Application For Amended Group Coverage -- Signature Pages:

NOTE: This document is important. It affects your legal rights and obligations.
This Application is for employee benefit coverage or administration provided by CIGNA Health and Life Insurance Company (CHLIC) or one of its affiliates.

30876

Other Benefits: ☐ None

If there are any additional benefits not previously indicated, please identify them here. In the Benefit column, list coverage affected, then in Description column describe the benefit. There will be an extra cost for each additional benefit listed. You may list up to 4 additions.

Benefit	Description

The Applicant understands that CHLIC will provide amended Booklets, if any, electronically to the Applicant. The Applicant is responsible for distributing booklets (electronically or otherwise) to employees.

The Applicant accepts and agrees that approval of the Application and the final rates, fees, and factors so determined will be based on the final enrollment and eligibility information provided to CHLIC by the Applicant, including the final proportion of employees electing coverage under the contract(s) for which Application is made. Approval and final rates, fees and factors will also be subject to qualification under the current underwriting rules and practices. Underwriting rules which are used by CHLIC, which include but are not limited to:

- CHLIC is the sole provider of medical expense benefits.
- No more than 10% of eligible employees will be covered under a retiree class of benefits.
- The number of employed family members related to all company officers will be less than or equal to the larger of 5 or 10% of the number of eligible employees.
- The Applicant will fund at least 50% of total plan costs or 100% of employee costs.
- Employee participation minimum standards that more than 50% of eligible employees will apply for coverage under the medical plan.
- Dependent participation minimum standards that more than 65% of employees with eligible dependents, excluding those who elect to waive benefits (dependents covered under another plan), will apply for dependent coverage under the medical plan.
- Life insurance standard that the average certificate amount for one class can be no greater than 2 ½ times the average certificate of the next lower class, and/or that there must be at least 2 employees per class excluding the highest class, which may include just 1 employee.

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Please note the terms Stop Loss and Excess Loss may be used interchangeably throughout this document.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

District of Columbia requires the following notice:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.

State law of Florida requires the following notice:

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

State law of Georgia requires the following notice:

The self-funded welfare benefit plan of the Plan Sponsor is not regulated nor approved under the insurance laws of Georgia.

State law of Louisiana requires the following notice:

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

State law of Maryland requires the following notice:

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

State law of New York requires the following notice:

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

State law of Oregon requires the following notice:

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

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Puerto Rico requires the following notice:

FRAUD WARNING: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; and if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

State law of Virginia requires the following notice:

FRAUD WARNING: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be in violation of state law.

State law of Washington requires the following notice:

FRAUD WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The following notices apply to Stop Loss coverage:

State law of Arkansas requires the following notice:

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and /or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employer/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

State law of Minnesota requires the following notice:

THE STOP LOSS POLICY IS NOT PROTECTED BY THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE MINNESOTA INSURANCE GUARANTY ASSOCIATION. IN THE CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED. ONLY THE ASSETS OF THIS INSURER WILL BE AVAILABLE TO PAY YOUR CLAIM.

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State law of Mississippi requires the following notice:

IMPORTANT NOTICE ABOUT THE STOP LOSS POLICY FOR WHICH YOU (APPLICANT) HAVE APPLIED. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS. READ THE FOLLOWING INFORMATION CAREFULLY.

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any dispute related to the policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration proceeding, one or more arbitrators, who are independent, neutral decision makers, render a decision after hearing the positions of the parties.
5. When you accept the insurance policy, you agree to resolve any dispute related to the policy by binding arbitration instead of a trial in court, including a trial by jury.
6. Binding arbitration generally takes the place of resolving disputes by a judge and jury.
7. Should you need additional information regarding the binding arbitration provision in the policy, you may contact our toll free assistance line at 1-866-244-8081.

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT: By my signature below, I acknowledge that I have read this statement. I understand that I am voluntarily surrendering the Applicant's right to have any dispute between the insurance company and myself resolved in court. This means that I am waiving the Applicant's right to a trial by jury.

The undersigned ("the Applicant ") hereby authorizes CHLIC to amend the contracts and policies issued by CHLIC, as specified in this Application. Such amendments to the policies, contracts, or booklets are to be effective 1/1/2011. CHLIC agrees to deliver the documents in a timely manner.

It is the Applicants responsibility, upon receipt of the amendment to the contract or policy or the booklet, to promptly review the amendment within a reasonable time, but not to exceed 60 days from the date of the cover letter, containing the amendment, is sent to the Applicant. If the Applicant agrees and accepts the amendment, the Applicant must sign and return the amendments within 60 days from the date of the cover letter. If the Applicant disapproves, the Applicant must contact us within 60 days from the date of the cover letter. If the Applicant fails to communicate with us within the time frame specified above, it will constitute the Applicant's acceptance of the amendment as submitted. In such event, the Applicant's signature given below is also intended hereby as the Applicant's execution of the amendment.

Full Legal Name of the Firm: City of Long Beach

Effective Date: 1/1/2011

By: (Printed Name): Patrick H. West

Assistant City Manager

Applicant Signature: _____

EXECUTED PURSUANT TO SECTION 301 OF THE CITY CHARTER.

Title: City Manager

APPROVED AS TO FORM

12-21, 2010

ROBERT E. SHANNON, City Attorney

By _____

AMY R. BURTON

DEPUTY CITY ATTORNEY

Dated : _____

CI Summary

CI 12.00 Facets migration/renewal amendment effective 01/01/2011

Renewal benefit changes:

OAP 100: a)Add combined primary/specialist OON $40 office visit copay. Benefit will be $40, then 50% b)Increase ER copay to $100 c)Increase network calendar year deductible to $150/$300family d)Increase non-network calendar year deductible to $350/$700 family e) Add a non-network $300 hospital per confinement deductible

OAP 90: a)Add combined primary/specialist OON $40 office visit copay. Benefit will be $40, then 50% b)Increase ER copay to $100 c) Increase network calendar year deductible to $150/$300 family d)Increase non-network calendar year deductible to $350/$700 family e)Add a non-network $300 hospital per confinement deductible.

PPO Plan: a)Change non-network coinsurance to 50% b)Add combined primary/specialist OON $50 office visit copay. Benefit will be $50, then 50% c)Increase the network calendar year deductible to $350/$700 family d)Increase non-network calendar year deductible to $550/$1,100 family

HDHP Plan: a)Change non-network coinsurance to 50% b)Apply deductible to OOP accumulation

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Updating to comply with the September 23, 2010 Patient Protection and Affordable Care Act regulations (PPACA):

1)Updating Dependent Age to 26/26. Termination will be at the end of the month in which they turn 26.

2)Changing medical plan lifetime maximums to unlimited.

3)Removing the non-network lifetime maximum of $500,000 on medical plans.

4)Changing to No Cost Share Preventive Care for Network and OOA.

5)DME will now have unlimited maximums.

6)Physical Therapy will now have unlimited maximums.

7)Speech, Hearing, Occupational Therapy will now have unlimited maximums.

8)Chiropractic Services will have visit maximums as described in the Facets benefit changes section.

9)Group will maintain non-Grandfathered status.

CI Summary

Banking

1)Monthly Premium:

a)Will continue Self-Accounting Statement to be mailed to the Billing Dept. (same arrangement as current) b)Monthly Premium transfer to continue via ACH. Approval received.

2)Claims Transfer frequency: Change claims transfer frequency to weekly with week delay from daily via ACH. No risk deposit required. Approval received.

3)Continue with same CFR Account arrangement to pay for the quarterly ASHN chiro network and LB Memorial Nurse Ambassadors. Approval received.

4)Terminal run-out: Change to Facets standard, which is 15 month terminal run-out provision from current 12 month.

General Facets Migration Changes:

1)Updating to CIGNA Contracts.

2)Suppress T-15 Employee letters as Rx info on ID card only applies to HDHP members. Members should have ID cards prior to the effective date.

3)Remove February 1 anniversary date for Early Retirees. Early Retirees will now have an anniversary date of 1/1, which will apply to everyone (Active, Early Retirees, Retirees).

4)Waiting Period changing to 1st of the month following 30 days from hire date, termination date will be end of month.

5)Client Specific Network with ASH to continue same arrangement. Approval received.

6)Client Specific Network with Associated Therapist mental health providers to continue with same arrangement. Approval received.

7)Client filed exemption for 2010 Mental Parity.

CI Summary

8)EOBs: a)Continuing with customized EOBs to include client specific Customer Service number rather than the regular Facets Customer Service number. b)EOB distribution now Applying Facets standard of issuing EOBs on all claims processed even if there is no balance due by the member.

9)ID Cards: Continue with customized client specific Customer Service phone number on ID Cards rather than the standard Facets Customer Service number.

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0)Continue with two separate policy numbers: a)Policy #050703 for medical and b)Policy #359620 for the hospital reimbursement. Approval received.

11)SPD required for all products under 050703, not for those under 359620.

12)Remove coverage for Dependents of minor dependents (grandchildren).

13)Abortions: Continue to exclude abortions on all plans, including the Medicare Supplemental plan. Approval received.

14)Health Conversion Provisions set up for old HMO plan: Remove provision.

15)Pre-Cert List: Apply Facets standard pre-cert list, including MedSolutions required on high tech radiology. Currently, MedSolutions is excluded.

16)Pre-Existing Limitation: Continue to Apply 6 month pre-existing across the board (new hires and late entrants). Pre-ex no longer applicable to dependents under 19 including newborns due to PPACA.

17)Common Accident provision included on all plans with the exception of the HDHP plan. Remove this benefit on all plans.

18)Supplemental Accident Provision: Remove current Supplemental Accident Provision on PPO Plan ($500, no deductible, 100% first 90 days following accident provision).

----------Facets Benefit changes:

1)Pre-Cert penalty rules: Apply Facets standard $250 pre-cert penalty rules.

2)Breakpoint: Apply Facets Out-of-pocket maximums as follows:

CI Summary

a)OAP 100: Network OOP not applicable since 100% coinsurance and no limit to non-network OOP

b)OAP 90: Network $2500/$5000 family and no limit to non-network

c)PPO: Network OOP $6,000/$12,000 family and no limit non-network

d)HDHP: Network $3700/7400 family. Family deductible is non-embedded so the family deductible needs to be met even if only one member accesses care.

3)Emergency Room/Urgent care Lab/X-Ray: Apply Facets standard to treat ER and Urgent Care as an event, including physician lab/X-Ray.

4)Emergency Room: Apply UCR for non-network services. ER paid as foll
ows:

a)OAP 100: 100% after $100 ER copay regardless of network status. ER copay waived, if admitted.

b)OAP 90: 100% after $100 ER copay regardless of network status. ER copay, waived if admitted.

c)PPO: 80% regardless of network status, deductible applies.

d)HDHP: 90% regardless of network status, deductible applies.

5)Non-network hospitalizations dollar cap: Remove the per day allowance on all plans. Benefit as follows:

a)OAP 100: Non-network hospital, $300 per confinement, then 50% coinsurance, deductible applies.

b)OAP 90: Non-network hospital, $300 per confinement, then 50% coinsurance, deductible applies.

c)PPO: Non-network $500 per confinement then 50%, deductible applies.

d)HDHP: Non-network 50%, no per confinement, deductible applies.

6)Network X-ray/Lab and Other Office Services. Continue with existing benefits as follows:

a)OAP 100: 100% after deductible for office DXL and surgery. Other Office Services 100%, no deductible.

b)OAP 90: 90% after deductible for office DXL and surgery. Other Office Services 100%, no deductible.

c)PPO: 80% after deductible for office DXL and surgery. Other Office Services 100%, no deductible.

d)HDHP: 90% after deductible

7)Apply Facets outpatient Mental Nervous/Chemical Dependency amounts towards OOP. Outpatient MH/SA Benefits paid as follows:

CI Summary

a)OAP 100: In-network $20 copay, 20 visits per cal year, 100%. Non-network payable at 50% coinsurance, deductible applies. Combined 20 visits for network and non-network.

b)OAP 90: $20 visit copay, 20 visits per cal year, 100%. Non-network payable at 50%, deductible applies. Combine 20 visits for network and non-network.

c)PPO Plan: In-network $25 visit copay, then 100%. Unlimited number of visits. Non-network payable at 50%, deductible applies.

d)HDHP: In-network 90%, deductible applies. Non-network 50%, deductible applies. Unlimited maximum.

8)Pre-admission testing for Birthing Centers, Home Health, Hospice and Skilled Nursing Facility:
Apply Facets standard to pay testing network driven.

9)Maternity coverage for dependent children: Continue to exclude maternity coverage. Approval received.

10)Hospice and Bereavement $300 benefit. Claim can be on members not covered: Apply Facets standard for Hospice and Bereavement to be paid under MH/SA. Remove $300 dollar limit.

11)Hospice: Unlimited max on all plans.

12)Skilled Nursing Facility: Apply Facets standard 100 days per cal yr. Eliminate current per day allowance. Remove the $90 covered per day benefit.

13)Home Health Care: Apply Facets standard 100 visits per cal year on all plans. Remove the current hourly restriction.

14)Chiropractic Services: 34 combined visits on all plans. Pay as follows:

a)OAP 100: Network payable at 100%. Non-network payable at 50%, after deductible.

b)OAP 90: Network payable at 90%, after deductible. Non-network payable at 50%, after deductible.

c)PPO Plan: Network payable at 80%, after deductible. Non-network payable at 50%, after deductible.

d)HDHP: Network payable at 90%, after deductible. Non-network payable at 50%, after deductible.

15)Acupuncture: 34 visits combined, payable at 50% regardless of network status on all plans. Remove the current $60 covered CY dollar limit of $1000.

16)Hearing aids: $500 max per Cal Year. Deductible and coinsurance applies on all plans. Combined $500 max for network and non-network.

CI Summary

17)Birth Control Devices including Sub-Cutaneous implants: Apply Facets standard to cover on HDHP plan both pills and devices.

18)Orthotics: $25 combined benefit per cal year. Deductible and coinsurance applies. Network driven.

19)Inpatient Mental Health/Substance Abuse. Unlimited maximums. Benefits as follows:

a)OAP 100: Network payable at 100%. Non-network payable at 50% coinsurance, calendar year deductible and $300 per confinement deductible.

b)OAP 90: Network payable at 90% after calendar year deductible. Non-network payable at 50%, calendar year deductible, $300 per confinement deductible then 50% coinsurance.

c)PPO: Network requires $200 per confinement deductible, then payable at 80%after calendar year deductible. Non-network requires $500 per confinement deductible then payable at 50% after calendar year deductible.

d)HDHP: In-network 90%, cal year deductible. Non-network 50% coinsurance and calendar year deductible apply.

20)Independent Lab provisions: Apply Facets standard to pay independent labs based on network status of provider performing the service. No longer payable based on referring physician status.

21)Rx Copays Processing for dual coverage: Continue with same Rx copay reimbursement for members with dual coverage. Members submit claim directly to CIGNA/Great-West for manual processing. Continue with same arrangement.

22)HDHP has Cigna Rx Medpharmacy. Continue with same arrangement. All other drug benefits are direct with Medco. Husband/wife teams who work for City have coordination of benefits with prescription drugs copays. Continue to accommodate COB processing of RX copays under medical. Continue with same arrangement.

23)Services received from a non-network provider in a zip code defined as out of area are currently paid as non-network. On Facets, will have the following OOA benefits:

OAP 100/50 Plan: OOA Coinsurance 80%, non-network deductible applies.

OAP 90/50 Plan: OOA Coinsurance 80%, non-network deductible applies.

PPO 80/50% Plan: OOA Coinsurance 80%, non-network deductible applies.

HDHP 90/50 Plan: OOA Coinsurance 80%, network deductible applies.

24)COB covered expenses apply prior to coordination applies to lifetime maximum: Apply Facets standard.

CI Summary

25)Disease Management fees and other surcharges accumulate to plan level maximum: Apply Facets standard to not apply disease management fees and other surcharges towards plan maximums.

26)Contracted OBGYN as specialists: Apply Facets standard and treat as primary office visit.

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)Seven-day newborn benefits: Apply Facets standard by removing the 7 day location as a hospital service within the first 7 days. Benefit paid based on provider location where service was received.

28)Attention Deficit Disorders office visits are covered under Outpatient Mental Health/Substance Abuse: Apply Facets standard by continuing this benefit to be covered under Mental Health/Substance Abuse.

29)Birth control devices including sub-cutaneous implants not covered. Depo Provera and Norplant are not covered when prescribed as a contraceptive birth control medication. Depo Provera will be covered when prescribed as a contraceptive birth control medication: Apply standard to cover on HDHP.

30)TENS covered if medically necessary. Approval received. Will go with Facets standard coverage of Biofeedback.

31)Keep existing 90% U&C percentiles for all plans.

Early Retiree Plan

1)Effective January 1st 2011, the two anniversary dates will be combined into one January effective date for all active, retirees and early retirees. Removing the Early Retiree February 1st effective date.

2)Waive all deductibles in January 2011 on all plans for Early Retirees.

3)Providing deductible credit for those who have met their deductible between October-December 2010 on the PPO and OAP plans. The HSA plan does not have deductible carryover.

4)Prorate deductible on OAP 100, OAP 90 and PPO and apply only 11 months of deductible to Early Retirees. Do not prorate deductible for HDHP due to IRS regulations.

CI Summary

5)CIGNA will run a report mid-year 2011 to provide the client with credit for waiving the January 2011 deductible for early retirees as this was a forced change due to Facets migration.

6)Mellon is not applicable to Early Retirees on the Health Savings Account for the HDHP plan.

Medicare Supplemental Plan:

1)Continue with current arrangement: Non-Participating Medicare providers and Medical services not covered under Medicare are not covered under this plan. Board approval received.

2)Apply deductible of $50 to Hearing Aids, Orthotics, Registered Nursing Services, IV Medications administered at Home. Board approval received.

3)Continue with current arrangement: Plan pays 100% of covered expenses not payable by Medicare including deductibles and copays plus any coinsurance required up to a $2,000 calendar max. IV Medications administered at home not covered by Medicare are not subject to the $2,000 CY maximum. Board approval received.

4)Continue with current arrangement: Psychiatric Hospital Part A deductible paid at 100% up to 100 days. Board approval received.

5)Skilled Nursing Facilities: Change to Facets standard of 100 day limit.

6)Registered Nursing Services: Paid at 80% after calendar year deductible up to a $5,000 lifetime maximum.

7)Hearing Aids: Paid at 80% after calendar year deductible up to a $500 calendar maximum.

8)Orthotics: Paid at 80% after calendar year deductible up to a $25 calendar maximum.

9)IV Medications adminstered at home will be paid 80% after calendar year deductible.

10)Elective Abortions: Continue to exclude elective abortions on MedSupp plan. Board approval received.

CI Summary

11)Continue with same arrangement to have immunizations not covered except for pneumococcal pneumonia vac. or immunizations required because of an injury or immediate risk of infection and Hepatitis B for certain persons at Risk. Board approval received.

12)Pre-certification not applicable.

FSA Plan:

FSA is not available for Early Retirees or Retirees. No benefit changes for FSA. Continue with FSA monthly reimbursement arrangement.