NINTH AMENDMENT

The parties, by signing below, agree that the Administrative Services Agreement for the City of Overland Park, Kansas Self-Insured Health Care Benefit Plan described in the Administrative Services Agreement as Contract No. 704447 issued by United HealthCare Services, Inc., formerly known as UnitedHealthcare Insurance Company effective January 1, 2004 for an initial Agreement Period of twelve months commencing on the effective date of January 1, 2004, and subsequently amended by eight renewal amendments, (hereinafter referred to as "Agreement"), is hereby further amended by the parties as follows:

Amendment Part I. Section 1. Definitions "Agreement Period" of said Agreement, as previously amended by the parties is hereby further amended to provide for an ninth additional one year term. Further, the parties agree more specifically that the term of the Agreement is extended for an additional one year term, effective for the period beginning on January 1, 2013 and ending on January 1, 2014, unless otherwise further renewed by the parties.

Amendment Part II. Section 12. Services Provisions of said Agreement, as previously amended by the parties is hereby further amended to replace the Section 12.4 Medical Management Services with the following Section 12.4 Personal Health Support.

Section 12.4 Personal Health Support. We will provide your Participants with Personal Health Support services that offer education, accelerate access to care, provide support around specific treatment decisions, if applicable, and provide surveillance and monitoring of chronic conditions. We will review Participants' diagnosis and proposed health care treatments with respect to whether or not the service is appropriate to treat the condition. The services are designed to facilitate Participant education, identify and prevent delays in treatments, and provide intervention with respect to Participants' health care needs that are highly likely to drive utilization and medical expenses of the Plan.

We will also provide (i) a primary contact, who is a Registered Nurse ("primary contact"), and who is assigned to each identified high-risk Participant (as identified through Our predictive modeling tool described herein) and maintains an ongoing relationship with such Participant. The primary contact is part of a designated team with clinical knowledge, which team may serve additional customers and will have knowledge of Your culture, philosophy, population demographics, industry, benefit plan design and additional programs offered by You to Your Participants, as such information is provided to Us by You, (ii) a client services lead, who is a Registered Nurse or Licensed Practical Nurse, is part of the clinical team and is a liaison to each customer serviced by the team, (iii) a predictive model tool refreshed every thirty days, which is used to identify and risk score Participants who have the greatest risk for future disease, and which risk score is used to prioritize, at the customer and clinical team level, assignment of Participants to the primary contact for outreach by disease type, and (iv) coordination with up to two of Your external vendors that provide disease management and/or care management services to Your Participants.

We will review health care services and supplies to determine whether they are covered services under the Plan. If We determine that services or supplies are not covered under the Plan, then We will provide the appeal services outlined in Section 12.2 of the Agreement.

Amendment Part III. Section 12. Services Provisions of said Agreement, as previously amended by the parties is hereby further amended to add the following Section 12.20 Disease Management Services.

Section 12.20 Disease Management Services. For the service fee specified in Exhibit A, We will provide disease management services independently or through a third party contracted entity or affiliate. These services are designed to proactively (i) identify and stratify Participants diagnosed with specific chronic medical conditions or who may be at risk for developing chronic medical conditions, (ii) provide assessment and intervention to support such Participants, as well as the Participants' physicians, and (iii) help such Participants comply with a physician's established plan of care as well as monitoring and educating Participants regarding the medical condition. The services are designed to provide intervention with respect to Participants' specific chronic medical conditions that are highly likely to drive medical expenses of the Plan. Participant and physician participation will be voluntary. These services include the congestive heart failure, coronary artery disease, diabetes, and asthma programs. You agree to provide Us (or cause Your vendor to provide Us), in a timely manner with all information that We reasonably require to provide Your Participants with disease management services in accordance with this Section and Our program guidelines.

We shall be entitled to rely on the information that is provided to Us in connection with Our provision of disease management services to Your Participants.

We can terminate the disease management services in whole or in part at any time for any reason if such termination applies to all of Our similarly situated self-funded customers. After the initial twelve (12) months of disease management services under this Agreement, You may terminate the disease management services upon thirty (30) days prior written notice to Us. In the unlikely event You terminate within the first twelve (12) months after the effective date of these disease management services, You will be responsible for the disease management services fees reflected in Exhibit A for the full twelve (12) month period.

We will provide reasonable transition services to Participants enrolled in a disease management program at the time of termination for a period not to exceed one hundred twenty (120) days following either party's notice of termination to the other, unless otherwise agreed to by the parties; provided however, We shall have no obligation to provide such transition services if termination is a result of Your material breach, Your failure to pay Us fees due, or Your failure to provide the funding required under Section 12.3 and services shall only be provided to those Participants currently enrolled in a disease management program prior to the termination date of the Agreement. All of the other terms of this Agreement will apply to these post-termination services.

Amendment Part IV. The parties agree that Exhibit A of said Agreement as previously amended by the Eighth Amendment to the Agreement, shall be amended to read as follows:

EXHIBIT A - SERVICE FEES

THE AMENDED FINANCIAL TERMS ARE AS FOLLOWS:

The following financial terms are effective for the period from January 1, 2013 to January 1, 2014,.

The fees for standard medical services described below, excluding optional and non-standard fees, are adjusted as set forth in the attached Exhibit C "PERFORMANCE STANDARDS FOR HEALTH BENEFITS" and Exhibit E "NETWORK PROVIDER DISCOUNTS".

You agree to pay Us for services performed in accordance with the terms of this Agreement the sum of the following standard Medical Service Fees:

2013*
$41.97 per month per Subscriber covered under the "UnitedHealthcare *Choice Plus HRA*" portion of the Plan.

$37.19 per month per Subscriber covered under the "UnitedHealthcare *Choice Plus"* portion of the Plan.

*The above amounts include an administrative service fee credit of $12.07.

Pharmacy AWP Contract Rate

Your contract rate for prescription drugs obtained through the home delivery Network Pharmacy for generic drugs is AWP-57% excluding specialty drugs. We use Medi-Span's national drug data file as the source for average wholesale price (AWP) information. We reserve the right to revise the pricing and adopt a new source or benchmark if there are material industry changes in pricing methodologies. We will provide a minimum 30 day notice of this change if it is possible for us to do so.

Administrative Service Fees - Optional and Non-Standard Fees

Service Fee for Facility Reasonable Charge Determination and Negotiation

A fee for our services, as described in the Agreement, equal to thirty percent (30%) of the amount of reductions obtained through our efforts.

We will bill you for the amounts that you owe us. The bill will reflect reductions obtained during the preceding month and adjustments, if any, from previous months.

Service Fee for Shared Savings Program

A fee equal to thirty-five percent (35%) of the "Savings Obtained" as a result of the Shared Savings Program described in the Agreement. "Savings Obtained" means the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Participant and the Plan, after the discount is taken.

Service Fee for Fraud and Abuse Management
You will pay Us a fee equal to thirty-two and five-tenths percent (32.5%) of the gross recovery amount.

Credit Balance Recovery Services
You will pay Us a fee not to exceed ten percent (10%) of the gross recovery amount.

External Reviews
For each subsequent external review beyond 5 total reviews per year, a fee of $500 will apply per review

Personal Health Support with Disease Management Services

$3.47** per Employee per month

Wellness Coaching Services

Included in Choice Plus HRA medical service fee; no charge for Choice Plus Plan.

Wellness Plan File Feeds

$1,765 Fee Waived for up to five feeds during 2013.

**Fees are calculated in the administrative fee credit

Amendment Part V. The parties agree that Exhibit C titled - PERFORMANCE STANDARDS FOR HEALTH BENEFITS of the Agreement as previously amended by Amendment Part V of the Eighth Amendment to the Agreement shall be amended to read as follow**s**

EXHIBIT C

PERFORMANCE STANDARDS FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees), (hereinafter referred to as "Fees") payable by You under this Agreement will be adjusted through a credit to your Service Fees in accordance with the performance guarantees set forth below unless otherwise defined in the guarantee. Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period beginning January 1, 2013 and ending on January 1, 2014 ("Guarantee Period"). With respect to the aspects of our performance addressed in this exhibit, these fee adjustments are your exclusive financial remedies.

We reserve the right from time to time to replace any report or change the format of any report referenced in these guarantees. In such event, the guarantees will be modified to the degree necessary to carry out the intent of the parties. We shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent We fail to meet these standards due to fire, embargo, strike, war, accident, act of God, acts of terrorism or Our required compliance with any law, regulation, or governmental agency mandate or anything beyond Our reasonable control.

Prior to the end of the Guarantee Period, and provided that this Agreement remains in force, We may specify

to You in writing new performance guarantees for the subsequent Guarantee Period. If We specify new performance guarantees, We will also provide you with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Claim is defined as an initial and complete written request for payment of a Plan benefit made by an enrollee, physician, or other healthcare provider on an accepted format. Unless stated otherwise, the claims are limited to medical claims processed through the UNET claims systems. Claims processed and products administered through any other system, including claims for other products such as vision, dental, flexible spending accounts, health reimbursement accounts, health savings accounts, or pharmacy coverage, are not included in the calculation of the performance measurements. Also, services provided under capitated arrangements are not processed as a typical claim; therefore capitated payments are not included in the performance measurements.

Claim Operations			
Time to Process in 10 Days			
Definition	The percentage of all claims We receive will be processed within the designated number of business days of receipt.		
Measurement	Percentage of claims processed		94%
	Time to process, in business days or less after receipt of claim	business days	10
▪ Criteria	Standard claim operations reports		
▪ Level	Site Level		
▪ Period	Annually		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$8,940
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	11 business days 12 business days 13 business days 14 business days 15 business days or more		
Financial Accuracy (FAR)			
Definition	Financial accuracy rate of not less than the designated percent.		
Measurement	Percentage of claims dollars processed accurately		99.3%
▪ Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars submitted for payment.		
▪ Level	Office Level		
▪ Period	Annually		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$8,940
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	99.29% - 99.06% 99.05% - 98.81% 98.80% - 98.56% 98.55% - 98.30% Below 98.30		
Procedural Accuracy			
Definition	Procedural accuracy rate of not less than the designated percent.		
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors		97%
▪ Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed without procedural (i.e. non-financial) errors.		
▪ Level	Office Level		
▪ Period	Annually		
Payment Period	Annually		

Fees at Risk	**Dollars at Risk** for this metric	$8,940
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% - 95.00% Below 95.00%	

Member Phone Service

Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Your Participants. They do not include calls made to care management personnel and/or calls to the senior center for Medicare Participants, nor do they include calls for services/products other than medical, such as mental health/substance abuse, pharmacy, dental, vision, flexible spending accounts, Health Reimbursement Account, Health Savings Account, etc.

Average Speed of Answer

Definition	Calls will sequence through our phone system and be answered by customer service within the parameters set forth.		
Measurement	Percentage of calls answered		100%
	Time answered in seconds, on average	seconds	30
▪ Criteria	Standard tracking reports produced by the phone system for all calls		
▪ Level	Team that services Your account		
▪ Period	Annually		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$8,940
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds		

Abandonment Rate

Definition	The average call abandonment rate will be no greater than the percentage set forth		
Measurement	Percentage of total incoming calls to customer service abandoned, on average		2%
▪ Criteria	Standard tracking reports produced by the phone system for all calls		
▪ Level	Team that services Your account		
▪ Period	Annually		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$8,940
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00%		
	Greater than 4.00%		

Call Quality Score

Definition	Maintain a call quality score of not less than the percent set forth		
Measurement	Call quality score to meet or exceed		93%
▪ Criteria	Random sampling of calls are each assigned a customer service quality score, using our standard internal call quality assurance program.		
▪ Level	Team that services Your account		
▪ Period	Annually		
Payment Period	Annually		
Fees at Risk	**Dollars at Risk** for this metric		$8,940
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%

Gradients	92.99% - 91.00% 90.99% - 89.00% 88.99% - 87.00% 86.99% - 85.00% Below 85.00%	
Satisfaction		
Employee (Member) Satisfaction		
Definition	The overall satisfaction will be determined by the question that reads *"Overall, how satisfied are you with the way we administer your medical health insurance plan?"*	
Measurement	Percentage of respondents, on average, indicating a grade of satisfied or higher	80%
▪ Criteria	Operations standard survey, conducted over the course of the year; may be customer specific for an additional charge.	
▪ Level	Office that services Your account	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$2,980
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	
Customer Satisfaction		
Definition	The overall satisfaction will be determined by the question that reads *"How satisfied are you overall with UnitedHealthcare?"*	
Measurement	Minimum score on a 10 point scale	score 5
▪ Criteria	Standard Customer Scorecard Survey	
▪ Level	Customer specific	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$2,980
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	

Amendment Part VI. The parties agree that the following Exhibit E to the Agreement titled - NETWORK PROVIDER DISCOUNTS as previously amended by Amendment Part VI of the Eighth Amendment to the Agreement shall be amended to read as follows:

EXHIBIT E

NETWORK PROVIDER DISCOUNTS

Adjustment to Standard Service Fees

The Administrative Fees shown in Section I for Employees covered under the UnitedHealthcare Choice Plus portion of the Plan, payable by You for the services provided under this Agreement, will be adjusted in accordance with the Network Provider discounts set forth in this Exhibit. Unless otherwise specified, these provider discounts are effective for the period from January 1, 2013 to January 1, 2014. The settlement of provider discounts will be performed on an annual basis at the time of the year end reconciliation.

Choice Plus Network Discount Guarantee	
Actual Network Discounts	**Dollar Adjustment to Medical Service Fees**
Less than 50.4%	-$54,000
50.4% to 51.4%	-$43,200

51.4% to 52.4%	-$32,400
52.4% to 53.4%	-$21,600
53.4% to 54.4%	-$10,800
54.4% to 60.4%	**Risk Free Corridor – No Adjustment**

Assumptions

- Target in-Network Provider Discount Percentage 57.4%.
- The target discount percentage is based on the current distribution percentage of in-network employees by market and assumes total replacement with UnitedHealthcare. The current distribution for the larger markets is illustrated below. The distribution of smaller markets are combined into the All Other market.
- We reserve the right to revise the target discount percentage should there be a significant change in this Employee distribution (+ or - 10% change in any of the markets identified below). The figures above are based upon the following markets and Employee counts:

Market		**Employee distribution**
509	Kansas City	792
	other	16
Total		**808**

Savings are defined as the sum of the difference between the covered billed charges (excluding ineligible and not covered charges) submitted by the network provider and the amount based on the negotiated rate with that provider.

This may also include specially negotiated discounts with network providers in outlier claim situations.

We reserve the right to exclude claims billed utilizing billing software, showing billed charges (excluding ineligible and not covered charges) equal to the negotiated rate from this guarantee.

Claims where UnitedHealthcare is the secondary payor are excluded from the Network Savings and Network Savings Factor determination.

Mental Health/Substance Abuse claims are excluded.
Medicare and Out of Area subscribers are excluded.

The in-Network Discount Percentage will be calculated by dividing total in-Network Discount Dollars[1] by total in-Network Eligible Charges[2].

[1] Total in-Network Discount Dollars include participating provider contractual discounts and special negotiated discounts.
[2] Total in-Network Eligible Charges will be participating provider eligible charges minus commercial and Medicare COB reductions for participating providers.

The terms of this Amendment are effective on January 1, 2013 ("Effective Date"), unless otherwise specified.

In this Amendment, "Our", "Us" and "We" mean UnitedHealthcare Insurance Company and/or its affiliated companies and "You" and "Your" mean City of Overland Park Kansas. The words may or may not be capitalized. Any other terms used in this Amendment have the meanings shown in the governing agreements and/or policies.

Nothing shown in this Amendment alters, varies or affects any of the terms, provisions or conditions of the above referenced Agreement as otherwise amended, other than as stated above.

United HealthCare Services, Inc.
185 Asylum Street
Hartford, CT 06103-3408

By _____
Authorized Signature

Print Name:
_____

Print Title:
_____

Date:
_____

City of Overland Park, Kansas
8500 Santa Fe Drive
Overland Park, Kansas 66212

By _____
Authorized Signature

Print Name:
_____

Print Title:
_____

Date:
_____

ATTEST:

_____
Marian Cook, City Clerk

APPROVED AS TO FORM:

_____
Michael R. Santos
City Attorney

50134620 (11/12)