FINANCIAL RENEWAL AND TERMS AMENDMENT

This Amendment ("Amendment") is made to the Administrative Services Agreement ("Agreement") by and between United HealthCare Services, Inc. ("United") and Milwaukee Public Schools ("Customer"), Contract No. 703772, and is effective on January 1, 2016 unless otherwise specified.

Any capitalized terms used in this Amendment have the meanings shown in the Agreement. These terms may or may not have been capitalized in prior contractual documents between the parties but will have the same meaning as if capitalized.

The agreements that are being amended include any and all amendments, if any, that are effective prior to the effective date of this Amendment.

Nothing shown in this Amendment alters, varies or affects any of the terms, provisions or conditions of the agreements other than as stated herein.

The parties, by signing below, agree to amend the agreements as contained herein.

Milwaukee Public Schools

By _____
Authorized Signature

Print Name _____

Print Title _____

Date _____

United HealthCare Services, Inc.

By _____
Authorized Signature

Print Name _____

Print Title _____

Date _____

Renewal 4Q 2014

The Administrative Services Agreement is amended on the dates as noted below.

Effective January 1, 2016 the Plan will no longer provide Individual Conversion Policies. Any references to services or fees for Individual conversion policies will no longer apply.

Effective April 1, 2016 the Agreement is amended by the addition of the following to Section I Care Management and Outreach Services in the Services Exhibit:

Disease Management Programs	Coordination with external vendors is subject to an additional fee.

EXHIBIT B

Contract No.: 703772 - Choice Plus (PPO) Plan
703772 - Choice (EPO) Plan
The following financial terms are effective for the period January 1, 2016 through December 31, 2019 unless indicated otherwise.

The Standard Medical Service Fees are the sum of the following:

The Standard Medical Service Fees are as stated below. These fees do not include state or Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan or United, including but not limited to those imposed pursuant to The Patient Protection and Affordable Care Act of 2010, as amended from time to time as these are the responsibility of the Plan.

The Standard Medical Fees are based upon an estimated minimum of 9,756 enrolled Employees.

For the the period January 1, 2016 through March 30, 2016

- $37.36 per Employee per month for the Choice Plus (PPO) Plan.
- $37.36 per Employee per month for the PPO Medicare Plan.
- $37.36 per Employee per month for the Choice (EPO) Plan.
- $37.36 per Employee per month for the EPO Medicare Plan.

For the the period April 1, 2016 through December 31, 2016

- $38.96 per Employee per month for the Choice Plus (PPO) Plan.
- $38.96 per Employee per month for the PPO Medicare Plan.
- $38.96 per Employee per month for the Choice (EPO) Plan.
- $38.96 per Employee per month for the EPO Medicare Plan.

For the the period January 1, 2017 through December 31, 2019

- $39.70 per Employee per month for the Choice Plus (PPO) Plan.
- 39.70 per Employee per month for the PPO Medicare Plan.
- $39.70 per Employee per month for the Choice (EPO) Plan.
- $39.70 per Employee per month for the EPO Medicare Plan.
    - Average Contract Size: 2.41

Other Fees

The optional and non-standard fees are the sum of the following

Service Description	Fee
Fraud and Abuse Management	Fee equal to thirty-two and five-tenths percent (32.5%) of the gross recovery amount
Hospital Audit Program Services	Fee not to exceed thirty-one percent (31%) of the gross recovery amount
Credit Balance Recovery Services	Fee not to exceed ten percent (10%) of the gross recovery amount.
Standardized Summary of Benefits and Coverage (SBC) as established under The Patient Protection and Affordable Care Act of 2010	We will provide, at no additional charge, standard format, electronic copies of the SBC documents (twice per year) for medical benefit plans administered by Us. Customer logos can be included on the SBC at no additional charge. Additional fees will apply for other services. We will not create SBCs for medical plans We do not

	administer.
Third Party Liability Recovery (Subrogation) Services	Fee equal to thirty-three and one-third percent (33.3%) of the gross recovery amount
Facility R&C Bill Management -- We will bill You for the amounts You owe Us. The bill will reflect reductions obtained during the preceding month and adjustments, if any, from previous months	Fee for Our services, equal to thirty percent (30%) of the amount of reductions obtained through Our efforts
Shared Savings Program	You will pay a fee equal to thirty-five percent (35%) of the "Savings Obtained" as a result of the Shared Savings Program. "Savings Obtained" means the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Participant and the Plan, after the discount is taken.
External Reviews	For each subsequent external review beyond 5 total reviews per year, a fee of $500 will apply per review.
Advanced Analytics and Recovery Services	Fee equal to twenty four percent (24%) of the gross recovery amount

Diabetes Prevention Program (DPP) Participating Member Fees Virtual Diabetes Prevention Program Included (if selected by Customer)			
Action	**Metric**	**Claim Payment**	**Cumulative Payment**
Member enrolls in program	Enrolled in a DPP class and attends at least one of the 16 sessions	$200	$200
Member participates in the program	Enrolled in a DPP class and attends at least four of the 16 sessions	$120	$320
Member completes the program	Enrolled in a DPP class and attends at least nine of the 16 sessions	$195	$515
Member completes the program and loses >=5% weight	Enrolled in a DPP class and attends at least nine of the 16 sessions and loses >= 5% within 60 days of class completion	$145	$660
-- OR --			
Member completes the program and loses >=9% weight	Enrolled in a DPP class and attends at least nine of the 16 sessions and loses >= 9% within 60 days of class completion	$180	$695
DPP Testing Event Fee			
Administration	Testing event administration fee per participant		$30
A1c test	Hemoglobin A1c test per participant		$15
Net Fees			$45
DPP At Home Lab Screening			
A1c Kit	Includes physician order, prefilled lab form and mailing		$20
A1c Results	Includes rehydration, analysis, results reporting and data load to portal		$25
Net Fees			$45

EXHIBIT C

PERFORMANCE STANDARDS FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees), (hereinafter referred to as "Fees") payable by You under this Agreement will be adjusted through a credit to your Service Fees in accordance with the performance guarantees set forth below unless otherwise defined in the guarantee. Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period beginning January 1, 2016 through December 31, 2019 (each twelve month period is the "Guarantee Period"). With respect to the aspects of our performance addressed in this exhibit, these fee adjustments are your exclusive financial remedies.

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

Prior to the end of the Guarantee Period, and provided that this Agreement remains in force, We may specify to You in writing new performance guarantees for the subsequent Guarantee Period. If We specify new performance guarantees, We will also provide you with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

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

These performance guarantees will be measured and applied in the aggregate for the Choice Plus (PPO) and Choice EPO Plan for the purposes of enrollments and fees.

Claim Operations			
Time to Process in 10 Days			
Definition	The percentage of all claims We receive will be processed within the designated number of business days of receipt.		
Measurement	Percentage of claims processed		94%
	Time to process, in business days or less after receipt of claim	business days	10
Criteria	Standard claim operations reports		
Level	Site Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Dollars at Risk for this metric		$92,857
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	11 business days 12 business days 13 business days 14 business days 15 business days or more		
Dollar Accuracy (DAR)			
Definition	Dollar accuracy rate of not less than the designated percent in any quarter.		
Measurement	Percentage of claims dollars processed accurately		99%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars paid.		

Level	Office Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$92,857
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	98.99% - 98.50% 98.49% - 98.00% 97.99% - 97.50% 97.49% - 97.00 Below 97.00%		
Procedural Accuracy			
Definition	Procedural accuracy rate of not less than the designated percent.		
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors		97%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed without procedural (i.e. non-financial) errors.		
Level	Office Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Dollars at Risk for this metric		$92,857
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% - 95.00% Below 95.00%		
Member Phone Service			
Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Your Participants. They do not include calls made to care management personnel and/or calls to the senior center for Medicare Participants, nor do they include calls for services/products other than medical, such as mental health/substance abuse, pharmacy, dental, vision, flexible spending accounts, Health Reimbursement Account, Health Savings Account, etc.			
Average Speed of Answer			
Definition	Calls will sequence through our phone system and be answered by customer service within the parameters set forth.		
Measurement	Percentage of calls answered		100%
	Time answered in seconds, on average	seconds	30
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Your account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Dollars at Risk for this metric		$92,857
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds		
Abandonment Rate			
Definition	The average call abandonment rate will be no greater than the percentage set forth		
Measurement	Percentage of total incoming calls to customer service abandoned, on average		2%
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Your account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Dollars at Risk for this metric		$92,857
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00%		

	Greater than 4.00%		
Call Quality Score			
Definition	Maintain a call quality score of not less than the percent set forth		
Measurement	Call quality score to meet or exceed		93%
Criteria	Random sampling of calls are each assigned a customer service quality score, using our standard internal call quality assurance program.		
Level	Office that services Your account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Dollars at Risk for this metric		$92,857
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	92.99% - 91.00% 90.99% - 89.00% 88.99% - 87.00% 86.99% - 85.00% Below 85.00%		
Satisfaction			
Employee (Member) Satisfaction			
Definition	The overall satisfaction will be determined by the question that reads "Overall, how satisfied are you with the way we administer your medical health insurance plan?"		
Measurement	Percentage of respondents, on average, indicating a grade of satisfied or higher		80%
Criteria	Operations standard survey, conducted over the course of the year; may be customer specific for an additional charge.		
Level	Office that services Your account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Dollars at Risk for this metric		$46,429
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Customer Satisfaction			
Definition	The overall satisfaction will be determined by the question that reads "How satisfied are you overall with UnitedHealthcare?"		
Measurement	Minimum score on a 10 point scale	score	5
Criteria	Standard Customer Scorecard Survey		
Level	Customer specific		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Dollars at Risk for this metric		$46,429
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		

UnitedHealthcare Choice Network Savings Guarantee

The Network Savings Guarantee is effective during the incurred period January 1, 2016 through December 31, 2019 and applies only to in-network claims paid within 3 months following the end of the Network Savings Guarantee Period.

Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period beginning January 1, 2016 through December 31, 2019 (each twelve month period is the "Guarantee Period").

Commitment

Actual Discount Range	Fees At Risk
Less Than 45.0%	$581,500
45.0% - 46.0%	$383,800
46.0% - 47.0%	$191,900

Greater Than 47.0%	$0

United agrees to reimburse Customer the applicable percentage of the standard medical fees (excluding optional and non-standard fees) at risk noted in the table above based on the shortfall in network discounts achieved and the defined range the result falls into up to a maximum of 15.% of the standard medical fees (excluding optional and non-standard fees).

The UnitedHealthcare Choice product and savings as presented in this document are available under the following assumptions and conditions*:

- Employees enrolled in a UnitedHealthcare Choice Network 7,434
- Target Network Savings Percentage (Illustrative) 47.0%
- Risk Free Corridor 0.0%
- For the UnitedHealthcare Choice network to be accessed, a sufficient benefit differential between in and out of network benefits must exist to promote in-network usage. Whether a sufficient benefit differential exists will be measured by UnitedHealthcare with the measurement based on coinsurance differentials, deductible differentials, out of pocket maximum differentials, and combinations of the former, among others.
- Savings are defined as the sum of: (1) the difference between the covered billed charges (excluding ineligible and not covered charges) submitted by the network provider and the amount based on the negotiated rate with that provider. This may also include specially negotiated discounts with network providers in outlier claim situations. No reasonable and customary (R&C) reductions are taken when a negotiated rate is in place with a network provider. The calculation is performed before the application of copayments, deductibles, or other coinsurance. (2) savings that result from the application of claims payment logic that bundles claims, consistent with provisions in our provider contracts.
- United reserves the right to exclude claims billed utilizing billing software, showing billed charges (excluding ineligible and not covered charges) equal to the negotiated rate from this guarantee.
- United reserves the right to exclude all claims for claimants with covered charges $75,000 or greater during the guarantee period.
- Claims where United is the secondary payor are excluded from the Network Savings and Network Savings Factor determination.
- Mental Health/Substance Abuse claims are excluded.

The table below contains anticipated enrollment by market. The Other category is made up of markets with smaller concentrations of employees.

Market Name	Employees	Employee %
MILWAUKEE	7,353	98.9%
Other	81	1.1%
Total/Average*	7,434	100.0%

Groups Customer adds after the plan's effective date will be factored into this guarantee according to their date, size and enrollment by network.

A minimum of 6,691 total employees enrolled in the UnitedHealthcare plan is required for the Network Savings Guarantee to remain in effect.

United reserves the right to revise this guarantee under the following circumstances:

- The benefits requested and/or quoted change prior to or after the effective date of this quotation.
- Changes in federal, state or other applicable legislation or regulation require changes to this guarantee.

* These numbers are estimated only. Final numbers will depend on actual enrollment by network.

At the time of reconciliation, discounts will be calculated per the language set forth in this guarantee and may not match figures shown in other client reports produced throughout the year.

UnitedHealthcare Choice Plus Network Savings Guarantee

The Network Savings Guarantee is effective during the incurred period January 1, 2016 through December 31, 2019 and applies only to in-network claims paid within 3 months following the end of the Network Savings Guarantee Period.

Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period beginning January 1, 2016 through December 31, 2019 (each twelve month period is the "Guarantee Period").

Commitment

Actual Discount Range	Fees At Risk
Less Than 45.0%	$193,800
45.0% - 46.0%	$128,000
46.0% - 47.0%	$64,000
Greater Than 47.0%	$0

United agrees to reimburse Customer the applicable percentage of the standard medical fees (excluding optional and non-standard fees) at risk noted in the table above based on the shortfall in network discounts achieved and the defined range the result falls into up to a maximum of 15.0% of the standard medical fees (excluding optional and non-standard fees).

The UnitedHealthcare Choice Plus product and savings as presented in this document are available under the following assumptions and conditions*:

- Employees enrolled in a UnitedHealthcare Choice Plus Network 2,426
- Target Network Savings Percentage (Illustrative) 47.0%
- Risk Free Corridor 0.0%
- For the United Choice network to be accessed, a sufficient benefit differential between in and out of network benefits must exist to promote in-network usage. Whether a sufficient benefit differential exists will be measured by UnitedHealthcare with the measurement based on coinsurance differentials, deductible differentials, out of pocket maximum differentials, and combinations of the former, among others.

- Savings are defined as the sum of: (1) the difference between the covered billed charges (excluding ineligible and not covered charges) submitted by the network provider and the amount based on the negotiated rate with that provider. This may also include specially negotiated discounts with network providers in outlier claim situations. No reasonable and customary (R&C) reductions are taken when a negotiated rate is in place with a network provider. The calculation is performed before the application of copayments, deductibles, or other coinsurance. (2) savings that result from the application of claims payment logic that bundles claims, consistent with provisions in our provider contracts.

- United reserves the right to exclude claims billed utilizing billing software, showing billed charges (excluding ineligible and not covered charges) equal to the negotiated rate from this guarantee.
- United reserves the right to exclude all claims for claimants with covered charges $75,000 or greater during the guarantee period.
- Claims where United is the secondary payor are excluded from the Network Savings and Network Savings Factor determination.
- Mental Health/Substance Abuse claims are excluded.

The table below contains anticipated enrollment by market. The Other category is made up of markets with smaller concentrations of employees.

Market Name	Employees	Employee %
MILWAUKEE	2,380	98.1%
Other	46	1.9%
Total/Average*	2,426	100.0%

Groups Customer adds after the plan's effective date will be factored into this guarantee according to their date, size and enrollment by network.

A minimum of 2,183 total employees enrolled in the UnitedHealthcare plan is required for the Network Savings Guarantee to remain in effect.

United reserves the right to revise this guarantee under the following circumstances:

- The benefits requested and/or quoted change prior to or after the effective date of this guarantee.
- Changes in federal, state or other applicable legislation or regulation require changes to this guarantee.

* These numbers are estimated only. Final numbers will depend on actual enrollment by network.

At the time of reconciliation, discounts will be calculated per the language set forth in this guarantee and may not match figures shown in other client reports produced throughout the year.