AMENDMENT TO PLAN MANAGEMENT AGREEMENT

The Plan Management Agreement between **Humana Insurance Company** ("Plan Manager"), and **Lexington Fayette Urban County Government** ("Client") effective on January 1, 2008 (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. Article II, Relationship Between the Parties, 2.4 has been deleted in its entirety and replaced with the following:

2.4 Accordingly, except as may otherwise be expressly provided herein, the Plan Manager is not a trustee, sponsor, or fiduciary with respect to directing the operation of the Plan or managing any assets of the Plan.

The Agreement is amended as provided above effective as of January 1, 2014.

II. Article III, General Duties of Client, 3.4 has been deleted in its entirety and replaced with the following:

3.4 The Client agrees to furnish each Participant written notification of the source of funding for Plan benefits as required by applicable law.

The Agreement is amended as provided above effective as of January 1, 2014.

III. Article III, General Duties of Client, 3.5 has been deleted in its entirety and replaced with the following:

3.5 The Client promises that current copies of the documents describing the Plan will be provided timely to the Plan Manager along with other appropriate materials governing the administration of the Plan. These documents and materials may include employee booklets, summary descriptions, employee communications significantly affecting the Plan, and any amendments or revisions. If the Plan Manager drafts and provides any of these documents to the Client as part of the services offered under this Agreement, the Client agrees to review, edit and provide its signature approving the documents in a timely manner. The Client understands that if the Plan Manager does not receive the Client's review and signature on these documents, the Plan Manager cannot treat them as final. If these documents are not finalized and distributed to Participants, the Client may be responsible for fines levied by the federal government when it requires these documents to be distributed timely to Plan Participants pursuant to federal law.

The Agreement is amended as provided above effective as of January 1, 2013.

IV. Article V, Claims Administration, has been amended to include the following:

5.12 Payment of covered expenses for services rendered by a provider is subject to the Plan Manager's claims processing edits. The amount determined to be payable under the Plan Manager's claims processing edits depends on the existence and interaction of several factors. Because the mix of these factors may be different for every claim, the amount paid for a covered expense may vary depending on the circumstances. Accordingly, it is not feasible to provide an exhaustive description of the claims processing edits that will be used to determine the amount payable for a covered expense, but examples of the most commonly used factors are:

- The intensity and complexity of a service;
- Whether a service is one of multiple services performed at the same service session such that the cost of the service to the provider is less than if the service had been provided in a separate service session. For example:
  - Two or more surgeries occurring at the same service session that do not require two preparation times; or
  - Two or more radiologic imaging views performed on the same body part;
- Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other health care professional who is billing independently is involved;
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;
- If the service is reasonably expected to be provided for the diagnosis reported;
- Whether a service was performed specifically for the Participant;
- Whether services can be billed as a complete set of services under one billing code.

The Plan Manager develops claims processing edits based on review of one or more of the following sources, including but not limited to:

- Medicare laws, regulations, manuals and other related guidance;
- Appropriate billing practices;
- National Uniform Billing Committee (NUBC);
- American Medical Association (AMA)/Current Procedural Technology (CPT);
- UB-04 Data Specifications Manual;
- International Classification of Diseases of the U.S. Department of Health and Humana Services and the Diagnostic and Statistical Manual of Mental Disorders;
- Medical and surgical specialty certification boards;
- The Plan Manager's medical coverage policies; and/or
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

Changes to any one of the sources may or may not lead the Plan Manager to modify current or adopt new claims processing edits.

Non-participating providers may bill Participant's for any amount this Plan does not pay even if such amount exceeds these claims processing edits. Any amount that exceeds the claims processing edits paid by the Participant will not apply to deductibles, out-of-pocket limits or Plan maximum out-of-pocket limits, if applicable. The Participant will also be responsible for any applicable deductible, coinsurance amount or copayment.

The Agreement is amended as provided above effective as of January 1, 2014.

V. Article VI, Reports, Records and Audits, 6.6, Sentence #5 has been deleted in its entirety and replaced with the following:

6.6 Audits for Clients that have terminated their Plan Administration with the Plan Manager must be conducted within one (1) year of the last day of the Plan year to be audited.

The Agreement is amended as provided above effective as of January 1, 2014.

VI. Article VII, Additional Administrative Services, 7.1 has been deleted in its entirety and replaced with the following:

7.1 Upon reasonable request by the Client or the Plan Administrator, the Plan Manager will provide a sample Summary Plan Description (SPD) or standard language concerning Plan benefits to assist the Plan Administrator in the preparation of the SPD. This service will be available at the commencement of this Agreement and on an as needed basis throughout the Plan year to assist the Client when language changes are made necessary from changes in Plan design, new federal legislation or other governmental requirements. The Plan Manager will also provide, upon reasonable request by the Client, a Summary of Benefits and Coverage ("SBC") document for the Client's yearly enrollment period. Notwithstanding the above, the Client understands that any language provided by the Plan Manager to the Client or the Plan Administrator shall not be construed as legal advice nor as a compliance delegation to the Plan Manager for the Client's SPD or SBC obligations under applicable law.

The Agreement is amended as provided above effective as of January 1, 2014.

VII. Article XVI, Miscellaneous, 16.3 has been deleted in its entirety and replaced with the following:

16.3 Assignment and Delegation. Neither the Plan Manager nor the Client may assign or otherwise transfer its rights and obligations under this Agreement to any other person or entity without the prior written consent of the other party. However, the functions to be performed by the Plan Manager may at any time be transferred, subcontracted or delegated to an affiliate, vendor or subcontracted entity of the Plan Manager. The Plan Manager retains final authority to provide oversight over those affiliates, vendors and subcontracted entities. The Plan Manager will make available information regarding delegated functions to the Client if requested. Any other attempted assignment, subcontracting, or delegation shall render this Agreement voidable at the option of the non-assigning party.

The Agreement is amended as provided above effective as of January 1, 2014.

VIII. Exhibit C, Clinical Program Services, C2.9 has been deleted in its entirety and replaced with the following:

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

(a) **HumanaFirst® Nurse Advice Line:** A toll-free, 24-hour medical information line, staffed by registered nurses who are available to answer health-related questions and help Participants decide where to best seek treatment. HumanaFirst® offers two lines to support Participant needs, including a line for immediate medical concerns and another for health planning and support.

(b) **Humana*Beginnings*®:** The Humana*Beginnings*® program educates and guides expectant mothers to make the best choices to achieve a healthy pregnancy and, ultimately, a healthy baby. Participants are offered guidance by phone from the time the Plan Manager is notified of the pregnancy through baby's first months.

(c) **Neonatal Intensive Care Unit (NICU) Management:** Specially trained case managers promote the highest standards of care for NICU infants and work with Participants throughout the NICU stay to help them prepare for a smooth transition home.

(d) **Gaps in Care:** The Plan Manager's clinical rules engine leverages expert medical opinions to identify gaps in care that address potential medical errors and instances of sub-optimal medical treatment. The established clinical rules compare a patients' pharmacy, laboratory and claims data to industry standard Quality of Care guidelines in order to identify patients at risk of highly specific patient-centric problems. Examples include: a misdiagnosis, a flawed surgical treatment or medical management, and lack of follow-up care or preventive treatment. In addition, a variety of preventive and pharmacy rules are included such as drug-to-drug interactions and drug-to-disease interactions. When gaps in care, drug to drug interaction, drug to disease interaction or a preventive

reminder is identified, an alert and a message, if appropriate, are generated to communicate the findings through physician and member messaging.

(e) **Preventive Reminders**, proactive, targeted campaigns that deliver messages to Participants of primary prevention care. Messages are delivered in a variety of methods including phone calls (live and voice activated), mail, text message or emails. Topics include mammography screenings, vaccinations, immunizations and more.

(f) **Chronic Condition Management** programs support the physician/patient relationship and care plan, emphasize education, promote self-management, evaluate outcomes to improve Participant overall health and offer nurse support.

Disease management programs have been developed to help Participants manage specific chronic medical conditions. Clinicians are available 24 hours a day to provide individual guidance through coaching, support and service coordination, to help lessen the day-to-day impact of chronic illnesses. Specific programs may change at the Plan Manager's sole discretion.

This Plan's disease management programs include:

1. Asthma
2. Cancer (active treatment only)
3. Chronic Obstructive Pulmonary Disease
4. Congestive Heart Failure
5. Coronary Artery Disease
6. Diabetes
7. End-Stage Renal Disease/Chronic Kidney Disease
8. Rare Diseases (Cystic Fibrosis, Hemophilia, Multiple Sclerosis, Myasthenia Gravis, Systemic Lupus Erythematosis, Amyotrophic Lateral Sclerosis (a.k.a. Lou Gehrig's Disease), Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP), Dermatomyositis, Parkinson's Disease, Polymyositis, Rheumatoid Arthritis, Scleroderma and Sickle Cell Anemia).

Personal Nurse®: In addition to disease-specific programs, the Plan Manager also offers Personal Nurse, which supports Participants with long-term, ongoing health needs and/or any chronic condition. Personal Nurses offer Participants dealing with a condition or illness, following treatment plans, or needing continued guidance in reaching their long-term health goals, the opportunity to develop a long-term partnership with an experienced registered nurse.

(g) **Humana Achieve (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.

(h) ***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: prescription drug information, information on specific health conditions, financial tools to help with budgeting for health care and more. *My*Humana Mobile allows Participants quick access to important information using their mobile device's browser, including member ID card detail information and an urgent care finder.

(i) **Humana Health Assessment** a confidential, online health survey located at *My*Humana.com. Upon completion of the assessment, Participants will receive an individualized health score and an action plan on how they can improve their health. Responses may also result in a referral to another clinical program.

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

(k) **Radiology Review** services that offers convenient scheduling of imaging procedures (CT, CTA, MRI, MRA and PET scans). Radiology Review is designed to help avoid issues such as inappropriate or unnecessary imaging studies that are costly and inconvenient to the patient, by educating ordering physicians on imaging procedures and best practice guidelines before the procedure is scheduled. Physicians call the Plan Manager to initiate the consultation and schedule any imaging procedure for a Participant.

(l) **Transition of Care:** Changing health care plans can be stressful, especially for those who are going through intense medical treatment, such as chemotherapy. The transition of care process helps Participant's make a smooth transition to Humana from their current health care plan with the least amount of disruption to their care.

(m) **Continuity of Care:** If a provider ceases being a participating provider, Participants may be able to continue treatment with the same provider for up to 90 calendar days if they are undergoing active treatment for a chronic or acute medical condition after the provider's termination with the participating provider's network. For pregnancy, if the Participant is in the 2nd or 3rd trimester, continuity of care is available through a 6 week postpartum period. Continuity of care is available only if the provider continues to practice in the geographical area of the network and the termination of the participating provider's contract was not due to misconduct on the part of the provider.

The Agreement is amended as provided above effective as of January 1, 2013.

IX. Exhibit D, Networks, has been amended to include the following:

D3.4 The Client agrees that the Plan Manager may utilize various methods of contracting discounts with Health Care Providers by building and maintaining Networks in an effort to reduce the Client's claims costs. Common methods include, but may not be limited to, discounts off of charged amounts, fee schedules and results-based reimbursements. The Plan Manager agrees to disclose and account for discounts via Client access to claims detail, access to reporting or through special billing. The Client agrees to pay claims or special bills according to the other provisions of this Agreement.

The Agreement is amended as provided above effective as of January 1, 2013 through December 31, 2013.

Exhibit D, Networks, D3.4 has been deleted in its entirety and replaced with the following:

D3.4 The Client agrees that the Plan Manager may utilize various methods of contracting with Health Care Providers to build and maintain Networks in an effort to reduce the Client's claims costs. Such methods will be utilized for all clients with an administrative services only arrangement with the Plan Manager, and are not specific only to the Client. Common methods include, but may not be limited to, discounts off of charged amounts, fee schedules and performance arrangements. If a Health Care Provider or vendor participates in any of the Plan Manager's programs in which performance incentives, rewards or bonuses ("Performance Payments") are earned and conditioned on the achievement of certain goals, outcomes or performance standards adopted by the Plan Manager, the Client will be responsible for funding those Performance Payments. The Client shall fund Performance Payments as soon as the Plan Manager makes the determination that the Health Care Provider or vendor is entitled to receive the payment under the Health Care Provider or vendor's contract. Such Performance Payments may be charged to the Client on an "as-earned" basis and will be itemized on the Client's reconciliation. The Plan Manager shall provide the Client with access to reports describing the amount of these Performance Payments made on behalf of the Client's Plan.

The Agreement is amended as provided above effective as of January 1, 2014.

X. Exhibit F, Schedule of Fees, F1.1 has been deleted in its entirety and replaced with the following:

F1.1 The monthly fees presented in this Exhibit "F" are valid for the period of time beginning January 1, 2013 and ending on December 31, 2013; and January 1, 2014 and ending on December 31, 2014, except as otherwise stated.

The Agreement is amended as provided above effective as of January 1, 2014.

XI. Exhibit F, Schedule of Fees, F2.1 has been deleted in its entirety and replaced with the following:

F2.1 General:

Administrative Fees:

January 1, 2013 through December 31, 2013

	Per Employee	Per Employee + Spouse/1	Per Employee + Child	Per Family
Medical and Prescription Drug	$41.14	$41.14	$41.14	$41.14

January 1, 2014 through December 31, 2014

	Per Employee	Per Employee + Spouse/1	Per Employee + Child	Per Family
Medical and Prescription Drug	$42.37	$42.37	$42.37	$42.37

Services NOT included in the Administrative Fees Listed Above*:

*Administrative fees indicated below are only applicable January 1, 2014- December 31, 2014.

Prescription Drug: Standard Exit Reports consisting of Prior Authorizations, Claims History and Deductible Accumulators. Exit reports requested upon termination of this Agreement must be in a standard Humana format and pricing will be negotiated at time of request.

Open File Transfer of Mail Order Prescriptions. File transfers requested upon termination of this Agreement must be in a standard Humana format and pricing will be negotiated at time of request.

All external review vendor costs related to an external claim appeal will be the responsibility of the Client. An additional $50 administration fee by the Plan Manager will also apply.

Ad-hoc Reporting $150 Per Hour

The Agreement is amended as provided above effective as of January 1, 2014.

XII. Exhibit F, Schedule of Fees, F3.1(b) has been deleted in its entirety and replaced with the following:

(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)".

The Agreement is amended as provided above effective as of January 1, 2013.

XIII. 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 January 1, 2013.

XIV. A new Exhibit I – Performance Guarantees – is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit I". This new Exhibit I 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 January 1, 2014.

XV. A new Exhibit J – Pharmacy Management – is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit J". This new Exhibit J 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 January 1, 2014.

XVI. A new Exhibit K – Medical Discount Guarantee Offer Arrangement – is added to the Agreement as stated in the attachment to this Amendment designated "Exhibit K". This new Exhibit K 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 January 1, 2014.

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

LEXINGTON FAYETTE URBAN COUNTY GOVERNMENT
Lexington, Kentucky

BY: _____

TITLE: _____

HUMANA INSURANCE COMPANY
Green Bay, Wisconsin

(By)_____
Gerald L. Ganoni
President

EXHIBIT G

Persons Authorized to Receive
Private Health Information

Name:	Chad Hancock
Title:	Finance
Company:	Lexington Lafayette Urban County Government
Address:	200 East Main Street Lexington, KY 40507

Name:	Mary Lyle
Title:	Health Services Advisor-Benefits Manager
Company:	Lexington Lafayette Urban County Government
Address:	200 East Main Street Lexington, KY 40507
Telephone:	859-258-3043
Fax:	859-258-3956
Email:	mlyle@lexingtonky.gov

Name:	Glenda George
Title:	Department of Law
Company:	Lexington Lafayette Urban County Government
Address:	200 East Main Street Lexington, KY 40507

Name:	John Maxwell
Title:	Director of Human Resources
Company:	Lexington Lafayette Urban County Government
Address:	200 East Main Street Lexington, KY 40507
Telephone:	859-258-3030
Fax:	859-258-3059
Email:	jmaxwell2@lexingtonky.gov

Name:	Cecily Chan
Title:	Senior Account
Company:	Lexington Lafayette Urban County Government
Address:	200 East Main Street Lexington, KY 40507
Telephone:	859-258-3318
Fax:	859-258-3956
Email:	cchan@lexingtonky.gov

Name:	Briggs Cochran
Company:	Benefit Insurance Marketing
Address:	1151 Red Mile Road Lexington, KY 40504

Name:	Benji Mars
Company:	Benefit Insurance Marketing
Address:	1151 Red Mile Road Lexington, KY 40504

Name:	Ellie Burnside
Company:	Benefit Insurance Marketing
Address:	1151 Red Mile Road Lexington, KY 40504

Name:	Matt Clifford
Company:	Benefit Insurance Marketing
Address:	1151 Red Mile Road Lexington, KY 40504

Name:	Jan LaBonde
Company:	Benefit Insurance Marketing
Address:	1151 Red Mile Road Lexington, KY 40504

Name:	Rose Taylor
Company:	Benefit Insurance Marketing
Address:	1151 Red Mile Road Lexington, KY 40504

Name:	Teresa Lainhart
Company:	Benefit Insurance Marketing
Address:	1151 Red Mile Road Lexington, KY 40504

EXHIBIT I

Performance Guarantees

January 1 2013 through December 31, 2013

Humana.

Performance Guarantee Proposal

Lexington Fayette Urban County Government (LFUCG)

Account Management

Category	Definition	Goal	Amount at Risk	Metric Reporting Type
Account Management Satisfaction	Humana acknowledges that its Account Management team must be responsive to the needs of our customers if Humana is to earn and sustain their trust. Therefore, Humana will perform a brief account management satisfaction survey to be completed by designated members of the client's benefits staff. The survey will be effective for the second half of the plan year (July 1 - December 31). The survey will address technical knowledge, accessibility, interpersonal skills, communication skills and overall performance. A scale from 1 to 5 will be used to measure performance where 1 means "very unsatisfied" and 5 means "extremely satisfied". The survey tool will be provided to the client 30 days after the end of the third quarter of the guarantee period. Humana's goal is an overall satisfaction score of 3 or higher with results averaged based on responses to ALL questions. The survey results will be reported in the client's annual report card.	Overall account management satisfaction score of 3 or higher.	$5,000	Client Specific

Claims Processing

Category	Definition	Goal	Amount at Risk	Metric Reporting Type
Clean Claim Turnaround - 14 Calendar Days	Humana agrees to a cycle time of 90% within 14 calendar days. Cycle time is measured from the date a clean claim is received to the date it is processed. "Processed" means paid or denied without requiring additional information from an external source. "Clean" is defined as needing no additional information from an external source.	90% within 14 calendar days	1% of annual base administrative fee	Global
Financial Accuracy	Humana agrees to a financial accuracy rate of 99%. The financial accuracy rate is defined as the percentage of dollars paid correctly. It is calculated by dividing the total claim dollars paid less the absolute value of overpayments and underpayments by the total claim dollars paid.	99%	1% of annual base administrative fee	Global
Payment Accuracy	Humana agrees to a payment accuracy rate of 97%. Payment accuracy is defined as the percentage of claims paid correctly. It is calculated by dividing the total number of correctly paid claims by the total number of claims paid.	97%	1% of annual base administrative fee	Global

Customer Service

Category	Definition	Goal	Amount at Risk	Metric Reporting Type
Abandonment Rate	Humana agrees to an abandonment rate of 3%. Abandonment rate is defined as the percent of callers that ended the call prior to reaching a customer service representative.	3%	1% of annual base administrative fee	Global
Telephone Response - 20 Seconds	Humana agrees to a telephone response time of 80% within 20 seconds. Telephone response is defined as the percent of calls answered within "n" seconds.	80% within 20 seconds	1% of annual base administrative fee	Global

Humana agrees to meet the performance standards as outlined in providing administrative services for the above mentioned client. This agreement is effective 1/1/2013 to 12/31/2013.

Humana is willing to place a total of 5% of the annual base administrative fee at risk for claims processing and customer service guarantees, along with $5,000 at risk for the account management survey at risk for failure to meet the stated performance standards. The base administrative fee excludes commissions, medical management, and any additional service purchased by the client, i.e., chronic condition management, HIPAA, COBRA, etc. Performance results will be reported annually based on results indicated above under metric reporting type. Payment of any penalties due to the client will be made following the end of the the plan year.

With respect to financial and payment accuracy, data is obtained through ongoing random audits based on a statistically valid sampling of all claims represented for payment.

During implementation if significant changes to the Client's Plan, or in the event a benefit change notification is not received from the Client on a timely basis, Humana will not be responsible for performance results or penalty amounts as described within this Agreement.

January 1 2014 through December 31, 2014

INSERT 2014 PERFORMANCE GUARANTEE

EXHIBIT J

Pharmacy Management

DEFINITIONS

J1.1 "90-Day Retail Network" means the Plan Manager provides for prescriptions with a greater than eighty-three (83) days' supply.

J1.2 "Average Wholesale Price" or "AWP" means the average wholesale price of a Covered Drug on the date the Covered Drug is processed according to the most current information provided to the Plan Manager by Medispan National Drug Data File reporting source, if available or another nationally recognized source in the prescription drug industry and approved by the Client. Under the Retail Pharmacy Program, AWP is based on the actual package size dispensed. Under the Mail Service Pharmacy Program, AWP is based on package size purchased. The Plan Manager shall not use or allow AWPs of licensed re-packagers where the data reporting source identifies an AWP price greater than the AWP price reported by the drug manufacturer who manufactured the product. The applicable AWP for Prescription Drug Claims filled at a Participating Pharmacy, including retail Prescription Drug Claims, retail on-line Prescription Drug Claims, and Member Submitted Claims, will be the AWP for the actual eleven digit National Drug Code (NDC) package size used by the Participating Pharmacy to fill the Prescription Drug Claim.

J1.3 "Brand Drug(s)" means single-source and/or multi-source non-generic prescription drugs as set forth in Medispan National Drug Data File as the primary source, and/or such other nationally recognized source adopted by the Plan Manager.

J1.4 "Copayment" means that portion of the charge for each prescription or refill of a Covered Drug (which amount also may be characterized as coinsurance or other similar term) dispensed to a Member that is the responsibility of the Member.

J1.5 "Covered Drug(s)" means those prescription drugs, supplies, and other items that are covered under the Plan which, under state or federal law, require a prescription or the Client is required by law to cover under the Plan or as mutually agreed to by the Client and the Plan Manager for purposes of this Agreement.

J1.6 "Dispensing Limit", if applicable under the Client's Plan, means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition, as determined by the Plan Manager.

J1.7 "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, if any. This list is subject to change without notice. Drugs may be subject to specific time constraints.

J1.8 "Formulary" means the lists of drugs and supplies and/or the list of FDA-approved prescription drugs and supplies developed by the Plan Manager's Pharmacy and Therapeutics Committee.

J1.9 "Generic Drug(s)" means a single and/or multi-source non-brand prescription drug, whether identified by its chemical, proprietary or non-proprietary name, as set forth in Medispan National Drug Data File as the primary source, and/or such other nationally recognized source adopted by the Plan Manager.

J1.10 "Mail Service Pharmacy" means a duly licensed pharmacy operated by the Plan Manager or its subsidiaries or affiliates, where prescriptions are filled and delivered to Members via the mail service.

J1.11 "Maximum Allowable Cost" or "MAC" consists of a list of off-patent Brand Drugs and all other Generic Drugs subject to maximum allowable cost payment schedules developed or selected by the Plan Manager. The payment schedules specify the maximum unit ingredient cost payable by the Client for drugs on the MAC list.

J1.12 "Member" means each person who is eligible as determined solely by the Client to receive prescription drug benefits under the Plan.

J1.13 "Member Submitted Claim" means: (i) a claim for reimbursement submitted to the Plan Manager by a Member for Covered Drugs dispensed by a pharmacy other than a Participating Pharmacy or Mail Service Pharmacy; (ii) a claim for reimbursement submitted to the Plan Manager for Covered Drugs filled at a Participating Pharmacy for which the Member paid cash; or (iii) subrogation claims for Covered Drugs submitted by the United States or any state under Medicaid or similar government health care programs.

J1.14 "Participating Pharmacy" means a pharmacy that has entered into an agreement with or has been designated by the Plan Manager to provide services to Members.

J1.15 "Prescription Drug Claim" means: (i) a Member Submitted Claim; (ii) any other prescription claims processed through the Plan Manager's claims adjudication systems or otherwise processed by the Plan Manager in accordance with the terms of this Agreement in connection with the Client's Plan.

J1.16 "Prior Authorization", if applicable under the Client's Plan, means the required prior approval from the Plan Manager for the coverage of certain prescription drugs, medicines and medications, including the dosage, quantity and duration.

J1.17 "Program Pricing Terms" mean the: (i) financial or pricing terms and allowances set forth in this Agreement, and (ii) the Rebates set forth in this Agreement.

J1.18 "Single-Source Generic Drug" means a Generic Drug that has either recently come off patent and does not generate discounts traditionally delivered by Generic Drugs, or has an exclusive pharmaceutical manufacturer.

J1.19 "Specialty Drug" means a pharmaceutical drug that is used in the management of chronic and or genetic disease that is defined as having at least three of the following characteristics: (i) limited or exclusive product distribution; (ii) the need for comprehensive Member training prior to and throughout therapy, including the importance of medication adherence; (iii) specialized medication handling, shipping, and storage requirements; (iv) risk of significant waste which may correlate to higher costs to the Client. The list of Specialty Drugs is subject to change as new drugs become available. The Plan Manager will provide the list of Specialty Drugs upon request.

J1.20 "Usual and Customary Price" or "U&C" means the actual retail price charged by a Participating Pharmacy for a specific drug in a cash transaction on the date the drug is dispensed as reported to the Plan Manager by the Participating Pharmacy.

J1.21 "Wholesale Acquisition Cost" or "WAC" means the suggested wholesale price for a given pharmaceutical product as published and used by the Plan Manager in the latest update of Medispan. In the event Medispan ceases publishing WAC and a new industry recognized source for WAC is chosen by the Plan Manager, then the Plan Manager will provided thirty (30) calendar days advance written notice of the new pricing source. The price will be updated at least once a week beginning with an initial update in January 1 of each year.

J1.22 "Zero Balance Claim" or "ZBC" means any pharmacy claim transaction that is equal to or less than the Member pay amount.

DRUG LIST AND PHARMACY PROGRAMS

J2.1 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 Drugs 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. In addition, rebates will be impacted if annual Drug List changes are not implemented. The additional charge will be calculated separately from the fees provided in Exhibits "F2.1" and "H6.1".

J2.2 Pharmacy Management administers the Dispensing Limits and Prior Authorization/Step Therapy Programs. These programs are designed to promote lower cost alternatives and patient safety.

REBATES

J3.1 **Effective January 1, 2013 through December 31, 2013:** The Client's pharmacy arrangement is not eligible for prescription drug rebates.

Effective January 1, 2014: 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. Rebates are calculated bi-annually and are paid within sixty (60) days of the end of the period.

J3.2 **Effective January 1, 2014:** Rebates can be impacted by government, regulatory or pharmaceutical industry action or the loss of a drug's patent protection. 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.

J3.3 **Effective January 1, 2014:** The Plan Manager's rebates are dependent upon the Client using the Plan Manager's standard Drug List and clinical edits therefore, if the Client opts out of these standards, rebates will be impacted.

J3.4 **Effective January 1, 2014:** The Plan Manager's rebate offer provided in this Exhibit "J" 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.

J3.5 **Effective January 1, 2014:** Rebates are calculated bi-annually and are paid within sixty (60) days of the end of the period. 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 guaranteed rebate payments exceed the rebates received. The Plan Manager will have the right to retain rebates received in excess of those it is obligated to pay. If a margin is realized, in excess of the guaranteed rebate level, the Plan Manager will use it to contribute to the cost of administering the pharmacy and rebate program as well as corporate margin goals.

METHODOLOGY

J4.1 Pricing Benchmarks: The parties understand that pricing indices historically used, (and that are the basis in this Agreement), are outside the control of the Client and the Plan Manager. The parties also understand there is extra-market industry, legal, governmental and regulatory activities which may lead to changes relating to, or elimination of, these pricing indices that could alter the financial positions of the parties as intended under this Agreement. The parties agree that, upon entering into this Agreement and thereafter, their mutual intent has been, and is to maintain, pricing stability as intended and not to advantage either party to the detriment of the other. Accordingly, to preserve this mutual intent, if the Plan Manager undertakes any of the following:

(a) Changes the AWP source across its book of business (e.g., from MediSpan to another nationally recognized source in the prescription drug industry); or

(b) Maintains AWP as the pricing index, in the event the AWP methodology and/or its calculation is changed, whether by the existing or alternative sources; or

(c) Transitions the pricing index from AWP to another index or benchmark (e.g., to Wholesale Acquisition Cost)

then Participating Pharmacy, Specialty Drug and Mail Service Pharmacy rates and guarantees, as applicable, will be modified as reasonably and equitably necessary to maintain the pricing intent under this Agreement. The Plan Manager shall provide the Client with at least sixty (60) day notice of the change (or if such notice is not practicable, as much notice as is reasonable under the circumstances) and written illustration of the financial impact of the pricing source or index change (e.g., specific drug examples). If the Client disputes the illustration of the financial impact of the pricing source, the parties agree to cooperate in good faith to resolve such disputes.

PHARMACY NETWORK DISCOUNTS AND DISPENSING FEES

J5.1 The Plan Manager is providing the Client with complete pass-through of its pharmacy network discounts and dispensing fees. The Client therefore receives the full value of the Plan Manager's network. Discounts can change over time and the Plan Manager does not assume the risk for those changes.

FINANCIAL TERMS

J6.1

REBATES *Effective beginning on January 1, 2014 and ending on December 31, 2014*		
Rebate Basis	**Retail Pharmacy**	**Mail Service Pharmacy**
Per Paid Claim	$2.00	$6.00

J7.1 Subsidiary Pharmacies:

The Plan Manager has several licensed pharmacy subsidiaries, including our specialty pharmacy. These entities may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. These subsidiary pharmacies contract for these arrangements on their own account in support of their various pharmacy operations. Many of these subsidiary arrangements relate to services provided outside of PBM arrangements, and are entered into irrespective of whether the particular drug is on one of the Plan Manager's national formularies. Discounts and fee-for-service payments received by the Plan Manager's subsidiary pharmacies are not part of the PBM Formulary or market share rebates paid to the Plan Manager in connection with the Plan Manager's PBM Formulary rebate programs. In addition, these subsidiary pharmacy arrangements are negotiated separately from the Plan Manager's PBM Formulary rebate contracts. As such, they are not eligible for payment to the Plan Manager's clients and are used as part of the operation of these subsidiary pharmacies.

J8.1 Emergencies:

The Plan Manager will allow immediate refills of medications to any Participant located in an "emergency area," defined as the area in which the President or the state's Governor has declared a major disaster or the Secretary of the Department of Health and Human Services (DHHS) has declared a public health emergency. For those Participants residing in the emergency area, the Plan Manager will remove all "refill too soon" edits for the period of the emergency declaration. Additionally, because the following conditions might exist during an emergency: a limited number of operational pharmacies, limitations on transportation and travel, and the disruption of U.S. mail, the Plan Manager may allow an affected Participant to obtain the maximum extended day supply, if requested and available at the time of refill. The manner in which policy and reaction to a crisis is administered is within the sole discretion of the Plan Manager.

PHARMACY FINANCIAL ASSUMPTIONS AND QUALIFICATIONS

J9.1 The Pharmacy Management Program assumes the following:

(a) The Client recognizes the Plan Manager as its Preferred Pharmacy Benefit Management Provider. At no time will the Client designate more than one Pharmacy Benefits Management Provider as Preferred.

(b) The Client is responsible for more than 50% of the aggregate annual drug costs.

(c) If the Client wishes to change the Plan Manager's standard approach to pharmacy plan management (e.g., quantity limits, step therapy and Prior Authorization lists) then the Plan Manager reserves the right to analyze the impact those changes may have on rebates or administration fees and to make those changes accordingly. No change however will be made to either the administration of the plan or the financial arrangement without mutual agreement.

EXHIBIT K

Medical Discount Guarantee Offer Arrangement

January 1 2013 through December 31, 2013

Proposal for:
Lexington Fayette Urban County Government

Humana.

Humana ChoiceCare Blend PPO ("PPO")
Medical Discount Guarantee Offer

Discount Guarantee

Exhibit 1

Lexington Fayette Urban County Government	In-Network Discount	Amount at Risk
Lexington Urban Zip 405*	56.0% - 50.0%	Risk-free corridor
	49.9% - 49.0%	2.00 % of Humana's base admin fee
	48.9% - 48.0%	4.00 % of Humana's base admin fee
	47.9% - 47.0%	6.00 % of Humana's base admin fee
	46.9% - 46.0%	8.00 % of Humana's base admin fee
	< 46.0%	10.00 % of Humana's base admin fee

Lexington Fayette Urban County Government	Target In Network Discount Percentage
Lexington Urban Zip 405*	53.0%

Humana's Discount Guarantee offer provides Lexington Fayette Urban County Government a significant and material cost of care advantage that we're confident no other vendor is prepared to match! For Lexington Fayette Urban County Government Active Employees, PRE65 Covered Retirees and Covered Dependents incurred in-network PPO medical claims, Humana will guarantee Lexington Fayette Urban County Government that its Discount Savings will be within the risk-free corridor listed above in Exhibit 1:

Guarantee period covers in-network PPO medical claims incurred from January 1st, 2013 through December 31st, 2013 and paid through February 2014.

Discount Guarantee Penalty Payment will be made by Humana to Lexington Fayette Urban County Government, according to the scale listed above in Exhibit 1:

Discount Guarantee applies to the Lexington Fayette Urban County Government Active Employees and PRE65 Retirees and Covered Dependents Eligible In-Network PPO Discount Savings incurred through in-network contracted providers.

Humana ChoiceCare Blend PPO ("PPO")
Medical Discount Guarantee Offer

This Discount Guarantee is subject to the following terms and conditions:

Discount savings is defined as the difference between the Eligible Incurred In-Network PPO Medical Billed Charge amounts and Medical Allowed Charge amounts resulting from negotiated discounts for In-Network Claims. Discount Percentage is defined as the Discount Savings divided by the Eligible Incurred In-Network Medical Billed Charges. The Net savings calculation accounts for reversals, adjustments and duplicate bills and excludes the following claims:

- Disallowed Services
- Medicare claims
- Transplant claims
- Center of Excellence Claims (defined as: A Tertiary care hospital which will reimburse expenses for a particular procedure–eg, liver transplantation, based on that center's higher than average rate of success)
- Pharmacy claims
- COB claims
- Claims where billed amount equals allowed amount, and,
- Claims with billed amount greater than $100,000.

Conditions of Discount Guarantee offer are as follows:

- The Discount Guarantee Calculation(s) will be finalized by May 31st, 2014 with any appropriate payments to be made on or before July 1st, 2014.
- The Discount Guarantee Calculation(s) will be calculated by Humana's Re-pricing Unit.
- The Discount Guarantee Offer assumes Humana total replacement of all Lexington Fayette Urban County Government Active Employees, PRE65 Retirees and dependents covered.
- The maximum combined penalty payout in any one year for all Humana performance guarantees, including the network discount guarantee, will be limited to 15% of the base administrative fee.
- Humana reserves the right to renegotiate the terms of this agreement if there is a +/- 10% change in the number of eligible subscribers during the plan year.

January 1 2014 through December 31, 2014

Proposal for:

Lexington Fayette County Urban Government

Humana ChoiceCare Blend PPO ('PPO')
Medical Discount Guarantee Offer

Discount Guarantee

Exhibit 1

Lexington Fayette County Urban Government	In-Network Discount	Amount at Risk
Lexington Urban Zips 405	56.0% - 50.0%	Risk-free corridor
	49.9% - 49.0%	2.00 % of Humana's base admin fee
	48.9% - 48.0%	4.00 % of Humana's base admin fee
	47.9% - 47.0%	6.00 % of Humana's base admin fee
	46.9% - 46.0%	8.00 % of Humana's base admin fee
	< 46.0%	10.00 % of Humana's base admin fee

Lexington Fayette County Urban Government	Target In-Network Discount Percentage
Lexington Urban Zips 405	53.0%

Humana's Discount Guarantee offer provides Lexington Fayette County Urban Government a significant and material cost of care advantage that we're confident no other vendor is prepared to match! For Lexington Fayette County Urban Government Active Employees, PRE65 Covered Retirees and Covered Dependents incurred in-network PPO medical claims, Humana will guarantee Lexington Fayette County Urban Government that its Discount Savings will be within the risk-free corridor listed above in Exhibit 1:

Guarantee period covers in-network PPO medical claims incurred from January 1st, 2014 through December 31st, 2014 and paid through February 2015.

Discount Guarantee Penalty Payment will be made by Humana to Lexington Fayette County Urban Government, according to the scale listed above in Exhibit 1:

Discount Guarantee applies to the Lexington Fayette County Urban Government Active Employees and PRE65 Retirees and Covered Dependents Eligible In-Network PPO Discount Savings incurred through in-network contracted providers.

Humana ChoiceCare Blend PPO ('PPO')
Medical Discount Guarantee Offer

This Discount Guarantee is subject to the following terms and conditions:

Discount savings is defined as the difference between the Eligible Incurred In-Network PPO Medical Billed Charge amounts and Medical Allowed Charge amounts resulting from negotiated discounts for In-Network Claims. Discount Percentage is defined as the Discount Savings divided by the Eligible Incurred In-Network Medical Billed Charges.

The Net savings calculation accounts for reversals, adjustments and duplicate bills and excludes the following claims:

- Disallowed Services
- Medicare claims
- Transplant claims
- Center of Excellence Claims (defined as: A Tertiary care hospital which will reimburse expenses for a particular procedure–eg, liver transplantation, based on that center's higher than average rate of success)
- Pharmacy claims
- Claims where billed amount equals allowed amount, and,
- Any claim with eligible billed charges in excess of $100,000.

Conditions of Discount Guarantee offer are as follows:

- The Discount Guarantee Calculation(s) will be finalized by May 31st, 2015 with any appropriate payments to be made on or before July 1st, 2015.
- The Discount Guarantee Calculation(s) will be calculated by Humana's Re-pricing Unit.
- The Discount Guarantee Offer assumes Humana total replacement of all Lexington Fayette County Urban Government Active Employees, PRE65 Retirees and dependents covered.
- The maximum combined penalty payout in any one year for all Humana performance guarantees, including the network discount guarantee, will be limited to 15% of the base administrative fee.
- Humana reserves the right to renegotiate the terms of this agreement if there is a +/- 10% change in the number of eligible subscribers during the plan year.
- The Discount Guarantee covers urban employees only based on the employee's zip code 405).