 381.96
9. for employees in Employee Class 9, $ 395.41
10. for employees in Employee Class 10, $ 799.23

5. Credit to the Benefit Payment Funding Account

Great-West shall credit to the Benefit Payment Funding Account:

(a) payments made by the Contractholder from time to time; and
(b) interest as of the end of the contract year at an interest rate determined each calendar quarter and shall be based on the 13-week United States Treasury Bill note as listed on the federal government web-site for the first Friday of such quarter. The term "contract year" is defined in the Group Contract.

6. Debits to the Benefit Payment Funding Account

Great-West shall have the right to withdraw from the Benefit Payment Funding Account:

(a) any amount required to pay benefits under the ASO Plan; and
(b) any other amounts owed to Great-West by the Contractholder when agreed to by both parties in writing.

7. Minimum Funding Requirement upon Termination

The Contractholder agrees to fund for the payment of benefits upon contract termination, for two months following the date of termination. The amount, determined by Great-West, shall be paid by the Contractholder to Great-West to deposit in the Benefit Payment Funding Account.

Such amount for each month shall be equal to the product of (a) and (b) below, where:
(a) is the number of Employees covered on the first day of the second prior Policy Month; and
(b) is the factor shown below for the employee's class and ASO plan:
1. for employees in Employee Class 1, $ 1,411.90
2. for employees in Employee Class 2, $ 1,407.38
3. for employees in Employee Class 3, $ 1,148.53
4. for employees in Employee Class 4, $ 608.65
5. for employees in Employee Class 5, $ 1,083.17
6. for employees in Employee Class 6, $ 1,109.05
7. for employees in Employee Class 7, $ 904.78
8. for employees in Employee Class 8, $ 477.26
9. for employees in Employee Class 9, $ 656.21
10. for employees in Employee Class 10, $ 1,312.40

The above factors are effective from December 1, 2006 for active employees and February 1, 2007 for retired employees.

Payment of the amount described above shall be due on the 8th working day of each month throughout the period during which this BPFA Agreement is in force. If payment is not made by the due date, this BPFA Agreement shall terminate. Any payment may be made in advance of the date it would otherwise be due.

8. Retention upon Termination

Retention is the amount paid to Great-West for ongoing claims administration for up to 12 months upon termination. The amount required to fund for retention upon termination, determined by Great-West, shall be paid by the Contractholder to Great-West.

Such amount shall be equal to the product of (a) and (b) below, where:

(a) is the number of Employees covered for the most recent month which precedes the date of Termination; and
(b) is the factor shown below for the employee's class and ASO plan:
    1. for employees in Employee Class 1, $ 155.52
    2. for employees in Employee Class 2, $ 164.95
    3. for employees in Employee Class 3, $ 164.95
    4. for employees in Employee Class 4, $ 127.85
    5. for employees in Employee Class 5, $ 121.41
    6. for employees in Employee Class 6, $ 135.68
    7. for employees in Employee Class 7, $ 135.68
    8. for employees in Employee Class 8, $ 101.38
    9. for employees in Employee Class 9, $ 37.80
    10. for employees in Employee Class 10, $ 75.61

The above factors are effective from December 1, 2006 for active employees and February 1, 2007 for retired employees.

9. Termination of this BPFA Agreement

This BPFA Agreement may be terminated at any time by either the Contractholder or Great-West, provided written notice of such termination is given at least 30 days in advance. In addition, Great-West may terminate this BPFA Agreement immediately upon:

(a) amendment of the ASO Plan in a manner deemed unsatisfactory by Great-West, provided that Great-West provided 60 days' written notice of such termination to the Contractholder.

(b) failure of the Contractholder to comply with any term or condition of this BPFA Agreement.

(c) termination of the Group Contract.

(d) termination of the Administrative Services Contract or the Excess Loss Policy.

Dated at Greenwood Village, Colorado this 23rd day of January, 2007.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

Senior Vice President
General Counsel and Secretary

President/CEO

For the Actuary

The terms of this agreement are accepted by the City of Long Beach this 26th day of July, 2007.

CITY OF LONG BEACH

By: __________

Title: City Manager

APPROVED AS TO FORM

July 19, 2007
ROBERT E. SHANNON, City Attorney

BY __________
DEPUTY CITY ATTORNEY