6.

CITY AT THE CENTER
WEST ALLIS

City of West Allis
Matter Summary

7525 W. Greenfield Ave.
West Allis, WI 53214

File Number	Title	Status
R-2009-0132	Resolution	Introduced

Resolution to approve an Amendment to the Plan Management Agreement for Administrative Services between the City of West Allis and Humana Health Insurance Company/Humana Dental Insurance Company, effective March 1, 2009.

Introduced: 5/19/2009

Controlling Body: Administration & Finance Committee

Sponsor(s): Administration & Finance Committee

COMMITTEE RECOMMENDATION adopt

ACTION DATE: MAY 19 2009

	MOVER	SECONDER	AYE	NO	PRESENT	EXCUSED
Barczak						
Czaplewski						
Kopplin			✓			
Lajsic	X		✓			
Narlock			✓			
Reinke		X	✓			
Roadt						
Sengstock						
Vitale			✓			
Weigel						
TOTAL			5	-		

SIGNATURE OF COMMITTEE MEMBER

Kurt E. Kopplin
Chair

Vice-Chair

Member

COMMON COUNCIL ACTION adopt

ACTION DATE: 5-19-09

	MOVER	SECONDER	AYE	NO	PRESENT	EXCUSED
Barczak WC						✓
Czaplewski	✓		✓			
Kopplin			✓			
Lajsic			✓			
Narlock		✓	✓			
Reinke			✓			
Roadt			✓			
Sengstock			✓			
Vitale			✓			
Weigel			✓			
TOTAL			9	-		1

CITY AT THE CENTER
WEST ALLIS

City of West Allis

Resolution

7525 W. Greenfield Ave.
West Allis, WI 53214

File Number: R-2009-0132

Final Action:
MAY 19 2009

Sponsor(s): Administration & Finance Committee

Resolution to approve an Amendment to the Plan Management Agreement for Administrative Services between the City of West Allis and Humana Health Insurance Company/Humana Dental Insurance Company, effective March 1, 2009.

WHEREAS, annually, the City updates its Administrative Services Agreement with Humana Health Insurance Company/Humana Dental Insurance Company; and,

WHEREAS, said Agreement provides for updated contact names, administrative fees, and performance guarantees for the subsequent coverage year.

NOW, THEREFORE, BE IT RESOLVED by the Common Council of the City of West Allis that the Amendment to the Agreement for Administrative Services is hereby approved as set forth in the attached document, effective March 1, 2009.

BE IT FURTHER RESOLVED that the proper City officers are authorized and directed to sign the attached Agreement.

ADM\ORDRES\ADMR377

ADOPTED MAY 19 2009

Paul M. Ziehler, City Admin. Officer, Clerk/Treas.

APPROVED 5/22/09

Dan Devine, Mayor

AMENDMENT TO PLAN MANAGEMENT AGREEMENT
for Administrative Services

The Plan Management Agreement between **Humana Insurance Company** and **HumanaDental Insurance Company** ("Plan Manager"), and **City of West Allis** ("Client") effective on March 1, 2007 (the "Agreement") is hereby amended, in accordance with Article 16.7 of the Agreement and for good and valuable consideration, in the following particulars:

I. References to Gerald L. Ganoni's FAX Number are hereby amended and shall be substituted with: FAX: 920-337-8129.

The Agreement is amended as provided above effective as of March 1, 2009.

II. Article II, Relationship Between the Parties, 2.7 has been deleted in its entirety and replaced with the following:

2.7 Except with respect to duties expressly assumed hereunder by the Plan Manager, the Plan Manager is not responsible for maintaining the Plan in compliance with the requirements of the Internal Revenue Code or any applicable laws and regulations governing or affecting the Plan.

The Agreement is amended as provided above effective as of March 1, 2009.

III. Article III, General Duties of Client, 3.6 has been deleted in its entirety and replaced with the following:

3.6 The Client promises that timely written notice will be provided to the Plan Manager of the Plan's management policies and practices, interpretations of the benefit provisions of the Plan, and changes in the Plan provisions. The Plan Manager is not responsible for failure to administer the Plan properly if directed otherwise by the Client or if materials are not provided timely by the Client to the Plan Manager to implement changes.

The Agreement is amended as provided above effective as of March 1, 2009.

IV. Article III, General Duties of Client, 3.7 has been deleted in its entirety and replaced with the following:

3.7 The Client shall provide accurate information to the Plan Manager as to the number and names of persons covered by the Plan and any other information necessary to enable the Plan Manager to provide the services required by this Agreement. This information shall be kept current on at least a monthly basis. The Plan Manager is not responsible for any claims paid in error due to inaccurate eligibility information.

The Agreement is amended as provided above effective as of March 1, 2009.

V. Article III, General Duties of Client, 3.12 has been deleted in its entirety and replaced with the following:

3.12 The Client will receive from the Plan Manager, a monthly invoice around the fifteenth (15th) of each month for payment due effective the first (1st) of the following month. The Client will reconcile their account and pay the monthly administrative fees from the total amount due on the Plan Manager's invoice. The Client pays their administrative fees by check or wire transfer equal to the monthly invoice. The amount of the fees may be adjusted monthly to reflect enrollment changes. The Client can arrange wire transfers by completing a form provided by the Plan Manager. Wire transfers will only be activated each month with prior approval from the Client. If paying by check, the Client should submit the check to the address listed on the invoice and should be accompanied by the return portion of the invoice. The Plan Manager must receive payment by the due date on the invoice.

The Agreement is amended as provided above effective as of March 1, 2009.

VI. Article III, General Duties of Client, 3.13 has been deleted in its entirety.

The Agreement is amended as provided above effective as of March 1, 2009.

VII. Article IV, General Duties of Plan Manager, 4.6 has been deleted in its entirety and replaced with the following:

4.6 With respect to its obligations under this Agreement, the Plan Manager will maintain professional liability and errors and omissions insurance in amounts sufficient to protect against losses with respect to occurrences arising out of failure to properly perform its obligations under this Agreement. Proof of coverage is available upon request.

The Agreement is amended as provided above effective as of March 1, 2009.

VIII. Article V, Claims Administration, 5.8 has been deleted in its entirety and replaced with the following:

5.8 Appeals of denied claims shall be processed in accordance with the applicable provisions of the Plan. The Client acknowledges that the Plan Administrator shall have the ultimate responsibility and authority to make final determinations with respect to claims and is responsible for providing Participants with a written explanation of that decision.

The Agreement is amended as provided above effective as of March 1, 2009.

IX. Article V, Claims Administration, 5.10 has been deleted in its entirety and replaced with the following:

5.10 With respect to claims for which provider discounts are available ("Provider Discounts"):

(a) The Client authorizes and directs the Plan Manager to process claims under this Agreement taking the Provider Discounts into account.

(b) However, the Client directs the Plan Manager that a Provider Discount will not be applied with respect to a claim if doing so would result in payment by the Plan of a greater expense than would be payable if the Provider Discount was not applied.

The Agreement is amended as provided above effective as of March 1, 2009.

X. Article VI, Reports and Records, 6.1 has been deleted in its entirety and replaced with the following:

6.1 The Plan Manager will provide standard reports to the Client or the Plan Administrator as mutually agreed upon by the Plan Manager and the Client. Reports requested outside of the standard reports are considered "ad hoc reports" and may be made available for an additional cost, upon mutual agreement between the Client and the Plan Manager.

The Agreement is amended as provided above effective as of March 1, 2009.

XI. Article VI, Reports and Records, 6.4 has been deleted in its entirety and replaced with the following:

6.4 The Plan Manager will prepare and make available records required to assist the Client or the Plan Administrator regarding legal action or regulatory review and reporting, upon reasonable request by the Client. The Client agrees to reimburse the Plan Manager for its reasonable costs of these services and the preparation, duplication, and transmission of these records.

The Agreement is amended as provided above effective as of March 1, 2009.

XII. Article VI, Reports and Records, has been amended to include the following:

6.6 Audits are governed by the Plan Manager's policy regarding Client audit requests (available upon request). Audits may be conducted by the Client or a third party on behalf of the Client provided all security documents, non-disclosure agreements and authorizations are completed and accepted by the Plan Manager. Request for an audit must be received sixty (60) days prior to the date in which the Client is requesting to perform said audit. Audits for active Clients must be conducted within two (2) years of the last day of the Plan year to be audited. Audits for Clients that have terminated their Plan with the Plan Manager must be conducted within one (1) year of the last day of the Plan year to be audited. Any audit that requires a review of more than three hundred (300) claims or is requested for more than one (1) week on-site the Client agrees that it may be subject to additional costs, the estimate for these costs will be provided prior to scheduling the audit. The audit will not be scheduled until the Plan Manager and the Client are in mutual agreement of the estimated additional cost. A report by the Plan Manager's independent accountant on the controls over claims adjudication (known as a SAS 70 report) is provided at no cost upon request.

The Agreement is amended as provided above effective as of March 1, 2009.

XIII. Article VII, Additional Administrative Services, 7.3 has been deleted in its entirety and replaced with the following:

7.3 The Plan Manager will assist the Client or the Plan Administrator in arranging to provide Clinical Program services with respect to the Plan only as specified in Exhibit "C".

The Agreement is amended as provided above effective as of March 1, 2009.

XIV. Article VII, Additional Administrative Services, 7.4 has been deleted in its entirety and replaced with the following:

7.4 The Plan Manager will provide the following miscellaneous administrative services, following its normal procedures:

(a) Production of basic Participant identification cards.

(b) Routine claims processing audit controls.

(c) Fraud investigation services.

The Agreement is amended as provided above effective as of March 1, 2009.

XV. Article VII, Additional Administrative Services, 7.5 has been deleted in its entirety and replaced with the following:

7.5 The Plan Manager will provide "Subrogation/Recovery" services (in addition to routine application of the coordination of benefits provisions of the Plan) for identifying and obtaining recovery of claims payments from all appropriate parties through operation of the subrogation or recovery provisions of the Plan.

(a) Subrogation / Recovery services will be provided by the Plan Manager following its normal procedures and such services may be performed by subcontractors and/or counsel selected by the Plan Manager.

(b) Subrogation / Recovery services include the following activities:

(1) Investigation of claims and obtaining additional information to determine if a person or entity may be the appropriate party for payment;

(2) Presentation of appropriate claims and demands for payment to parties determined to be liable;

(3) Notification to Participants that recovery or subrogation rights will be exercised with respect to a claim; and

(4) Filing and prosecution of legal proceedings against any appropriate party for determination of liability and collection of any payments for which such appropriate party may be liable.

(c) In the event of termination of this Agreement, Subrogation/Recovery services will be continued only in respect to claims processed under this Agreement and those continued services will be provided until completion. Subrogation/Recovery services will cease immediately if the termination of this Agreement results from a material default in the delivery of such subrogation services.

(d) The cost to the Client for providing services under this Article 7.5 is presented within Exhibit "F3.1 (a)", in accordance with Article IX. However, there will be no cost to the Client for recovery of claims payments made in error by the Plan Manager exclusive of any other cause. Also in this context, the Plan Manager may not be obligated to file and prosecute legal proceedings against persons for determination of liability and collection of any payments.

(e) Subrogation/Recovery services will be provided by the Plan Manager following its normal procedures when a group has contracted with a third party vendor (ex. Stop Loss carrier). Any recoveries are reported to the Client. The Client is responsible for any required notifications/reimbursements to their contracted third parties.

The Agreement is amended as provided above effective as of March 1, 2009.

XVI. Article VII, Additional Administrative Services, 7.7 has been deleted in its entirety.

The Agreement is amended as provided above effective as of March 1, 2009.

XVII. Article VII, Additional Administrative Services, 7.10 has been deleted in its entirety and replaced with the following:

7.10 In the event the Client's overall employee enrollment in this Plan (active employees and COBRA continuees) has decreased by 10% or more since the beginning of each renewal policy period, due to one of the following reasons:

(1) The Client makes design changes to the Plan or employee benefit programs, including changes required by applicable law or regulatory action resulting in employees being terminated from the Plan; or

(2) The Client revises its corporate structure or organization resulting in employees being terminated from the Plan; or

(3) Due to employee choice of participation in the Plan, results in employees being terminated from the Plan

the Plan Manager will continue processing Claims, for the terminated employees, which are incurred prior to the date of such change as provided in Article V of this Agreement.

Such claims will be processed as long as this Agreement is in force. The Client will be billed an additional administrative fee per employee as provided under Exhibit "F3.1(d)". Claims incurred prior to the employee's termination date will be processed by the Plan Manager as long as this Agreement is in force or if a supplemental agreement is entered into.

This Article 7.10 will not apply in the event the Plan Administrator provides timely written notification to the Plan Manager directing that services described in this Article are not required.

The Agreement is amended as provided above effective as of March 1, 2009.

XVIII. Article XI, Termination, 11.1 has been deleted in its entirety and replaced with the following:

11.1 This Agreement may be terminated by the Plan Manager at the end of any contract period upon advance written notice of at least one hundred eighty (180) days. This Agreement may be terminated by the Client at the end of any contract period upon advance written notice.

The Agreement is amended as provided above effective as of March 1, 2009.

XIX. Article XI, Termination, 11.2(c) has been deleted in its entirety.

The Agreement is amended as provided above effective as of March 1, 2009.

XX. Article XI, Termination, ¦1.3(b) has been deleted in its entirety and replaced with the following:

(b) The commission by the other party of any material breach of this Agreement which is not cured in connection with the performance of its duties under this Agreement. However, a material breach of this Agreement may be cured within thirty (30) days after written notice from the other party.

The Agreement is amended as provided above effective as of March 1, 2009.

XXI. Article XI, Termination, has been amended to include the following:

11.9 Upon termination of this Agreement, the Client may elect to have the Plan Manager process claims for a run-out period of either three (3) months or twelve (12) months. The administration fee for three (3) months of run-out will be equal to a one time payment of three (3) months worth of Administrative Fees. The administration fee for twelve (12) months of run-out will be equal to a one time payment of four (4) months worth of the Administrative Fees. Medical: The monthly run-out administration fee will be the full renewal Administrative fee times current enrollment. Dental: The monthly run-out administration fee will be the full renewal Administrative fee times the average enrollment of twelve (12) months prior to the written notice of termination. If commissions are to be paid to a broker during the run-out period, they should be included in the renewal Administrative Fee before calculating the amount to be billed to the Client for run-out. The total run-out administration fee must be paid in full to the Plan Manager by the Client no later than the fifteenth (15th) of the month prior to termination and an executed Supplemental Agreement must be received by the Plan Manager in order for claims processing to continue after the active Agreement period has expired. The Client agrees that the Plan Manager will have no obligation to process claims beyond the end date of the Supplemental Agreement.

The Agreement is amended as provided above effective as of March 1, 2009.

XXII. Article XIII, Hold Harmless, has been amended to include the following:

13.4 In the event that the general obligations of this Article XIII may be construed in such a manner so as to conflict with more specific provisions of this Agreement with respect to a particular issue, the more specific and comprehensive provisions shall be given effect.

The Agreement is amended as provided above effective as of March 1, 2009.

XXIII. A new Exhibit C – Clinical Program Services - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit C". This new Exhibit C shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

XXIV. A new Exhibit F – Schedule of Fees - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit F". This new Exhibit F shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

XXV. A new Exhibit G – Persons Authorized to Receive Private Health Information - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit G". This new Exhibit G shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

XXVI. A new Exhibit H – Pharmacy Management - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit H". This new Exhibit H shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

IN WITNESS WHEREOF, the Plan Manager and the Client have executed this Amendment on_____, 20___.

CITY OF WEST ALLIS
West Allis, Wisconsin

BY: _____

TITLE: _____

HUMANA INSURANCE COMPANY
De Pere, Wisconsin

(By)_____
Khalid Nazir
Vice President

HUMANADENTAL INSURANCE COMPANY
Green Bay, Wisconsin

(By)_____
Gerald L. Ganoni
President

EXHIBIT C

Clinical Program Services

These Clinical Program services are performed by the Plan Manager in connection with Plan provisions aimed at monitoring quality, containing costs, and promoting efficient delivery of Covered Services (see below) in appropriate settings.

In all circumstances, the Client understands and agrees that these services are performed solely for the purpose of implementing Plan provisions and assisting in utilization management decision making which results in the delivery of appropriate levels of Plan benefits. The assistance provided through these services does not constitute the practice of medicine.

None of the Clinical Program services performed by the Plan Manager under this Agreement constitute a claims review determination or a guarantee of coverage or benefits eligibility. Benefits eligibility will be determined in the normal course of claims processing.

DEFINITIONS

C1.1 "Covered Services" means health care services or supplies to which a health care coverage provision of the Plan might apply.

C1.2 "Emergency" care means Covered Services received by a Participant related to a sudden and unexpected change in the Participant's physical or mental condition which is severe enough to require immediate hospital level care.

C1.3 "Health Care Provider" means any physician, practitioner, hospital, facility, laboratory, or any other provider of health care services or supplies which are Covered Services under the terms of the Plan.

C1.4 Clinical Program services are performed employing processes generally described as follows. These concepts may be described similarly by the terms of the Plan, differing only with respect to terminology.

(a) "Utilization Review" means the process of assessing the appropriateness, utility, or necessity of hospital admissions, surgical procedures, outpatient care, and other health care services as required under the provisions of the Plan. Utilization Review includes:

(1) "Precertification", which is the process of assessing the appropriateness, utility, or necessity of proposed non-emergency hospital admissions, surgical procedures, outpatient care, and other health care services.

(2) "Concurrent Review", which is the process of assessing the continuing appropriateness, utility, or necessity of additional days of hospital confinement, outpatient care, and other health care services.

(b) "Retrospective Review" means the process of assessing after the fact the appropriateness, utility, or necessity of hospital admissions, additional days of hospital confinement, surgical procedures, outpatient care, and other health care services, as required under the provisions of the Plan.

(c) "Case Management" means the process of assessing whether an alternative plan of care would more effectively provide necessary health care services in an appropriate setting, as required under the provisions of the Plan.

(d) "Transplant Management" means hands-on support to Participants in need of organ and tissue transplants. The Transplant Management Team guides Participants to the Plan Manager's National Transplant Network (NTN), designed to control costs and deliver a superior transplant experience. They review coverage, coordinate benefits, facilitate services and follow the transplant recipient's progress from initial referral through treatment and recovery.

CLINICAL PROGRAM SERVICES

C2.1 Precertification, Concurrent Review, and Retrospective Review will be performed by the Plan Manager, or a consulting health care professional engaged by the Plan Manager, which may use criteria and protocols developed with input from health care experts.

C2.2 The Plan Manager will provide or arrange for the provision of Precertification services, under applicable Plan provisions.

(a) In the event that a proposed treatment cannot be Precertified:

(1) The Plan Manager, the person requesting Precertification, and the attending Health Care Provider may, if sufficient information is provided, discuss possible treatment alternatives available under the Plan which might be Precertified.

(2) In the event that the attending Health Care Provider chooses not to select possible treatment alternatives which might be Precertified or otherwise wishes to pursue Precertification of the proposed treatment as originally proposed, the Precertification process will proceed to resolution on the basis of available information.

(b) Precertification will be completed within the time periods prescribed in the Plan, or if there are none, within a reasonable time after a request is made.

C2.3 During the Precertification and Concurrent Review processes, each hospital admission is evaluated for discharge planning needs, and home health care, and Case Management potential, as appropriate.

C2.4 The Plan Manager will provide or arrange for the provision of Concurrent Review services, under applicable Plan provisions.

C2.5 The Plan Manager will provide or arrange for the provision of Retrospective Review services, under applicable Plan provisions.

(a) For Emergency inpatient admissions, Retrospective Review services will not be performed unless they are requested within the earlier of:

(1) The period of time following admission specified in the Plan; or

(2) If no time is specified in the Plan, 48 hours following admission.

(b) When required notification is not provided so that Precertification is not performed, Retrospective Review services will be performed only if specifically required by the Plan.

C2.6 Notices of the results of the Precertification, Concurrent Review, and Retrospective Review processes, provided in accordance with the provisions of the Plan, will include information about the Plan Manager's standard procedures for having those results reconsidered. Results of these processes do not constitute claims determinations, and reconsideration of these results does not constitute an appeal of a disputed claim.

C2.7 The Plan Manager will provide or arrange for the provision of Case Management services under applicable Plan provisions.

C2.8 The Plan Manager will provide or arrange for the provision of Transplant Management services under applicable Plan provisions.

C2.9 The Plan Manager will provide or arrange for the provision of the following additional services, under applicable Plan provisions.

(a) **Integrated Medical and Behavioral Health Care Management**, which addresses medical and co-morbid behavioral health conditions. Teams of care managers integrate the delivery of care plans and other guidance so that a primary contact will address both physical and behavioral health conditions. Clinical associates screen Participants for behavioral health conditions in order to proactively identify Participants who might benefit from an integrated care plan.

(b) **Personal Nurse®** services which provide Participants with a specially trained nurse and provides information and tools that can help Participants understand their health care options, take control of their health needs and get the most from their plan benefits. Participation is voluntary and Participants can choose to opt out at any time. Participants are identified as potential candidates who meet all of the following criteria:

(1) Humana is the third party administrator;
(2) Active enrollment status;
(3) Expected/actual hospital admission.

(c) ***My*Humana**, a personal, password-protected home page located at www.humana.com. Participants can log-in anytime to find a participating provider, look up benefits or check the status of a claim. Additional features include: shop-and-compare tools to help Participants choose hospitals and doctors, prescription drug information, a health encyclopedia, information on specific health conditions, financial tools to help with budgeting for health care and more.

(d) **Humana Health Assessment** a confidential, online lifestyle questionnaire located at *My*Humana.com. Upon completion of the assessment, Participants will receive a customized health report that identifies health risks and provides steps they can take to gain more control of their health.

(e) **Preventive Reminders**, proactive, targeted campaigns that deliver messages to Participants of primary prevention care. Messages are delivered in a variety of methods including Voice Activated Technology (VAT), mailers/postcards or emails. Topics include mammography screenings, vaccinations, immunizations and more.

(f) **Wellness Calendar Program** is an electronic package that the Employer will receive each month with a dedicated focus on a wellness topic.

HEALTH CARE PROVIDERS

C3.1 The Client agrees that the Plan Manager shall not be held responsible for the actions of Health Care Providers acting as licensed professionals within the scope of their professional practice, and that in no event shall the hold harmless and indemnity provisions of this Agreement apply against the Plan Manager with respect to any expense caused by the acts or omissions of Health Care Providers.

REPORTS

C4.1 Special reports may be provided by the Plan Manager, if requested by the Client and the contents, composition, and cost is mutually agreed upon.

MISCELLANEOUS

C5.1 The Plan Manager will provide these Clinical Program services in accordance with the provisions of the Plan which are in effect and which have been communicated to the Plan Manager by the Client at the time the services are provided.

C5.2 If the Plan Administrator directs the Plan Manager to make a Clinical Program services determination which is different than the determination which would otherwise be made by the Plan Manager, the Plan Manager will follow the determination of the Plan Administrator, provided the Plan Administrator's determination is first communicated to the Plan Manager in writing.

However, the Plan Manager may decide that it will communicate this determination only as directed in special written instructions from the Plan Administrator which are acceptable to the Plan Manager.

C5.3 The Plan Manager is an independent contractor with respect to the services provided under Article 7.3 and Exhibit "C" of this Agreement, Article 2.5 of this Agreement notwithstanding.

C5.4 The obligations of the Plan Manager under Article 7.3 and Exhibit "C" of this Agreement shall terminate upon the expiration of this Agreement.

EXHIBIT F

Schedule of Fees

F1.1 The monthly fees presented in this Exhibit "F" are valid for the period of time beginning March 1, 2009 and ending on February 28, 2010, except as otherwise stated.

F2.1 General:

Administrative Fees:

Indemnity Plan	Per Employee	Per Family
Medical and Prescription Drug	$25.81	$25.81

CHC Plan	Per Employee	Per Family
Medical and Prescription Drug	$31.56	$31.56

	Single	Family
Dental	$4.40	$4.40

F3.1 Specific:

(a) Under Article 7.5 of this Agreement, the administrative fee for providing Subrogation / Recovery Services is 30% of all amounts recovered under that Article. The administrative fee will be applied towards the gross recovery, exclusive of any legal fees. Fees are calculated based on gross recovery. Expenses incurred are taken out of the Plan Manager's fee when it is the Plan Manager's choice to retain counsel. If the Client requests legal action outside the normal course of handling, it will be the Client's responsibility to pay legal fees incurred.

(b) With respect to access to provider networks in accordance with Article 7.8 of this Agreement or other similar provider arrangements arranged through the Plan Manager, the Client understands that a special access fee may be payable, depending upon the network or arrangement. The Client and the Plan Manager agree that the Client will be obligated to pay any special fee under this Exhibit "F3.1(b)" only upon advance written notice to and written consent by the Client.

(c) With respect to access to and application of the Shared Savings Program in accordance with Article 7.9 and Exhibit "D-1", the Client agrees to pay a fee equal to 30% of the "savings" on medical services realized by virtue of application of the Shared Savings Program Provider Discounts.

(d) The fee payable for run-out claims processing under Article 7.10 of this Agreement can be one of two options. The Client can choose for the Plan Manager to process run-out claims for either three (3) or twelve (12) months. The fee for handling these run-out claims for three (3) months is equal to three (3) months of Administrative fees or for twelve (12) months is equal to four (4) months of Administrative fees. The run-out fee will be calculated based on the total number of employees that were terminated from the Plan. The total run-out fee must be received by the Plan Manager to begin the claims processing for the selected run-out period.

F4.1 Payment:

(a) Fees set forth in Exhibit "F2.1" are payable to the Plan Manager once per month, unless otherwise indicated.

(b) Any special access fees payable under Exhibit "F3.1(b)" shall be paid by the Client to the Plan Manager as billed.

EXHIBIT G

Persons Authorized to Receive Private Health Information

Name:	Audrey Key
Title:	Human Resources Manager
Company:	City of West Allis
Address:	7525 West Greenfield Avenue West Allis, WI 53214
Telephone:	(414) 302-8274
Fax:	(414) 302-8275
Email:	akey@ci.west-allis.wi.us

Name:	David Wepking
Title:	Safety & Training Coordinator
Company:	City of West Allis
Address:	7525 West Greenfield Avenue West Allis, WI 53214
Telephone:	(414) 302-8835
Fax:	(414) 302-8275
Email:	dwepking@ci.west-allis.wi.us

Name:	Jane Barwick
Title:	Senior Human Resources Analyst
Company:	City of West Allis
Address:	7525 West Greenfield Avenue West Allis, WI 53214
Telephone:	(414) 302-8272
Fax:	(414) 302-8275
Email:	jbarwick@ci.west-allis.wi.us

Name:	Lynn Jopek
Title:	Principal Secretary
Company:	City of West Allis
Address:	7525 West Greenfield Avenue West Allis, WI 53214
Telephone:	(414) 302-8270
Fax:	(414) 302-8275
Email:	ljopek@ci.west-allis.wi.us

Name: Virginia Wright
Company: Willis HRH
Address: 2323 North Mayfair Road
Milwaukee, WI 53226
Telephone: (414) 259-8820
Fax: (414) 475-0559
Email: virginia.wright@willis.com

Name: Dan Aschenbrener
Company: Willis HRH
Address: 2323 North Mayfair Road
Milwaukee, WI 53226
Telephone: (414) 259-8859
Fax: (414) 475-0739
Email: dan.ashenbrener@willis.com

Name: Sheryl Kuhary
Title: Assistant City Attorney
Company: City of West Allis
Address: 7525 West Greenfield Avenue
West Allis, WI 53214
Telephone: (414) 302-8449
Fax: (414) 302-8275
Email: skuhary@ci.west-allis.wi.us

Name: Kris Moen
Title: Finance Supervisor
Company: City of West Allis
Address: 7525 West Greenfield Avenue
West Allis, WI 53214
Telephone: (414) 302-8251
Fax: (414) 302-8275
Email: kmoen@ci.west-allis.wi.us

Name: Gary Schmid
Title: Manager of Finance / Controller
Company: City of West Allis
Address: 7525 West Greenfield Avenue
West Allis, WI 53214
Telephone: (414) 302-8252
Fax: (414) 302-8275
Email: gschmid@ci.west-allis.wi.us

Name: Mary Yusefzadeh
Title: Human Resources Secretary
Company: City of West Allis
Address: 7525 West Greenfield Avenue
West Allis, WI 53214
Telephone: (414) 302-8271
Fax: (414) 302-8275
Email: myusefzadeh@ci.west-allis.wi.us

Company: Willis HRH
Address: 2323 North Mayfair Road, Suite 600
Milwaukee, WI 53226
Telephone: (414) 475-1344
Fax: (414) 475-0739

Company: Ingenix, Inc.
Address: 121258 Technology Drive
Eden, Prairie, MN 55344

EXHIBIT H

Pharmacy Management

DEFINITIONS

H1.1 "Brand Name Medication" means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand name by an industry-recognized source used by the Plan Manager.

H1.2 "Drug List" means a list of prescription drugs, medicines, medications and supplies specified by the Plan Manager. This list indicates applicable Dispensing Limits and/or any Prior Authorization requirements. This list is subject to change without notice. Drugs may be subject to specific time constraints.

H1.3 "Specialty Drug" means a drug, medicine or medication used as a specialized therapy developed for chronic, complex sicknesses or bodily injuries. Specialty Drugs may:

(a) Require nursing services or special programs to support patient compliance;
(b) Require disease-specific treatment programs;
(c) Have limited distribution requirements; or
(d) Have special handling, storage or shipping requirements.

DRUG LIST

H2.1 Pharmacy Management administers a standard Drug List that is updated on an annual basis, or as appropriate, as drugs enter or exit the market. Changes may also occur as Brand Name Medications lose their patents. Annual changes are effective January 1 of each year. Additional fees may be assessed to Clients that opt out of the annual changes. The additional charge will be calculated separately from the fees provided in Exhibit "H6.1". In addition, rebates payable to the Client will be impacted if annual Drug List changes are not implemented.

REBATES

H3.1 Rebates are defined as revenue received from pharmaceutical manufacturers for the placement of their product within the Plan Manager's Drug List and for the market share that product achieved within its therapeutic class.

H3.2 Rebates are quoted on every paid prescription and include Specialty Drugs and prescriptions for less than a 30-day supply. Rebates are calculated bi-annually and are paid within 60 days of the end of the period.

H3.3 Rebates can be impacted by government, regulatory or pharmaceutical industry action. In the event that changes impact the Plan Manager's pharmacy rebate program, the Plan Manager reserves the right to calculate the impact these changes have on guaranteed rebates.

H3.4 The Plan Manager's rebates are dependent upon the Client using the Plan Manager's standard Drug List; therefore if the Client opts out of the standard Drug List, rebates will be impacted.

H3.5 The Plan Manager's rebate offer provided in this Exhibit "H" is based upon the pharmacy benefit plan design proposed and subsequently agreed upon or altered during the implementation process. A material modification of the plan design or program specifications may result in pricing modifications by the Plan Manager.

H3.6 The Plan Manager assumes all of the risks, excluding those risks listed above, associated with negotiating and contracting with participating pharmaceutical manufactures. Except in those instances provided above, the Plan Manager is required to pay guaranteed rebate payments to the Client even if those exceed the rebates received. The Plan Manager will have the right to retain rebates received in excess of those it is obligated to pay. The Plan Manager's guaranteed rebate level is below the expected rebate payments that it expects to receive, if this margin is realized, it will be used to contribute to the cost of administering the pharmacy and rebate program as well as corporate margin goals.

PHARMACY NETWORK DISCOUNTS AND DISPENSING FEES

H4.1 The Plan Manager will assume all of the risks associated with negotiating and contracting with participating pharmacies and pharmaceutical manufacturers. In accordance with the pricing listed herein, the Plan Manager will be responsible for any amounts that it owes participating pharmacies that exceeds the reimbursement it receives. The Plan Manager will also retain any amounts that it receives that are in excess of the amounts it is obligated to pay. These amounts will be used to contribute to the cost of administering the pharmacy and rebate program as well as corporate margin goals.

H4.2 The Plan Manager's retail and mail order discounts exclude Specialty Drugs.

METHODOLOGY

H5.1 The Plan Manager uses Average Wholesale Price (AWP) methodology utilizing First Data Bank or other industry-recognized standards as the primary pricing source, but reserves the right to change to another industry-recognized standard at the Plan Manager's sole discretion. If the Plan Manager decides to change its pricing source, the Plan Manager agrees to:

(a) When possible, provide the Client with at least 30 days notice of the change;
(b) Pass through all financial impacts of the pricing source change to the Client;
(c) Provide the Client with written illustration of the financial impact of the pricing source change (e.g., specific drug examples) and written statement of the expected aggregate annual impact of the pricing source change. When possible, the Plan Manager will provide written illustration and statement noted above to the Client at least 30 days prior to the change.

H5.2 In the event of a pricing methodology change or a pricing source change, if the Plan Manager does not agree to pass through pricing improvements to the Client, or if the change results in higher gross cost (before member cost share) to the Client, then the Client reserves the right to re-negotiate contract terms or to terminate with 90 days written notice at any point during contract term without any termination charges.

H5.3 Recent federal class action lawsuit involving First Data Bank and McKesson has revealed inflation in published Average Wholesale Prices (AWP). First Data Bank stated in October 2006 that it will discontinue publishing the benchmark data within 2 years. As a result, the pharmacy community is in the midst of research to determine what pricing source will be used to replace AWP. In addition, in 2009, a change will be made to effectively lower AWP. In many instances the underlying pharmacy reimbursement will also decrease (saving plans money), and in other instances the underlying pharmacy reimbursement will remain the same (resulting in no financial impact to plans). This event will have an impact on reported pharmacy discounts off of AWP. As this impact is understood, the Plan Manager's guaranteed rates will change accordingly.

FEES

H6.1

GUARANTEE PHARMACY NETWORK DISCOUNTS	
RETAIL SERVICES:	
Average Whole Sale Price (AWP) Discounts:	
Brand Discount	15.80%
Generic Non-MAC Discount	26.00%
Dispensing Fee:	
Brand	$1.80
Generic	$1.80
90-DAYS AT RETAIL:	
Average Whole Sale Price (AWP) Discounts:	
Brand Discount	15.80%
Generic Non-MAC Discount	26.00%
Dispensing Fee:	
Brand	$1.80
Generic	$1.80
MAIL SERVICES:	
Average Whole Sale Price (AWP) Discounts:	
Brand Discount	22.00%
Generic Non-MAC Discount	55.00%

PHARMACY REBATES	
REBATES:	**RX 2 Plan** $1.25 per retail prescription **RX 3 Plan** $2.00 per retail prescription **Integrated** Not Eligible
	3x retail rate(s) above for a mail order prescription

H6.2 The Plan Manager's Pharmacy's sources of revenue are described and limited to those areas listed above. The Plan Manager's revenue comes from the following sources:

(a) Pharmaceutical manufacturer revenue collected above the guaranteed rebate level; and
(b) Pharmacy network discounts and dispensing fees that are more favorable than the guaranteed levels.

Paul,

Please see my responses below to the questions you raised regarding Humana's Plan Management Agreement:

Q. 2007 was Plan Management Agreement for Administrative Services; 2009 just says Plan Management Agreement – does this need to be changed?

A. The document title was revised in 2008 by Humana; 2009's document mirrors 2008.

Q. Where is the 2008 Plan Management Agreement [PMA]? Did it get approval from Council?

A. The 2008 document was an "Amendment to Plan Management Agreement" for 2007. HR questioned whether the 2008 Amendment needed Council approval; like you, we were unable to find documentation of such (possible rationale: amendment vs. full plan agreement, therefore not warranting Council approval). Attorney's Office recommends that the 2009 PMA be submitted to Council as it is a full agreement.

Q. Where are Exhibits C, F, G, & H being referenced in the document?

A. These exhibits are referenced on the bottom of page 7 and on page 8 of the 2009 PMA.

If you wish to see the complete file of changes that the Attorney's Office has reviewed and approved, I would be happy to show you. Please let me know if you have further questions.

Thanks,

Jane

AMENDMENT TO PLAN MANAGEMENT AGREEMENT
for Administrative Services

The Plan Management Agreement between **Humana Insurance Company** and **HumanaDental Insurance Company** ("Plan Manager"), and **City of West Allis** ("Client") effective on March 1, 2007 (the "Agreement") is hereby amended, in accordance with Article 16.7 of the Agreement and for good and valuable consideration, in the following particulars:

I. References to Gerald L. Ganoni's FAX Number are hereby amended and shall be substituted with: FAX: 920-337-8129.

The Agreement is amended as provided above effective as of March 1, 2009.

II. Article II, Relationship Between the Parties, 2.7 has been deleted in its entirety and replaced with the following:

2.7 Except with respect to duties expressly assumed hereunder by the Plan Manager, the Plan Manager is not responsible for maintaining the Plan in compliance with the requirements of the Internal Revenue Code or any applicable laws and regulations governing or affecting the Plan.

The Agreement is amended as provided above effective as of March 1, 2009.

III. Article III, General Duties of Client, 3.6 has been deleted in its entirety and replaced with the following:

3.6 The Client promises that timely written notice will be provided to the Plan Manager of the Plan's management policies and practices, interpretations of the benefit provisions of the Plan, and changes in the Plan provisions. The Plan Manager is not responsible for failure to administer the Plan properly if directed otherwise by the Client or if materials are not provided timely by the Client to the Plan Manager to implement changes.

The Agreement is amended as provided above effective as of March 1, 2009.

IV. Article III, General Duties of Client, 3.7 has been deleted in its entirety and replaced with the following:

3.7 The Client shall provide accurate information to the Plan Manager as to the number and names of persons covered by the Plan and any other information necessary to enable the Plan Manager to provide the services required by this Agreement. This information shall be kept current on at least a monthly basis. The Plan Manager is not responsible for any claims paid in error due to inaccurate eligibility information.

The Agreement is amended as provided above effective as of March 1, 2009.

V. Article III, General Duties of Client, 3.12 has been deleted in its entirety and replaced with the following:

3.12 The Client will receive from the Plan Manager, a monthly invoice around the fifteenth (15th) of each month for payment due effective the first (1st) of the following month. The Client will reconcile their account and pay the monthly administrative fees from the total amount due on the Plan Manager's invoice. The Client pays their administrative fees by check or wire transfer equal to the monthly invoice. The amount of the fees may be adjusted monthly to reflect enrollment changes. The Client can arrange wire transfers by completing a form provided by the Plan Manager. Wire transfers will only be activated each month with prior approval from the Client. If paying by check, the Client should submit the check to the address listed on the invoice and should be accompanied by the return portion of the invoice. The Plan Manager must receive payment by the due date on the invoice.

The Agreement is amended as provided above effective as of March 1, 2009.

VI. Article III, General Duties of Client, 3.13 has been deleted in its entirety.

The Agreement is amended as provided above effective as of March 1, 2009.

VII. Article IV, General Duties of Plan Manager, 4.6 has been deleted in its entirety and replaced with the following:

4.6 With respect to its obligations under this Agreement, the Plan Manager will maintain professional liability and errors and omissions insurance in amounts sufficient to protect against losses with respect to occurrences arising out of failure to properly perform its obligations under this Agreement. Proof of coverage is available upon request.

The Agreement is amended as provided above effective as of March 1, 2009.

VIII. Article V, Claims Administration, 5.8 has been deleted in its entirety and replaced with the following:

5.8 Appeals of denied claims shall be processed in accordance with the applicable provisions of the Plan. The Client acknowledges that the Plan Administrator shall have the ultimate responsibility and authority to make final determinations with respect to claims and is responsible for providing Participants with a written explanation of that decision.

The Agreement is amended as provided above effective as of March 1, 2009.

IX. Article V, Claims Administration, 5.10 has been deleted in its entirety and replaced with the following:

5.10 With respect to claims for which provider discounts are available ("Provider Discounts"):

(a) The Client authorizes and directs the Plan Manager to process claims under this Agreement taking the Provider Discounts into account.

(b) However, the Client directs the Plan Manager that a Provider Discount will not be applied with respect to a claim if doing so would result in payment by the Plan of a greater expense than would be payable if the Provider Discount was not applied.

The Agreement is amended as provided above effective as of March 1, 2009.

X. Article VI, Reports and Records, 6.1 has been deleted in its entirety and replaced with the following:

6.1 The Plan Manager will provide standard reports to the Client or the Plan Administrator as mutually agreed upon by the Plan Manager and the Client. Reports requested outside of the standard reports are considered "ad hoc reports" and may be made available for an additional cost, upon mutual agreement between the Client and the Plan Manager.

The Agreement is amended as provided above effective as of March 1, 2009.

XI. Article VI, Reports and Records, 6.4 has been deleted in its entirety and replaced with the following:

6.4 The Plan Manager will prepare and make available records required to assist the Client or the Plan Administrator regarding legal action or regulatory review and reporting, upon reasonable request by the Client. The Client agrees to reimburse the Plan Manager for its reasonable costs of these services and the preparation, duplication, and transmission of these records.

The Agreement is amended as provided above effective as of March 1, 2009.

XII. Article VI, Reports and Records, has been amended to include the following:

6.6 Audits are governed by the Plan Manager's policy regarding Client audit requests (available upon request). Audits may be conducted by the Client or a third party on behalf of the Client provided all security documents, non-disclosure agreements and authorizations are completed and accepted by the Plan Manager. Request for an audit must be received sixty (60) days prior to the date in which the Client is requesting to perform said audit. Audits for active Clients must be conducted within two (2) years of the last day of the Plan year to be audited. Audits for Clients that have terminated their Plan with the Plan Manager must be conducted within one (1) year of the last day of the Plan year to be audited. Any audit that requires a review of more than three hundred (300) claims or is requested for more than one (1) week on-site the Client agrees that it may be subject to additional costs, the estimate for these costs will be provided prior to scheduling the audit. The audit will not be scheduled until the Plan Manager and the Client are in mutual agreement of the estimated additional cost. A report by the Plan Manager's independent accountant on the controls over claims adjudication (known as a SAS 70 report) is provided at no cost upon request.

The Agreement is amended as provided above effective as of March 1, 2009.

XIII. Article VII, Additional Administrative Services, 7.3 has been deleted in its entirety and replaced with the following:

7.3 The Plan Manager will assist the Client or the Plan Administrator in arranging to provide Clinical Program services with respect to the Plan only as specified in Exhibit "C".

The Agreement is amended as provided above effective as of March 1, 2009.

XIV. Article VII, Additional Administrative Services, 7.4 has been deleted in its entirety and replaced with the following:

7.4 The Plan Manager will provide the following miscellaneous administrative services, following its normal procedures:

(a) Production of basic Participant identification cards.

(b) Routine claims processing audit controls.

(c) Fraud investigation services.

The Agreement is amended as provided above effective as of March 1, 2009.

XV. Article VII, Additional Administrative Services, 7.5 has been deleted in its entirety and replaced with the following:

7.5 The Plan Manager will provide "Subrogation/Recovery" services (in addition to routine application of the coordination of benefits provisions of the Plan) for identifying and obtaining recovery of claims payments from all appropriate parties through operation of the subrogation or recovery provisions of the Plan.

(a) Subrogation / Recovery services will be provided by the Plan Manager following its normal procedures and such services may be performed by subcontractors and/or counsel selected by the Plan Manager.

(b) Subrogation / Recovery services include the following activities:

(1) Investigation of claims and obtaining additional information to determine if a person or entity may be the appropriate party for payment;

(2) Presentation of appropriate claims and demands for payment to parties determined to be liable;

(3) Notification to Participants that recovery or subrogation rights will be exercised with respect to a claim; and

(4) Filing and prosecution of legal proceedings against any appropriate party for determination of liability and collection of any payments for which such appropriate party may be liable.

(c) In the event of termination of this Agreement, Subrogation/Recovery services will be continued only in respect to claims processed under this Agreement and those continued services will be provided until completion. Subrogation/Recovery services will cease immediately if the termination of this Agreement results from a material default in the delivery of such subrogation services.

(d) The cost to the Client for providing services under this Article 7.5 is presented within Exhibit "F3.1 (a)", in accordance with Article IX. However, there will be no cost to the Client for recovery of claims payments made in error by the Plan Manager exclusive of any other cause. Also in this context, the Plan Manager may not be obligated to file and prosecute legal proceedings against persons for determination of liability and collection of any payments.

(e) Subrogation/Recovery services will be provided by the Plan Manager following its normal procedures when a group has contracted with a third party vendor (ex. Stop Loss carrier). Any recoveries are reported to the Client. The Client is responsible for any required notifications/reimbursements to their contracted third parties.

The Agreement is amended as provided above effective as of March 1, 2009.

XVI. Article VII, Additional Administrative Services, 7.7 has been deleted in its entirety.

The Agreement is amended as provided above effective as of March 1, 2009.

XVII. Article VII, Additional Administrative Services, 7.10 has been deleted in its entirety and replaced with the following:

7.10 In the event the Client's overall employee enrollment in this Plan (active employees and COBRA continuees) has decreased by 10% or more since the beginning of each renewal policy period, due to one of the following reasons:

(1) The Client makes design changes to the Plan or employee benefit programs, including changes required by applicable law or regulatory action resulting in employees being terminated from the Plan; or

(2) The Client revises its corporate structure or organization resulting in employees being terminated from the Plan; or

(3) Due to employee choice of participation in the Plan, results in employees being terminated from the Plan

the Plan Manager will continue processing Claims, for the terminated employees, which are incurred prior to the date of such change as provided in Article V of this Agreement.

Such claims will be processed as long as this Agreement is in force. The Client will be billed an additional administrative fee per employee as provided under Exhibit "F3.1(d)". Claims incurred prior to the employee's termination date will be processed by the Plan Manager as long as this Agreement is in force or if a supplemental agreement is entered into.

This Article 7.10 will not apply in the event the Plan Administrator provides timely written notification to the Plan Manager directing that services described in this Article are not required.

The Agreement is amended as provided above effective as of March 1, 2009.

XVIII. Article XI, Termination, 11.1 has been deleted in its entirety and replaced with the following:

11.1 This Agreement may be terminated by the Plan Manager at the end of any contract period upon advance written notice of at least one hundred eighty (180) days. This Agreement may be terminated by the Client at the end of any contract period upon advance written notice.

The Agreement is amended as provided above effective as of March 1, 2009.

XIX. Article XI, Termination, 11.2(c) has been deleted in its entirety.

The Agreement is amended as provided above effective as of March 1, 2009.

XX. Article XI, Termination, 11.3(b) has been deleted in its entirety and replaced with the following:

(b) The commission by the other party of any material breach of this Agreement which is not cured in connection with the performance of its duties under this Agreement. However, a material breach of this Agreement may be cured within thirty (30) days after written notice from the other party.

The Agreement is amended as provided above effective as of March 1, 2009.

XXI. Article XI, Termination, has been amended to include the following:

11.9 Upon termination of this Agreement, the Client may elect to have the Plan Manager process claims for a run-out period of either three (3) months or twelve (12) months. The administration fee for three (3) months of run-out will be equal to a one time payment of three (3) months worth of Administrative Fees. The administration fee for twelve (12) months of run-out will be equal to a one time payment of four (4) months worth of the Administrative Fees. Medical: The monthly run-out administration fee will be the full renewal Administrative fee times current enrollment. Dental: The monthly run-out administration fee will be the full renewal Administrative fee times the average enrollment of twelve (12) months prior to the written notice of termination. If commissions are to be paid to a broker during the run-out period, they should be included in the renewal Administrative Fee before calculating the amount to be billed to the Client for run-out. The total run-out administration fee must be paid in full to the Plan Manager by the Client no later than the fifteenth (15th) of the month prior to termination and an executed Supplemental Agreement must be received by the Plan Manager in order for claims processing to continue after the active Agreement period has expired. The Client agrees that the Plan Manager will have no obligation to process claims beyond the end date of the Supplemental Agreement.

The Agreement is amended as provided above effective as of March 1, 2009.

XXII. Article XIII, Hold Harmless, has been amended to include the following:

13.4 In the event that the general obligations of this Article XIII may be construed in such a manner so as to conflict with more specific provisions of this Agreement with respect to a particular issue, the more specific and comprehensive provisions shall be given effect.

The Agreement is amended as provided above effective as of March 1, 2009.

XXIII. A new Exhibit C – Clinical Program Services - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit C". This new Exhibit C shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

XXIV. A new Exhibit F – Schedule of Fees - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit F". This new Exhibit F shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

XXV. A new Exhibit G – Persons Authorized to Receive Private Health Information - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit G". This new Exhibit G shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

XXVI. A new Exhibit H – Pharmacy Management - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit H". This new Exhibit H shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

IN WITNESS WHEREOF, the Plan Manager and the Client have executed this Amendment on_____, 20___.

CITY OF WEST ALLIS
West Allis, Wisconsin

BY: _____

TITLE: _____

HUMANA INSURANCE COMPANY
De Pere, Wisconsin

(By)_____
Khalid Nazir
Vice President

HUMANADENTAL INSURANCE COMPANY
Green Bay, Wisconsin

(By)_____
Gerald L. Ganoni
President

XXIV. A new Exhibit F – Schedule of Fees - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit F". This new Exhibit F shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

XXV. A new Exhibit G – Persons Authorized to Receive Private Health Information - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit G". This new Exhibit G shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

XXVI. A new Exhibit H – Pharmacy Management - is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit H". This new Exhibit H shall supersede and be substituted for any previously existing exhibit to the Agreement of the same or similar designation.

The Agreement is amended as provided above effective as of March 1, 2009.

IN WITNESS WHEREOF, the Plan Manager and the Client have executed this Amendment on May 27, 2009.

CITY OF WEST ALLIS
West Allis, Wisconsin

BY: Paul M. Ziellen

TITLE: City Adm. Off./Clerk Treas

HUMANA INSURANCE COMPANY
De Pere, Wisconsin

(By) Khalid Nazir
Khalid Nazir
Vice President

HUMANADENTAL INSURANCE COMPANY
Green Bay, Wisconsin

(By) _____
Gerald L. Ganoni
President

EXHIBIT C

Clinical Program Services

These Clinical Program services are performed by the Plan Manager in connection with Plan provisions aimed at monitoring quality, containing costs, and promoting efficient delivery of Covered Services (see below) in appropriate settings.

In all circumstances, the Client understands and agrees that these services are performed solely for the purpose of implementing Plan provisions and assisting in utilization management decision making which results in the delivery of appropriate levels of Plan benefits. The assistance provided through these services does not constitute the practice of medicine.

None of the Clinical Program services performed by the Plan Manager under this Agreement constitute a claims review determination or a guarantee of coverage or benefits eligibility. Benefits eligibility will be determined in the normal course of claims processing.

DEFINITIONS

C1.1 "Covered Services" means health care services or supplies to which a health care coverage provision of the Plan might apply.

C1.2 "Emergency" care means Covered Services received by a Participant related to a sudden and unexpected change in the Participant's physical or mental condition which is severe enough to require immediate hospital level care.

C1.3 "Health Care Provider" means any physician, practitioner, hospital, facility, laboratory, or any other provider of health care services or supplies which are Covered Services under the terms of the Plan.

C1.4 Clinical Program services are performed employing processes generally described as follows. These concepts may be described similarly by the terms of the Plan, differing only with respect to terminology.

(a) "Utilization Review" means the process of assessing the appropriateness, utility, or necessity of hospital admissions, surgical procedures, outpatient care, and other health care services as required under the provisions of the Plan. Utilization Review includes:

(1) "Precertification", which is the process of assessing the appropriateness, utility, or necessity of proposed non-emergency hospital admissions, surgical procedures, outpatient care, and other health care services.

(2) "Concurrent Review", which is the process of assessing the continuing appropriateness, utility, or necessity of additional days of hospital confinement, outpatient care, and other health care services.

(b) "Retrospective Review" means the process of assessing after the fact the appropriateness, utility, or necessity of hospital admissions, additional days of hospital confinement, surgical procedures, outpatient care, and other health care services, as required under the provisions of the Plan.

(c) "Case Management" means the process of assessing whether an alternative plan of care would more effectively provide necessary health care services in an appropriate setting, as required under the provisions of the Plan.

(d) "Transplant Management" means hands-on support to Participants in need of organ and tissue transplants. The Transplant Management Team guides Participants to the Plan Manager's National Transplant Network (NTN), designed to control costs and deliver a superior transplant experience. They review coverage, coordinate benefits, facilitate services and follow the transplant recipient's progress from initial referral through treatment and recovery.

CLINICAL PROGRAM SERVICES

C2.1 Precertification, Concurrent Review, and Retrospective Review will be performed by the Plan Manager, or a consulting health care professional engaged by the Plan Manager, which may use criteria and protocols developed with input from health care experts.

C2.2 The Plan Manager will provide or arrange for the provision of Precertification services, under applicable Plan provisions.

(a) In the event that a proposed treatment cannot be Precertified:

(1) The Plan Manager, the person requesting Precertification, and the attending Health Care Provider may, if sufficient information is provided, discuss possible treatment alternatives available under the Plan which might be Precertified.

(2) In the event that the attending Health Care Provider chooses not to select possible treatment alternatives which might be Precertified or otherwise wishes to pursue Precertification of the proposed treatment as originally proposed, the Precertification process will proceed to resolution on the basis of available information.

(b) Precertification will be completed within the time periods prescribed in the Plan, or if there are none, within a reasonable time after a request is made.

C2.3 During the Precertification and Concurrent Review processes, each hospital admission is evaluated for discharge planning needs, and home health care, and Case Management potential, as appropriate.

C2.4 The Plan Manager will provide or arrange for the provision of Concurrent Review services, under applicable Plan provisions.

C2.5 The Plan Manager will provide or arrange for the provision of Retrospective Review services, under applicable Plan provisions.

(a) For Emergency inpatient admissions, Retrospective Review services will not be performed unless they are requested within the earlier of:

(1) The period of time following admission specified in the Plan; or

(2) If no time is specified in the Plan, 48 hours following admission.

(b) When required notification is not provided so that Precertification is not performed, Retrospective Review services will be performed only if specifically required by the Plan.

C2.6 Notices of the results of the Precertification, Concurrent Review, and Retrospective Review processes, provided in accordance with the provisions of the Plan, will include information about the Plan Manager's standard procedures for having those results reconsidered. Results of these processes do not constitute claims determinations, and reconsideration of these results does not constitute an appeal of a disputed claim.

C2.7 The Plan Manager will provide or arrange for the provision of Case Management services under applicable Plan provisions.

C2.8 The Plan Manager will provide or arrange for the provision of Transplant Management services under applicable Plan provisions.

C2.9 The Plan Manager will provide or arrange for the provision of the following additional services, under applicable Plan provisions.

(a) **Integrated Medical and Behavioral Health Care Management**, which addresses medical and co-morbid behavioral health conditions. Teams of care managers integrate the delivery of care plans and other guidance so that a primary contact will address both physical and behavioral health conditions. Clinical associates screen Participants for behavioral health conditions in order to proactively identify Participants who might benefit from an integrated care plan.

(b) **Personal Nurse®** services which provide Participants with a specially trained nurse and provides information and tools that can help Participants understand their health care options, take control of their health needs and get the most from their plan benefits. Participation is voluntary and Participants can choose to opt out at any time. Participants are identified as potential candidates who meet all of the following criteria:

(1) Humana is the third party administrator;
(2) Active enrollment status;
(3) Expected/actual hospital admission.

(c) ***My*Humana**, a personal, password-protected home page located at www.humana.com. Participants can log-in anytime to find a participating provider, look up benefits or check the status of a claim. Additional features include: shop-and-compare tools to help Participants choose hospitals and doctors, prescription drug information, a health encyclopedia, information on specific health conditions, financial tools to help with budgeting for health care and more.

(d) **Humana Health Assessment** a confidential, online lifestyle questionnaire located at *My*Humana.com. Upon completion of the assessment, Participants will receive a customized health report that identifies health risks and provides steps they can take to gain more control of their health.

(e) **Preventive Reminders**, proactive, targeted campaigns that deliver messages to Participants of primary prevention care. Messages are delivered in a variety of methods including Voice Activated Technology (VAT), mailers/postcards or emails. Topics include mammography screenings, vaccinations, immunizations and more.

(f) **Wellness Calendar Program** is an electronic package that the Employer will receive each month with a dedicated focus on a wellness topic.

HEALTH CARE PROVIDERS

C3.1 The Client agrees that the Plan Manager shall not be held responsible for the actions of Health Care Providers acting as licensed professionals within the scope of their professional practice, and that in no event shall the hold harmless and indemnity provisions of this Agreement apply against the Plan Manager with respect to any expense caused by the acts or omissions of Health Care Providers.

REPORTS

C4.1 Special reports may be provided by the Plan Manager, if requested by the Client and the contents, composition, and cost is mutually agreed upon.

MISCELLANEOUS

C5.1 The Plan Manager will provide these Clinical Program services in accordance with the provisions of the Plan which are in effect and which have been communicated to the Plan Manager by the Client at the time the services are provided.

C5.2 If the Plan Administrator directs the Plan Manager to make a Clinical Program services determination which is different than the determination which would otherwise be made by the Plan Manager, the Plan Manager will follow the determination of the Plan Administrator, provided the Plan Administrator's determination is first communicated to the Plan Manager in writing.

However, the Plan Manager may decide that it will communicate this determination only as directed in special written instructions from the Plan Administrator which are acceptable to the Plan Manager.

C5.3 The Plan Manager is an independent contractor with respect to the services provided under Article 7.3 and Exhibit "C" of this Agreement, Article 2.5 of this Agreement notwithstanding.

C5.4 The obligations of the Plan Manager under Article 7.3 and Exhibit "C" of this Agreement shall terminate upon the expiration of this Agreement.

EXHIBIT F

Schedule of Fees

F1.1 The monthly fees presented in this Exhibit "F" are valid for the period of time beginning March 1, 2009 and ending on February 28, 2010, except as otherwise stated.

F2.1 General:

Administrative Fees:

Indemnity Plan	Per Employee	Per Family
Medical and Prescription Drug	$25.81	$25.81

CHC Plan	Per Employee	Per Family
Medical and Prescription Drug	$31.56	$31.56

	Single	Family
Dental	$4.40	$4.40

F3.1 Specific:

(a) Under Article 7.5 of this Agreement, the administrative fee for providing Subrogation / Recovery Services is 30% of all amounts recovered under that Article. The administrative fee will be applied towards the gross recovery, exclusive of any legal fees. Fees are calculated based on gross recovery. Expenses incurred are taken out of the Plan Manager's fee when it is the Plan Manager's choice to retain counsel. If the Client requests legal action outside the normal course of handling, it will be the Client's responsibility to pay legal fees incurred.

(b) With respect to access to provider networks in accordance with Article 7.8 of this Agreement or other similar provider arrangements arranged through the Plan Manager, the Client understands that a special access fee may be payable, depending upon the network or arrangement. The Client and the Plan Manager agree that the Client will be obligated to pay any special fee under this Exhibit "F3.1(b)" only upon advance written notice to and written consent by the Client.

(c) With respect to access to and application of the Shared Savings Program in accordance with Article 7.9 and Exhibit "D-1", the Client agrees to pay a fee equal to 30% of the "savings" on medical services realized by virtue of application of the Shared Savings Program Provider Discounts.

(d) The fee payable for run-out claims processing under Article 7.10 of this Agreement can be one of two options. The Client can choose for the Plan Manager to process run-out claims for either three (3) or twelve (12) months. The fee for handling these run-out claims for three (3) months is equal to three (3) months of Administrative fees or for twelve (12) months is equal to four (4) months of Administrative fees. The run-out fee will be calculated based on the total number of employees that were terminated from the Plan. The total run-out fee must be received by the Plan Manager to begin the claims processing for the selected run-out period.

F4.1 Payment:

(a) Fees set forth in Exhibit "F2.1" are payable to the Plan Manager once per month, unless otherwise indicated.

(b) Any special access fees payable under Exhibit "F3.1(b)" shall be paid by the Client to the Plan Manager as billed.

EXHIBIT G

Persons Authorized to Receive Private Health Information

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Name: Gary Schmid
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Fax:	(414) 475-0739
Company:	Ingenix, Inc.
Address:	121258 Technology Drive Eden, Prairie, MN 55344

EXHIBIT H

Pharmacy Management

DEFINITIONS

H1.1 "Brand Name Medication" means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand name by an industry-recognized source used by the Plan Manager.

H1.2 "Drug List" means a list of prescription drugs, medicines, medications and supplies specified by the Plan Manager. This list indicates applicable Dispensing Limits and/or any Prior Authorization requirements. This list is subject to change without notice. Drugs may be subject to specific time constraints.

H1.3 "Specialty Drug" means a drug, medicine or medication used as a specialized therapy developed for chronic, complex sicknesses or bodily injuries. Specialty Drugs may:

(a) Require nursing services or special programs to support patient compliance;
(b) Require disease-specific treatment programs;
(c) Have limited distribution requirements; or
(d) Have special handling, storage or shipping requirements.

DRUG LIST

H2.1 Pharmacy Management administers a standard Drug List that is updated on an annual basis, or as appropriate, as drugs enter or exit the market. Changes may also occur as Brand Name Medications lose their patents. Annual changes are effective January 1 of each year. Additional fees may be assessed to Clients that opt out of the annual changes. The additional charge will be calculated separately from the fees provided in Exhibit "H6.1". In addition, rebates payable to the Client will be impacted if annual Drug List changes are not implemented.

REBATES

H3.1 Rebates are defined as revenue received from pharmaceutical manufacturers for the placement of their product within the Plan Manager's Drug List and for the market share that product achieved within its therapeutic class.

H3.2 Rebates are quoted on every paid prescription and include Specialty Drugs and prescriptions for less than a 30-day supply. Rebates are calculated bi-annually and are paid within 60 days of the end of the period.

H3.3 Rebates can be impacted by government, regulatory or pharmaceutical industry action. In the event that changes impact the Plan Manager's pharmacy rebate program, the Plan Manager reserves the right to calculate the impact these changes have on guaranteed rebates.

H3.4 The Plan Manager's rebates are dependent upon the Client using the Plan Manager's standard Drug List; therefore if the Client opts out of the standard Drug List, rebates will be impacted.

H3.5 The Plan Manager's rebate offer provided in this Exhibit "H" is based upon the pharmacy benefit plan design proposed and subsequently agreed upon or altered during the implementation process. A material modification of the plan design or program specifications may result in pricing modifications by the Plan Manager.

H3.6 The Plan Manager assumes all of the risks, excluding those risks listed above, associated with negotiating and contracting with participating pharmaceutical manufactures. Except in those instances provided above, the Plan Manager is required to pay guaranteed rebate payments to the Client even if those exceed the rebates received. The Plan Manager will have the right to retain rebates received in excess of those it is obligated to pay. The Plan Manager's guaranteed rebate level is below the expected rebate payments that it expects to receive, if this margin is realized, it will be used to contribute to the cost of administering the pharmacy and rebate program as well as corporate margin goals.

PHARMACY NETWORK DISCOUNTS AND DISPENSING FEES

H4.1 The Plan Manager will assume all of the risks associated with negotiating and contracting with participating pharmacies and pharmaceutical manufacturers. In accordance with the pricing listed herein, the Plan Manager will be responsible for any amounts that it owes participating pharmacies that exceeds the reimbursement it receives. The Plan Manager will also retain any amounts that it receives that are in excess of the amounts it is obligated to pay. These amounts will be used to contribute to the cost of administering the pharmacy and rebate program as well as corporate margin goals.

H4.2 The Plan Manager's retail and mail order discounts exclude Specialty Drugs.

METHODOLOGY

H5.1 The Plan Manager uses Average Wholesale Price (AWP) methodology utilizing First Data Bank or other industry-recognized standards as the primary pricing source, but reserves the right to change to another industry-recognized standard at the Plan Manager's sole discretion. If the Plan Manager decides to change its pricing source, the Plan Manager agrees to:

(a) When possible, provide the Client with at least 30 days notice of the change;
(b) Pass through all financial impacts of the pricing source change to the Client;
(c) Provide the Client with written illustration of the financial impact of the pricing source change (e.g., specific drug examples) and written statement of the expected aggregate annual impact of the pricing source change. When possible, the Plan Manager will provide written illustration and statement noted above to the Client at least 30 days prior to the change.

H5.2 In the event of a pricing methodology change or a pricing source change, if the Plan Manager does not agree to pass through pricing improvements to the Client, or if the change results in higher gross cost (before member cost share) to the Client, then the Client reserves the right to re-negotiate contract terms or to terminate with 90 days written notice at any point during contract term without any termination charges.

H5.3 Recent federal class action lawsuit involving First Data Bank and McKesson has revealed inflation in published Average Wholesale Prices (AWP). First Data Bank stated in October 2006 that it will discontinue publishing the benchmark data within 2 years. As a result, the pharmacy community is in the midst of research to determine what pricing source will be used to replace AWP. In addition, in 2009, a change will be made to effectively lower AWP. In many instances the underlying pharmacy reimbursement will also decrease (saving plans money), and in other instances the underlying pharmacy reimbursement will remain the same (resulting in no financial impact to plans). This event will have an impact on reported pharmacy discounts off of AWP. As this impact is understood, the Plan Manager's guaranteed rates will change accordingly.

FEES

H6.1

GUARANTEE PHARMACY NETWORK DISCOUNTS	
RETAIL SERVICES:	
Average Whole Sale Price (AWP) Discounts:	
Brand Discount	15.80%
Generic Non-MAC Discount	26.00%
Dispensing Fee:	
Brand	$1.80
Generic	$1.80
90-DAYS AT RETAIL:	
Average Whole Sale Price (AWP) Discounts:	
Brand Discount	15.80%
Generic Non-MAC Discount	26.00%
Dispensing Fee:	
Brand	$1.80
Generic	$1.80
MAIL SERVICES:	
Average Whole Sale Price (AWP) Discounts:	
Brand Discount	22.00%
Generic Non-MAC Discount	55.00%

PHARMACY REBATES	
REBATES:	**RX 2 Plan** $1.25 per retail prescription **RX 3 Plan** $2.00 per retail prescription **Integrated** Not Eligible
	3x retail rate(s) above for a mail order prescription

H6.2 The Plan Manager's Pharmacy's sources of revenue are described and limited to those areas listed above. The Plan Manager's revenue comes from the following sources:

(a) Pharmaceutical manufacturer revenue collected above the guaranteed rebate level; and
(b) Pharmacy network discounts and dispensing fees that are more favorable than the guaranteed levels.