UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN

TIARA YACHTS, INC.,	)	
	)	
Plaintiff,	)	Case No. 1:22-cv-603
	)	
v.	)	
	)	Judge Robert J. Jonker
BLUE CROSS BLUE SHIELD OF MICHIGAN,	)	
	)	Magistrate Judge Ray Kent
	)	
Defendant.	)	**Oral Argument Requested**
	)	

DEFENDANT'S MOTION TO DISMISS PLAINTIFF'S COMPLAINT FOR FAILURE TO STATE A CLAIM

Defendant Blue Cross Blue Shield of Michigan ("BCBSM"), through its undersigned counsel, hereby moves, pursuant to Federal Rules of Civil Procedure 8, 9(b), and 12(b)(6), to dismiss Plaintiff's Complaint (ECF No. 1). BCBSM respectfully requests that the Court grant this Motion for the reasons set forth in the accompanying brief.

Pursuant to L. Civ. R. 7.1(d), BCBSM's counsel, Sarah L. Cylkowski, in good faith sought concurrence in the relief requested in this motion from counsel for Plaintiff Tiara Yachts via e-mail on August 25, 2022. Tiara Yachts' counsel opposed the requested relief.

Dated: August 25, 2022

Respectfully submitted,

/s/ Tacy F. Flint

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DEFENDANT'S BRIEF IN SUPPORT OF ITS MOTION TO DISMISS PLAINTIFF'S COMPLAINT FOR FAILURE TO STATE A CLAIM

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INTRODUCTION

For 13 years, from January 2006 through December 2018, BCBSM processed many thousands of claims for all of the participants in Tiara Yachts' health benefit plan. ECF No. 1, PageID.3 ¶¶ 17–19. For every health care claim submitted by a Tiara Yachts employee or beneficiary for coverage during that time period, BCBSM reviewed the claim, determined the amount owed to the provider, and processed the claim, including sending payment for the claim to the provider. *Id.* ¶¶ 18–21.

Tiara Yachts and BCBSM signed a series of Administrative Services Contracts (ASCs) to govern the services that BCBSM would provide. In the ASC, the parties agreed to explicit terms setting forth a clear and time-limited process through which Tiara Yachts could dispute the amounts that BCBSM paid to providers on participants' behalf. *See* Ex. A, ASC Art. II § D ("Group shall notify BCBSM in writing of any Claim that Group disputes within 60 days of Group's access to a paid Claims listing.").[1] In addition, the ASC authorized Tiara Yachts to

[1] BCBSM attaches the relevant ASCs made between BCBSM and S2 Yachts, Inc. (the former name for Tiara Yachts, *see* ECF No. 1, PageID.1 ("Tiara Yachts, Inc., formerly S2 Yachts, Inc. ('Tiara Yachts')")) to this motion, given that Tiara Yachts relies upon and incorporates the parties' contracts. *See Carrier Corp. v. Outokumpu Oyj*, 673 F.3d 430, 441 (6th Cir. 2012) ("Documents that a defendant attaches to a motion to dismiss are considered part of the pleadings if they are referred to in the plaintiff's complaint and are central to her claim."); *see* ECF No. 1, PageID.3 ¶¶ 17–18 (outlining how the ASC delegates to BCBSM its "Plan administration responsibilities that Tiara Yachts would otherwise retain,

initiate an overall audit of all claims payments. *Id.* § G. This right, too, was time-limited—to claims paid in the prior 24 months—because "[b]oth parties acknowledge[d] that Claims with incurred dates over two years old may be more costly to retrieve and that it may not be possible to recover over-payments for these Claims." *Id.* Further, Tiara Yachts agreed that any audit would be completed "at its own expense." *Id.*

The Complaint does not allege that Tiara Yachts made use of either of these provisions. Instead of timely disputing or auditing BCBSM's claims payments under the contractual terms it agreed to, Tiara Yachts seeks to use the federal judicial process to bring a belated challenge to BCBSM's claims processing. Tiara Yachts points to a supposed error in BCBSM's claims-processing software, through which BCBSM supposedly overpaid claims submitted by out-of-state providers in connection with *other* health benefit plans *unrelated to Tiara Yachts*. ECF No. 1, PageID.6-7 ¶¶ 39–45. Theorizing that this alleged software error affected Tiara Yachts as well—but failing to identify any actual overpayment BCBSM made in connection with *its* plan—Tiara Yachts asks this Court to order BCBSM to pay it "monetary damages" under ERISA. *Id.* But ERISA does not provide "a cause of action for extra-contractual damages caused by improper or

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including but not limit to interpreting Plan terms, calculating benefits, and using Tiara Yachts' Plan assets to pay for health care services").

untimely processing of benefit claims." *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985). None of Tiara Yachts' belated claims-processing disputes nor anything else in the Complaint supports relief under ERISA.

In particular, ERISA does not authorize the relief Tiara Yachts seeks in connection with its claims of improper claim-processing because the type of relief it seeks is unavailable to it under 29 U.S.C. § 1132(a). Tiara Yachts also fails to state a claim under ERISA with respect to its allegations regarding claims-processing or BCBSM's operation of the Shared Savings Program, through which BCBSM retained a contractually specified fee for certain cost recovery actions. Finally, the claims are untimely under ERISA's statute of limitations.

For all of these reasons, the Complaint should be dismissed.

BACKGROUND

I. The Parties

Tiara Yachts. Tiara Yachts is the sponsor of a self-insured employee benefit plan (the "Plan"). ECF No. 1, PageID.1 ¶ 1. Rather than purchase a group health insurance plan from an insurer, the sponsor of a self-insured benefit plan pays the actual employee healthcare costs covered by the plan directly. *Id.* at PageID.2 ¶ 10. Because employers generally lack a network of healthcare providers and claims processing capabilities, self-insured plans typically contract with a third-party to process and pay employees' healthcare claims and to provide access to a network

of healthcare providers. *Id.* ¶ 12. Tiara Yachts contracted with BCBSM, a claims administrator, for this purpose. *Id.* ¶ 15.

BCBSM. BCBSM is a Michigan non-profit mutual insurance company. BCBSM offers claims administration services under ASCs to self-funded plans like the Tiara Yachts Plan. *Id.* at PageID.3 ¶¶ 18-19. As part of its business, BCBSM contracts with healthcare professionals, facilities, and other providers (collectively, "providers") to create a network of providers that agree to provide care at contractually specified rates to members of plans served by BCBSM. Providers who have entered contracts with BCBSM—called "in-network" or "participating" providers—contract with BCBSM to provide care or services to members under specific reimbursement terms. Because non-participating providers are not limited by contract in what they can charge members, a plan's terms typically provide that the plan will pay up to a certain amount on claims submitted by non-participating providers.

II. Tiara Yachts' Complaint

Tiara Yachts alleges that, under ERISA, BCBSM breached its fiduciary duty to Tiara Yachts, ECF No. 1, PageID.16, 20 ¶¶ 105–09,[2] and engaged in a

[2] Tiara Yachts' Complaint contains two separate sections corresponding to paragraphs 105–09. For purposes of this citation, we refer to paragraphs 105–09 which correspond to Tiara Yachts' statements of its ERISA counts. For all further citations to Tiara Yachts' Complaint that may overlap with other numbered sections in the Complaint, we refer to paragraphs most closely related in context.

prohibited transaction in violation of 29 U.S.C. § 1106. In purported support of these claims, Tiara Yachts relies upon two categories of allegations.

Claims processing. Most of Tiara Yachts' allegations relate to BCBSM's claims processing—that is, the steps BCBSM took in reviewing claims that health care providers submitted for payment, and making payments on those provider claims. Significantly, these are not allegations that BCBSM *kept* Plan funds for itself, but rather that it paid out more to providers when processing claims than Tiara Yachts now thinks it should have.

First, Tiara Yachts alleges that some unspecified non-participating providers were improperly paid at the full amount they charged, when the plan terms may have provided for the provider to be paid at a lower rate. ECF No. 1, PageID.6–9 ¶¶ 37–65. Tiara Yachts alleges that this claim processing error resulted from a software flaw called "flip logic," through which certain non-participating provider claims were "flipped" to payment at the full amount they charged. *Id.* at PageID.7 ¶¶ 48–49. The Complaint states that BCBSM employee Dennis Wegner[3] allegedly

[3] Tiara Yachts alleges that Mr. Wegner was terminated and subsequently sued BCBSM alleging violations of the Michigan Whistleblowers' Protect Act and Michigan Bullard-Plawecki Employee Right-to-Know Act. ECF No. 1, PageID.9 ¶ 65. Tiara Yachts fails to note that the lawsuit was dismissed, as is reflected in public records subject to judicial notice. Ex. B., Register of Actions, *Wegner v. Blue Cross Blue Shield of Michigan*, Case No. 19-001808-CD (Mich. 3rd Jud. Dist.).

became aware of a similar overpayment to a provider in connection with another plan, unrelated to Tiara Yachts, when that customer contacted BCBSM to dispute the payment. *Id.* at PageID.6 ¶¶ 38–39.

Notably, Tiara Yachts does not identify any overpayments allegedly made in connection with its Plan. Instead of pointing to any claim BCBSM supposedly overpaid on Tiara Yachts' behalf, the Complaint states that "BCBSM knew the majority, if not all, of self-funded, non-auto customers on its NASCO platform, including Tiara Yachts, were impacted by this system flaw," *id.* at PageID.7 ¶ 46, citing to Exhibits A and B to the Complaint. These Exhibits do not mention Tiara Yachts, nor do they state that all BCBSM customers experienced overpaid claims. *See* ECF No.1-2, PageID.27 ("*Majority* of non-Auto groups on NASCO Classic are following [flip] logic.") (emphasis added); *see* ECF No. 1-3, PageID.31–39. Nor does Tiara Yachts allege that it ever contacted BCBSM to dispute any claims as overpaid, as the Complaint acknowledges other customers did. *See* ECF No. 1, PageID.6 ¶¶ 38–39.

Another form of claims processing error alleged in the Complaint relates to the format in which the claims were submitted for *other customers*. *Id.* at PageID.17–19 ¶¶ 101–08. Tiara Yachts alleges that "[c]ommon errors associated with BCBSM's NASCO claims processing system include, for example: unbundling, upcoding, medically unlikely claims, [and] non-adherence to payment

guidelines." *Id.* at PageID.18 ¶ 103. The format in which claims are submitted is commonly called "clinical editing." Tiara Yachts alleges, in essence, that BCBSM allowed providers to submit claims with improper clinical editing—*i.e.*, in a format that, according to Tiara Yachts, enabled providers to receive "improper payments" from other customers serviced by BCBSM.

Tiara Yachts is explicit, however, in acknowledging that its Complaint does not identify any claims paid *on behalf of the Tiara Yachts Plan* where allegedly improper clinical editing was used. Tiara Yachts concedes that it is relying on generalized allegations of "[c]ommon errors associated with BCBSM's NASCO claims processing system." *Id.* According to Tiara Yachts, it need not allege any breach in connection with its Plan because "errors or deficiencies identified in claims associated with one customer can reasonably be expected to exist for other customers." *Id.* at PageID.3 ¶ 15.

In its final set of allegations related to claims processing, Tiara Yachts addresses potential—not actual—deficiencies in the claims data BCBSM collected and maintained. *Id.* at PageID.12–15 ¶¶ 86–100. Claims data is "information gathered from medical bills or claims submitted to BCBSM," such as data that "identifies who rendered a service, the rendering provider(s) specialties and credentials, what service(s) was performed, what amount was billed for the service, what amount BCBSM allowed to be paid out of what was charged, who BCBSM

paid, when and where the service was provided, the patient's identity and age, and diagnoses." *Id.* at PageID.12 ¶ 88. Tiara Yachts alleges that "BCBSM maintained exclusive control and access to Tiara Yachts claims data," and states that Tiara Yachts does not have access to this data. *Id.* at PageID.13 ¶ 91. Tiara Yachts goes on to allege that *if* BCBSM does not have complete claims data for Tiara Yachts' Plan, then BCBSM *may have* breached its fiduciary duty: "Tiara Yachts' claims data should reflect all information necessary to ascertain whether a claim was properly processed and/or paid. To the extent it does not, BCBSM's failure to collect and/or maintain such data would itself be a breach of fiduciary duty." *Id.* ¶ 92. Tiara Yachts alleges that if any such data deficiencies exist, they "may include" one of seven issues listed in the Complaint. *Id.* ¶ 93.

Shared Savings. The second focus of Tiara Yachts' Complaint is the Shared Savings Program, through which Tiara Yachts contends BCBSM engaged in a prohibited transaction under ERISA. *Id.* at PageID.9–12 ¶¶ 70–85. The Shared Savings Program is a program through which BCBSM contracted with third-party vendors to adopt new measures for avoiding or recovering overpayments to providers due to provider billing errors. ECF No. 1-6, PageID.52. Although BCBSM had "historically performed several cost management services within the base administrative fee" paid by customers, BCBSM's customers sought "new ideas" to obtain additional savings. *Id.* at PageID.53. Through the Shared Savings

Program, BCBSM retained third-party vendors to conduct forensic bill review of certain claims prior to payment, to engage in "Advanced Payment Analytics" of all claims paid, and to detect and recover credit balances on hospital patient accounting systems. *Id.* at PageID.53–55. Instead of charging a flat administrative fee for these services, BCBSM used a "shared savings" model: If BCBSM succeeded in avoiding or recovering overpayments, BCBSM retained 30% of the amount saved. ECF No. 1, PageID.11 ¶ 83. ASC customers such as Tiara Yachts were initially included within the Shared Savings Program, but had the opportunity to opt out as desired. ECF No. 1-6, PageID.53. The Shared Savings Program—and the specified percentage of savings to be retained by BCBSM—was fully disclosed in the ASC. Ex. C, 2018 Amendment to ASC ¶ 1 ("On and after the effective date of the new Shared Savings Program . . . BCBSM will retain as administrative compensation a percentage of all funds recovered through subrogation as set forth in Schedule A."); Ex. D, 2018 Schedule A to ASC ¶ 17 ("BCBSM will retain as administrative compensation 30% of the recoveries or cost avoidance.").

Tiara Yachts alleges that the Shared Savings Program was a "scheme" that BCBSM "devised" so that it could "profit" when it "knowingly and improperly pa[id] claims." ECF No. 1, PageID.11–12 ¶¶ 84, 87. In Tiara Yachts' telling, BCBSM allegedly deliberately made improper payments on the front-end, so that it could recover more savings—and retain additional administrative fees—through

the Shared Savings Program on the back-end. *Id.* at PageID.11 ¶ 84. Tiara Yachts does not, however, make any allegations establishing that BCBSM retained any part of overpayments recovered or avoided for Tiara Yachts under the Shared Savings Program. Indeed, the Shared Savings Program—which became effective January 1, 2018 (ECF No. 1-6, PageID.53)—applied only during the last year of Tiara Yachts' contractual relationship with BCBSM. *See* ECF No. 1, PageID.3 ¶ 17 (contract terminated in December 2018).

LEGAL STANDARD

"In order to survive a motion to dismiss, the plaintiff's complaint must allege facts, which if proved, would entitle the claimant to relief." *Helfrich v. PNC Bank, Ky., Inc.*, 267 F.3d 477, 480 (6th Cir. 2001). "[A] complaint does not suffice if it tenders 'naked assertions' devoid of 'further factual enhancement.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoted source omitted). Moreover, a complaint "demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation," and "labels and conclusions" will not do. *Id.* "Factual allegations must be enough to raise a right to relief above the speculative level." *Bell Atl. v. Twombly*, 550 U.S. 544, 555 (2007). A complaint must "possess enough heft" to establish "something beyond the mere possibility" of a violation. *Id.* at 556–58.

This is particularly true in the ERISA context. As the Supreme Court has stated, a motion to dismiss for failure to state a claim is an "important mechanism

for weeding out meritless [ERISA] claims." *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 425 (2014). As such, a motion to dismiss "requires careful judicial consideration of whether the complaint states a claim that the defendant has acted imprudently [under ERISA]." *Id.* (citing Fed. R. Civ. P. 12(b)(6); *Iqbal*, 556 U.S. at 677–80; and *Twombly*, 550 U.S. at 554–63). Tiara Yachts' complaint cannot withstand this "careful" judicial scrutiny.

ARGUMENT

I. Tiara Yachts' Belated Challenge to Claims Processed and Paid Years Ago Does Not Support Relief under ERISA.

The majority of Tiara Yachts' Complaint contends that BCBSM made errors of various kinds when it processed claims submitted by providers for reimbursement in connection with Tiara Yachts' Plan, supposedly causing BCBSM to pay claims at a higher rate than it should have under the ASC. Tiara Yachts fails to note that the parties' contract provided it specific and explicit mechanisms for auditing and disputing overpayments or errors in claims processing. *See* Ex. A, ASC Art. II §§ D, G. Tiara Yachts likewise fails to note that it agreed to submit an audit request or dispute within a *specified time period*. That is because, as the ASC explicitly recognized, it "may not be possible to recover over-payments" after any significant passage of time. *See id.* § G. Accordingly, Tiara Yachts agreed that—to the extent it even sought *information* about claims

paid more than two years prior—the audit would be at Tiara Yachts' own expense. *Id.*

Tiara Yachts chose not to timely exercise its contract rights to challenge overpayments. Instead, attempting to avoid the terms of the bargain that it struck, Tiara Yachts repackages its several-years-old claims processing disputes as a supposed ERISA fiduciary duty claim. However, ERISA does not provide "a cause of action for extra-contractual damages caused by improper or untimely processing of benefit claims." *Mass. Mut. Life Ins.*, 473 U.S. at 148. Instead, ERISA's "carefully integrated civil enforcement provisions" create an "interlocking, interrelated, and interdependent remedial scheme" that does not "authorize other remedies" beyond those that Congress "incorporated expressly." *Id.* at 146. ERISA's enforcement provisions under 29 U.S.C. § 1132(a) provide the particular avenues allowing participants or fiduciaries to enforce their rights under an ERISA plan—and the statute does not support relief for Tiara Yachts here.

A. ERISA's remedial scheme does not authorize Tiara Yachts to recover supposed overpayments to providers from BCBSM.

The gravamen of Tiara Yachts' claims-processing dispute is that, for some unidentified number of claims paid out to unidentified providers years ago, BCBSM paid more than it allegedly should have under the ASC. According to Tiara Yachts, this occurred either because BCBSM allegedly paid non-participating providers using "flip logic," *see, e.g.*, ECF No.1, Page.ID.7 ¶ 50

("BCBSM would pay whatever was charged for a service, regardless of whether the claim was proper under the plan terms."), or because BCBSM allegedly paid out claims submitted using improper formatting that somehow masked improper charges, *see id.* at PageID.19–20 ¶ 108(g)–(h) (alleging an ERISA violation for "[c]onsistently paying claims suffering from a range of coding and billing issues . . . [and] [f]ailing . . . to prevent Tiara Yachts' Plan assets from being used to pay improper charges."). These allegations—which are about BCBSM's *payments to providers*, not about funds that BCBSM retained—do not support any relief available under ERISA.

1. Section 1132(a)(3) does not authorize any relief to Tiara Yachts.

Section 1132(a)(3) authorizes a fiduciary to bring suit to obtain either an injunction or "other appropriate equitable relief." As the Supreme Court has made clear, "'[e]quitable' relief'" as authorized in Section 1132(a)(3) "'must mean *something* less than *all* relief.'" *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 258 n.8 (1993)). Section 1132(a)(3) thus does not support a "suit[] for 'money damages'"—that is, "compensation for loss resulting from the defendant's breach of legal duty"—because a suit seeking such relief is "quintessentially an action at law." *Id.* at 210 (internal quotation marks and citations omitted).

Instead, if a plaintiff is to obtain monetary relief under Section 1132(a)(3), it must be a form of such relief that was "*typically* available in equity." *Id.* (internal quotation marks). As relevant here, if a plaintiff seeks restitution—as Tiara Yachts seeks—its claim lies under ERISA only to the extent it seeks *equitable*, not *legal*, restitution. As the Supreme Court has explained in the context of ERISA, "for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property *in the defendant's possession.*" *Id.* at 214 (emphasis added); *see also Cent. States, Se. & Sw. Areas Health & Welfare Fund v. First Agency, Inc.*, 756 F.3d 954, 960 (6th Cir. 2014). If the funds sought are not in the defendants' possession, then Section 1132(a)(3) does not allow relief.

In *Knudson*, for example, the Supreme Court rejected an ERISA claim to settlement proceeds that had been disbursed to two trust accounts, and not to the defendants. 534 U.S. at 214. As the Court explained, ERISA did not support relief where "[t]he basis for [plaintiffs'] claim is not that [defendants] hold particular funds that, in good conscience, belong to [plaintiffs], but that [plaintiffs] are contractually entitled to *some* funds." *Id.* Similarly, in *Montanile v. Board of Trustees of National Elevator Industry Health Benefit Plan*, the Supreme Court rejected an ERISA claim under Section 1132(a)(3) with respect to settlement funds that the defendant had received, but had dissipated prior to suit. 577 U.S. 136, 146–

48 (2016). The Court explained that in equity, where funds have been dissipated, there can be no equitable restitution: "Even though the defendant's conduct was wrongful, the plaintiff could not attach the defendant's general assets instead" of specific funds. *Id.* at 145. Accordingly, under Section 1132(a)(3), a plaintiff has no claim to monies that the defendant has disbursed, because the plaintiff may not obtain payment out of the defendant's general assets.

Here, it is clear that all that Tiara Yachts seeks with respect to BCBSM's alleged overpayments to providers is restitution of funds that are no longer in BCBSM's possession. As the Complaint makes clear, these funds were *paid out* to providers—not retained by BCBSM. *See, e.g.*, ECF No. 1, PageID.7 ¶ 50 ("BCBSM would pay [to non-participating providers] whatever was charged for a service, regardless of whether the claim was proper under the plan terms or other applicable reimbursement guidelines."); *id.* at PageID.15 ¶ 102 ("BCBSM's NASCO claims processing system has been found to consistently result in improper payments" to providers). Even if Tiara Yachts could establish that BCBSM acted wrongfully in making these alleged overpayments (which it cannot), Section 1132(a)(3) does not support any judgment against BCBSM's general assets in connection with those overpayments.

Nor is any other equitable relief available to Tiara Yachts. In particular, Tiara Yachts lacks Article III standing to obtain prospective relief because the

ASC has been terminated, and there is no ongoing relationship between Tiara Yachts and BCBSM. *See Smith v. Health Care Serv. Corp.*, 2021 WL 963814, at *4 (N.D. Ill. Mar. 15, 2021) (rejecting ERISA claim for injunctive relief, because "'[p]ast exposure to illegal conduct' would not confer standing upon Smith to seek prospective forms of relief absent 'a real and immediate threat of repeated injury'") (quoting *O'Shea v. Littleton*, 414 U.S. 488, 495–96 (1974)). No potential judgment that BCBSM is required to process claims differently in the future would redress any injury of Tiara Yachts, because BCBSM is no longer processing claims in connection with Tiara Yachts' Plan. There is thus no relief available to Tiara Yachts under Section 1132(a)(3).

2. Section 1132(a)(2) affords Tiara Yachts no relief either.

To the extent Tiara Yachts seeks monetary relief under 29 U.S.C. § 1132(a)(2), that provision does not help it either. Section 1132(a)(2) authorizes a fiduciary to bring suit for "appropriate relief under Section 1109." In turn, Section 1109 states that a fiduciary may be held "personally liable to make good to such plan any losses *to the plan* resulting from" a breach of fiduciary duty. 29 U.S.C. § 1109(a) (emphasis added). Section 1109 thus authorizes only suits for relief to be awarded to *an ERISA plan*—not relief to be awarded to a plan sponsor or any other entity. *See Mass. Mut. Life Ins.*, 473 U.S. at 140–41 (rejecting claim for relief under Section 1109 when that relief would not go to the plan itself).

In short, Section 1109 on its face does not support an award of relief to an entity other than the plan, such as an employer like Tiara Yachts. Indeed, ERISA does not authorize a plan fiduciary to sue for its own benefit, but authorizes suit solely for the benefit of the plan and its participants. *See Guyan Int'l, Inc. v. Prof'l Benefits Adm'rs, Inc.*, 689 F.3d 793, 800 (6th Cir. 2012); *Borroughs v. BCBSM*, 2012 WL 3887438, at *9–10 (E.D. Mich. Sept. 7, 2012).

That is definitive here, because Tiara Yachts' Complaint makes clear that Tiara Yachts is the only plaintiff—and the relief it seeks is for its own benefit, not for the Plan. The Complaint's caption lists Tiara Yachts as the sole Plaintiff, *see* ECF No.1, PageID.1 ("Tiara Yachts, . . . hereby states . . . as follows."), and Tiara Yachts does not allege that it is suing in a representative capacity on behalf of the Plan. Tiara Yachts repeatedly and consistently alleges that the purported breach harmed Tiara Yachts the employer, which the Complaint makes clear is distinct from the Plan. *See, e.g.*, *id.* at PageID.2 ¶ 3 ("Tiara Yachts brings this suit to recover the misappropriated funds and obtain all other relief to which *it* is entitled.") (emphasis added); *id.* ¶ 10 ("Tiara Yachts paid the actual employee health care costs covered by the Plan."); *id.* at PageID.8 ¶ 54 ("Tiara Yachts should have been paying for out-of-state, non-par claims at a lower rate."); *id.* at PageID.20 ¶ 109 ("BCBSM's breach of its fiduciary duty has proximately caused substantial damages to Tiara Yachts."). The Complaint is explicit that Tiara

Yachts' legal theory is "that BCBSM breached its fiduciary duty owed *to Tiara Yachts*." *Id.* at PageID.22 (emphasis added). And the only relief Tiara Yachts seeks runs in *its own favor*—not the Plan's. *See, e.g.*, *id.* (requesting an award of restitution "to Tiara Yachts").

The Sixth Circuit has held that an ERISA lawsuit was not pursued for the benefit of the plan when the plaintiff "explicitly sought personal recovery," as Tiara Yachts does here. *Pfahler v. Nat'l Latex Prods. Co.*, 517 F.3d 816, 826–27 (6th Cir. 2007) (collecting cases); *see also Loo v. Cajun Operating Co.*, 130 F. Supp. 3d 1097, 1105–06, 1109–10 (E.D. Mich. 2015) (dismissing claims brought by plan administrator under Sections 1132(a)(2) because "any benefit would inure to [the administrator] and not to the Plan"). Accordingly, Tiara Yachts' claims that BCBSM breached a purported duty owed to Tiara Yachts—and claims for relief directed to Tiara Yachts—cannot be pursued under Sections 1109(a) or 1132(a)(2).

B. Tiara Yachts' allegations regarding claims processing errors fail to state a claim.

In addition to the unavailability of any relief under ERISA's civil enforcement provisions, Tiara Yachts' allegations of claims processing errors fail to state a claim under the statute.

1. The allegations regarding clinical editing do not support any breach of fiduciary duty claim.

Tiara Yachts contends that BCBSM breached its fiduciary duty in the clinical editing process, whereby BCBSM supposedly paid claims that were improperly coded by providers. ECF No.1, PageID.15 ¶¶ 101–08. No court has ever held that allegations regarding clinical editing support a claim for breach of fiduciary duty—and this Court should not be the first.

a. *BCBSM did not breach any fiduciary duty with respect to claims-processing because BCBSM does not act as a fiduciary when it negotiates payment requirements with providers.*

When a claims-processor applies clinical editing requirements to codes submitted by providers, the claims-processor is not engaging in a fiduciary act. What information must be presented by the provider to obtain payment of a claim, the rate of pay, and/or how information must be presented, are matters negotiated between BCBSM and providers—not between BCBSM and any plan for which it acts as a fiduciary. Courts have accordingly been clear that the relationship "between a health care provider and an insurance plan is not an ERISA-regulated relationship." *See, e.g.*, *Summit Estate, Inc. v. Cigna Healthcare of Cal., Inc.*, 2017 WL 4517111, at *15 (N.D. Cal. Oct. 10, 2017).

This is especially obvious with respect to participating providers, for whom BCBSM negotiates payment terms that apply across the entire BCBSM provider

network—not solely to any individual plan. The Sixth Circuit expressly has held that BCBSM does not act in its fiduciary capacity when it makes contractual arrangements with its provider network. *DeLuca v. BCBSM*, 628 F.3d 743, 747 (6th Cir. 2010) (holding that BCBSM "was not acting as a fiduciary" when negotiating contractual rates with Michigan network healthcare providers). And courts have reached the same conclusion with respect to non-participating providers. *See, e.g.*, *Summit Estate*, 2017 WL 4517111, at *15 (holding that ERISA does not govern non-participating providers' claim for payment at the "usual and customary rate" because the relationship "between a health care provider and an insurance plan is not an ERISA-regulated relationship").

In essence, Tiara Yachts' claim amounts to a contention that Tiara Yachts is entitled to particular rates for the healthcare services provided to Plan participants, and that because BCBSM allegedly allowed providers to use improper clinical editing, BCBSM paid rates different from what Tiara Yachts was entitled to for the care provided. But as *DeLuca* made clear, BCBSM has no fiduciary obligation to Tiara Yachts or the Plan to pay providers particular rates. *DeLuca*, 628 F.3d at 747 (expressly stating that BCBSM is not "saddl[ed] . . . with the fiduciary obligation to negotiate . . . Plan-specific rates"). The ASC likewise makes this clear. *See, e.g.*, Ex. A, 2016 ASC Art. II § K(1) ("BCBSM negotiates provider reimbursement rates and settles provider obligations on its own behalf, not Group. Through this

contract, Group receives the benefit of BCBSM provider rates, *but it has no entitlement to a particular rate* or to unbundle the service-based or value-based components of Claims.") (emphasis added). Because BCBSM did not act as a fiduciary when it addressed clinical editing requirements with providers, claims based on improper clinical editing do not state a claim for breach of fiduciary duty.

b. *Tiara Yachts fails to allege facts to support duty and breach.*

Even if BCBSM did act as a fiduciary in connection with providers' clinical editing (which it did not), Tiara Yachts has failed to allege facts that state a claim for breach of any fiduciary duty. As a threshold matter, the Complaint fails to plead that Tiara Yachts actually suffered from any clinical editing errors, instead relying upon mere conjecture that BCBSM's claims processing system—but *not* claims processed for the Tiara Yachts Plan under that system—"has been found" to suffer from this issue. *See* ECF No. 1, PageID.15 ¶¶ 101–03 (stating that "BCBSM processes all claims for all non-auto NASCO customers . . . on the same claims processing system," which allegedly suffers from four "common errors," but failing to identify any of Tiara Yachts' claims suffering from those four errors). *Twombly* and *Iqbal* make clear that the "mere possibility" that a defendant engaged in improper conduct does not satisfy a Plaintiff's pleading standard. *Twombly*, 550 U.S. at 557–58; *Iqbal*, 556 U.S. at 679.

In addition, the Complaint fails to allege facts establishing how clinical editing errors constitute a breach of any particular duty. Fiduciary duty claims are premised on the notion of duty—the duty of prudence, or the duty of care. Here, Tiara Yachts has not alleged facts about what standard a prudent fiduciary would have met with regard to clinical editing, or alleged facts detailing how BCBSM fell short of whatever standard that may be when it processed claims for the Plan. This is fatal to Tiara Yachts' claim. *See, e.g.*, *Meiners v. Wells Fargo & Co.*, 898 F.3d 820, 822 (8th Cir. 2018) (granting motion to dismiss because "[t]o show that 'a prudent fiduciary in like circumstances' would have selected a different fund based on the cost or performance of the selected fund, a plaintiff must provide a sound basis for comparison—a meaningful benchmark," and Plaintiff had failed to do so).

Simply alleging error is insufficient to state a proper claim under ERISA. Indeed, "[t]he fiduciary duty of care . . . requires prudence, not prescience." *Senior Lifestyle Corp. v. Key Benefit Adm'rs, Inc.*, 2020 WL 2039928, at *13 (S.D. Ind. Apr. 28, 2020), *reconsideration denied*, 2020 WL 3642512 (S.D. Ind. July 6, 2020). In the few cases where plaintiffs have attempted arguments similar to Tiara Yachts', they have been soundly rejected, precisely because ERISA does not impose a fiduciary obligation to process claims without error. *See, e.g.*, *id.* (granting summary judgment on all ERISA claims in favor of third-party administrator of self-funded plan because the fiduciary duty of care "requires

prudence, not prescience"); *Daniel F. v. Blue Shield of Cal.*, 2011 WL 830623, at *10, *14 (N.D. Cal. Mar. 3, 2011) (granting summary judgment on California Parity Act claims because regulation requires, "[a]t most . . . 'reasonable' processes, not perfection," in claims processing, and there were no other bases under ERISA to support claim).

In sum, without factual allegations to support what standard ERISA imposes in the context of clinical editing, Tiara Yachts cannot establish any breach merely by alleging isolated errors.

2. Tiara Yachts' allegations regarding data deficiencies fail.

Tiara Yachts' allegations concerning supposed data deficiencies do not state any claim for breach of fiduciary duty. As discussed, the Complaint does not plead any cognizable claim that BCBSM failed to properly maintain the data and instead rests upon a mere hypothetical: "Tiara Yachts' claim data *should* reflect all information necessary to ascertain whether a claim was properly processed and/or paid. *To the extent it does not*, BCBSM's failure to collect and/or maintain such data *would* itself be a breach of fiduciary duty." ECF No. 1, PageID.13 ¶ 92 (emphasis added). Rule 8 requires "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). Tiara Yachts' allegation that BCBSM *should* maintain its data, and that BCBSM breaches its duty *if* it does not do so, does not satisfy this basic requirement. Indeed, nowhere

does Tiara Yachts allege facts that BCBSM actually failed to maintain its data in an appropriate manner—let alone plead any facts suggesting that BCBSM committed a breach of its ERISA duties in this regard. These hypotheticals do not survive a motion to dismiss. *Iqbal*, 556 U.S. at 663–64 (stating that a complaint cannot rely upon "mere conclusory statements," and that "while legal conclusions can provide the complaint's framework, they must be supported by factual allegations").

II. Tiara Yachts' Allegations Regarding the Shared Savings Program Do Not State a Claim.

The other category of allegations in the Complaint—relating to the Shared Savings Program—do not state a claim either. These allegations fail to state a claim for at least two independent reasons. First, Tiara Yachts is required to satisfy the rigorous requirements of Rule 9(b) in connection with its claim that BCBSM knowingly executed a scheme to defraud customers through the Shared Savings Program—and it fails to do so. Indeed, the Complaint fails to allege any facts establishing that BCBSM actually retained any savings in connection with Tiara Yachts, thus failing even to satisfy Rule 8. Second, what facts are alleged make clear that BCBSM did not act as a fiduciary in retaining any contracted-for compensation through the Program.

A. Tiara Yachts fails to allege facts establishing any breach.

1. The Complaint fails to satisfy Rule 9(b).

Tiara Yachts alleges that BCBSM breached its fiduciary duty and/or engaged in a prohibited transaction when it retained funds recovered from providers through the Shared Savings Program. ECF No. 1, PageID.9–12 ¶¶ 70–85. Extending beyond mere allegations of wrongdoing, the Complaint specifically alleges that BCBSM engaged in both knowing and intentional misconduct in creating and implementing the Program. In particular, the Complaint states that "BCBSM *formulated* a plan to capitalize on its misconduct" (*id.* at PageID.9 ¶ 70), given that BCBSM "*knew*" that "improper payments existed . . . as a result of its flip logic and beyond" (*id.* at PageID.11 ¶ 83) (emphases added). Not hiding the ball about the fraudulent nature of its claim, Tiara Yachts continues: "Essentially, BCBSM *devised a scheme* that would allow it to profit on its own mismanagement of plan assets. The more improper payments BCBSM let slide through its system, the more money it would make on the back end." *Id.* ¶ 84 (emphasis added).

Sixth Circuit case law is clear that Rule 9(b)'s heightened pleading standard applies under ERISA when "the primary theory of liability contained in plaintiffs' fiduciary-duty claims . . . sound in fraud." *Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 551 (6th Cir. 2012). A claim "sounds in fraud" even "where fraud is not a necessary element of a claim," *Hennigan v. Gen. Elec. Co.*, 2010 WL 3905770, at

*14 (E.D. Mich. Sept. 29, 2010), and even if the allegations "do not employ the word 'fraud.'" *Crocker v. KV Pharm. Co.*, 782 F. Supp. 2d 760, 785 (E.D. Mo. 2010); *see also Urban v. Comcast Corp.*, 2008 WL 4739519, at *9 (E.D. Pa. Oct. 28, 2008) (applying Rule 9(b) although the "claims do not employ the word 'fraud'"). Here, Tiara Yachts' allegations regarding the Shared Savings Program plainly sound in fraud: BCBSM allegedly deliberately made inflated payments to providers (ECF No.1, PageID.11 ¶ 83), "devised" or "formulated" a scheme to capitalize on this knowing misconduct, and subsequently secured money for itself on the "back end" of the claims payment process. *Id.* at PageID 9, 11 ¶¶ 70–71, 84.

Because Rule 9(b)'s heightened pleading standards applies to Tiara Yachts' claim, the Complaint must "allege the time, place, and content of the alleged misrepresentation," the "fraudulent scheme," the "fraudulent intent of the defendants," and the "injury resulting from the fraud." *Cataldo*, 676 F.3d at 551 (quoting *Bennett v. MIS Corp.*, 607 F.3d 1076, 1100 (6th Cir. 2010)). In other words, the Complaint must plead "the who, what, when, where and how" of the fraud. *In re United Am. Healthcare Corp. Sec. Litig.*, 2007 WL 313491, at *19 (E.D. Mich. Jan. 30, 2007).

The Complaint falls far short of this standard. It does not allege any overpayment BCBSM knowingly made in connection with the Tiara Yachts Plan. Nor is there any allegation of any transaction in which BCBSM supposedly

recouped and retained improper payments in connection with Tiara Yachts' Plan through this allegedly fraudulent scheme. ECF No. 1, PageID.11 ¶ 84 (alleging that the Shared Savings Program "scheme" "came at the expense of BCBSM's self-insured customers, including Tiara Yachts," and then failing to point to any transaction involving the Plan).

2. The Complaint fails even to satisfy Rule 8.

Even if Rule 9(b) does not apply, Tiara Yachts' failure to point to *any* payments recovered through the Shared Savings Program also fails to satisfy Rule 8's more lenient pleading standard. *Iqbal*, 556 U.S. at 678 ("[A] complaint [does not] suffice if it tenders 'naked assertions' devoid of 'further factual enhancement.'"). In fact, the Complaint as a whole is contrary to any allegation that BCBSM recovered payments under the Program. The crux of Tiara Yachts' theory is that BCBSM as a final matter did *not* sufficiently catch enough errors in the claims payment process and overpaid out of the Plan's assets. This contradiction does not satisfy any proper pleading standard under Rule 8. *See Clark v. Viacom Int'l Inc.*, 617 F. App'x 495, 507 (6th Cir. 2015) ("[T]he complaint at issue here is self-contradictory and has therefore failed to plausibly allege [a claim].").

B. Tiara Yachts fails to allege facts to support the existence of any fiduciary duty.

Tiara Yachts' Complaint also fails to allege that BCBSM acted as a fiduciary in retaining contracted-for compensation in connection with the Shared Savings Program. As Tiara Yachts concedes, the ASC expressly and openly provided that BCBSM would retain a contractually fixed percentage (30 percent) of recovered third-party payments as an administrative fee. ECF No. 1, PageID.11, 21 ¶¶ 80, 112; *see also* Ex. C, 2018 Amendment to ASC ¶ 1 ("On and after the effective date of the new Shared Savings Program . . . BCBSM will retain as administrative compensation a percentage of all funds recovered through subrogation as set forth in Schedule A."); Ex. D, 2018 Schedule A to ASC ¶ 17 ("BCBSM will retain as administrative compensation 30% of the recoveries or cost avoidance."). Under binding Sixth Circuit precedent, by retaining expressly contracted-for compensation in an amount specified by contract, BCBSM did not act as a fiduciary. *Seaway Food Town, Inc. v. Med. Mut. of Ohio*, 347 F.3d 610, 619 (6th Cir. 2003).

Seaway is instructive. In that case, Blue Cross Blue Shield of Ohio (BCBS) entered into a contract to serve as the claims administrator for Plaintiff's employee health benefit plan. *Id.* at 612. The parties' contract stated that, for any of BCBS's contracts with providers that allowed discounts, "BCBS will retain any payments resulting therefrom." *Id.* at 616. The Sixth Circuit held that, based upon this

contractual language, BCBS's control over such funds did not give rise to ERISA fiduciary status. *Id.* at 618. The Court stated: "[W]here parties enter into a contract term at arm's length and where the term confers on one party the unilateral right to retain funds as compensation for services rendered with respect to an ERISA plan, *that party's adherence to the term does not give rise to ERISA fiduciary status* unless the term authorizes the party to exercise discretion with respect to that right." *Id.* at 619 (emphasis added).

Unable to dispute that the contract specified a fixed percentage payment, Tiara Yachts alleges that BCBSM retained discretion over the amounts retained because "the amount of 'recoveries' were in the unilateral control of BCBSM." ECF No. 1, PageID.21 ¶ 113. According to the Complaint, BCBSM could allegedly control what overpayments were made and what "improper payments" were recovered—so that it ultimately determined in its discretion what amount of compensation it would retain "on the back end." *Id*. In other words, Tiara Yachts' theory is that BCBSM had controlled the amount of recovered payments to which the fixed-fee percentage would apply.

The necessary premise of this theory is Tiara Yachts' contention that BCBSM exercised unilateral discretion over the amounts recovered through the Shared Savings Program. But the notion that BCBSM had "unilateral control" over recoveries is directly contradicted by the Complaint, which alleges that recoveries

were made according to a four-step process that relied on both third-party vendors and successful recovery of payments from providers. In particular, Tiara Yachts acknowledges that a third-party vendor controlled the first-step Pre-Pay Review Process (ECF No. 1, PageID.10 ¶ 73), the second-step Advanced Payment Analytics process (*id.* ¶ 77), and the fourth-step Credit Balance Recovery process (ECF No. 1-6, PageID.55–56). The Complaint thus confirms that BCBSM did not have "unilateral control" over the amount of its compensation—and thus does not turn BCBSM's retention of a contractually specified administrative fee into a fiduciary act. *See In re Fid. ERISA Fee Litig.*, 990 F.3d 50, 57 (1st Cir. 2021) (affirming dismissal of ERISA claim on the ground that "a series of independent decisions" was not "the equivalent of Fidelity controlling its compensation from plans" and thus did not constitute a fiduciary function).

III. The Claims Are Time-Barred.

Finally, the claims fail because they are untimely. Tiara Yachts appears to assert claims based upon payments BCBSM made dating back to at least 2006, through the time the ASC terminated in 2018. *See, e.g.*, ECF No. 1, PageID.3 ¶ 17 ("BCBSM and Tiara Yachts first executed an Administrative Services Contract on January 1, 2006."); *id.* at PageID.7 ¶ 49 ("BCBSM implemented flip logic in 1997."). Under ERISA, claims for breach of fiduciary duty must be brought no later than (a) three years after the plaintiff had actual knowledge of the breach, or

(b) six years after the breach occurred. 29 U.S.C. § 1113. These claims are therefore untimely.

Tiara Yachts had actual knowledge of claims paid on its behalf because this information was routinely provided as required under the ASC. *See, e.g.*, Ex. A, ASC Art. II § D (stating that Tiara Yachts was provided with "access to a paid Claims listing"); *see also* ECF No. 1-6, PageID.59 ("Blue Cross will include line items on the monthly customer invoice. In addition, detailed reporting will be accessible via e-bookshelf to provide claim level detail to support the charges each month."); Ex. A, 2016 ASC Art. II § G (acknowledging that Tiara Yachts also could access claims data for purposes of an audit). Accordingly, at that time, Tiara Yachts had knowledge as to whether claims had been paid according to the terms of its Plan. Moreover, Tiara Yachts concedes that other ASC customers had sufficient information to dispute overpayments made using flip logic, ECF No. 1, PageID.6 ¶¶ 38–39, and that Tiara Yachts' experience with BCBSM's claims processing system was "consistent[]" with other customers' experience, *id.* at PageID.14–15 ¶¶ 101–02.

Tiara Yachts was thus required to bring any suit based upon the purported overpayments within three years—meaning that no overpayment later than July 1, 2019 can support a breach of fiduciary duty claim. Because all claims allegedly at issue were paid prior to this date, none of Tiara Yachts' claims regarding

overpayments survive ERISA's statute of limitations. *See* ECF No. 1, PageID.3 ¶ 17 ("Tiara Yachts terminated the relationship [with BCBSM] in or about December of 2018.").

At a minimum, even if actual knowledge is not demonstrated on the face of the Complaint, alleged overpayments made more than six years ago do not support a claim under ERISA. Tiara Yachts' allegation is that BCBSM breached its fiduciary duties under ERISA by improperly paying individual claims. *See, e.g.*, ECF No.1, PageID.12 ¶ 89 (describing the importance of line-item detail, including "what was ultimately paid," for "*each* claim") (emphasis added); *id.* at PageID.13 ¶ 92 ("Tiara Yachts' claim data should reflect all information necessary to ascertain whether *a* claim was properly processed and/or paid.") (emphasis added). Each individual supposed overpayment constitutes an alleged breach. *See Gruby v. Brady*, 838 F. Supp. 820, 830–31 (S.D.N.Y. 1993) (holding that claims prior to six-year limit were time-barred because defendants' breach "gave rise to a new cause of action each time the Fund was injured, that is, each time excessive benefit payments were made"). Accordingly, claims that were allegedly overpaid later than July 1, 2016 cannot support a claim for breach of fiduciary duty.

CONCLUSION

For these reasons, BCBSM respectfully asks this Court to dismiss the Complaint in its entirety, with prejudice. If the Court decides that any part of the

Complaint can go forward and that ERISA's three-year statute of limitations does not apply, it should dismiss Tiara Yachts' claims to the extent they rely upon payments BCBSM made before July 1, 2016.

Dated: August 25, 2022

Respectfully submitted,

/s/ Tacy. F. Flint

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CERTIFICATE OF COMPLIANCE

Pursuant to L. Civ. R. 7.2(b)(i), I hereby certify that this document complies with L. Civ. R. 7.2(b)(ii) because this document, generated using Microsoft Word 2010, contains 7,686 words.

/s/ Tacy F. Flint
Tacy F. Flint

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN

TIARA YACHTS, INC.,	)	
	)	
Plaintiff,	)	Case No. 1:22-cv-603
	)	
v.	)	
	)	Judge Robert J. Jonker
BLUE CROSS BLUE SHIELD OF MICHIGAN,	)	Magistrate Judge Ray Kent
	)	
Defendant.	)	
	)	

APPENDIX OF EXHIBITS TO
DEFENDANT'S MOTION TO DISMISS PLAINTIFF'S
COMPLAINT FOR FAILURE TO STATE A CLAIM

INDEX OF EXHIBITS

Exhibit No.	Description
A	2016 Administrative Services Contract ("ASC")
B	Register of Actions, *Wegner v. Blue Cross Blue Shield of Michigan*, Case No. 19-001808-CD (Mich. 3rd Jud. Dist.)
C	2018 Amendment to Administrative Services Contract
D	2018 Schedule A to Administrative Services Contract

Exhibit A

CID-275980

Administrative Services Contract –Weekly Invoiced Program

S2 Yachts, Inc

This Contract commences on 1/1/2016 (the "Effective Date") and is made between Blue Cross Blue Shield of Michigan, a Michigan non-profit mutual insurance corporation, with offices at 600 Lafayette East, Detroit, Michigan 48226-2998 ("BCBSM") and S2 Yachts, Inc with offices at 725 East 40th Street, Holland, MI 49423 ("Group"), as the plan sponsor and administrator of its group health care plan ("Plan").

BCBSM and Group have agreed that BCBSM shall administer Claims processing for the Plan. This Contract sets forth the administrative responsibilities of BCBSM and Group's financial and other obligations with respect to BCBSM's role as a service provider to the Plan.

By entering into this Contract, Group and BCBSM hereby agree that, to the extent the Plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), their relationship is that of Group as "Plan Fiduciary" and BCBSM as "Service Provider" as those terms are used in Department of Labor guidance including 29 C.F.R. §2550.408b-2.

BCBSM and Group agree as follows:

ARTICLE I
DEFINITIONS

A. "Amounts Billed" means the amount that Group shall reimburse and pay BCBSM for Claims which have been processed and paid by BCBSM or another BCBS Plan under the terms of this Contract, Pharmacy Benefits if applicable, the Administrative Fee set forth in Schedule A, any Additional Administrative Compensation ("AAC") as set forth in Schedule A, Michigan Claims Tax, Pharmacy benefit fees as set forth in Schedule A, Health Care Provider Interest, and other fees and charges as set forth in Schedules A and B.

B. "BCBS Plan" means a company that has been licensed by BCBSA other than BCBSM.

C. "BCBSA" means the Blue Cross and Blue Shield Association.

D. "BlueCard Program" means the national program established by BCBSA under which Enrollee Claims are processed by BCBS Plans when Enrollees receive health care services outside of the geographic area that BCBSM serves. BCBSA mandates the policies, procedures and disclosures of the BlueCard Program and amends them from time to time. Schedule B sets forth BCBSA's required disclosures for the BlueCard Program and is incorporated into this Contract. If BCBSA amends the disclosures, such amendments shall automatically become a part of this Contract upon BCBSM giving 60 days prior written notice to Group.

E. "Claim" means a request for payment from a health care provider for a health care service provided to an Enrollee, with an incurred date for the service during the term of this Contract. Claims billed to Group include all amounts that BCBSM reimburses health care providers including both service-based and value-based reimbursement. BCBSM negotiates provider reimbursement rates on its own behalf and may set the rate for health care services to cover any BCBSM obligation to health care providers. BCBSM does not retain any portion of Claims as compensation. Provider reimbursement is governed by separate agreements with providers, BCBSM standard operating procedures for Claims, and BCBSM Quality Programs.

Claims received from an out-of-state BCBS Plan for a health care service provided to an Enrollee out-of-state are paid according to that BCBS Plan's health provider contracts and processed according to BlueCard Program standard operating procedures. Pursuant to the BlueCard Program, as described in Schedule B, out-of-state Claims may include a BlueCard Access Fee for processing the claim. Out-

of-state Claims are reported and billed to the Group as they are received by BCBSM from the out-of-state BCBS Plan.

F. "Contract" means this Administrative Services Contract – Weekly Invoiced Program, as may be amended from time to time, and any Schedules, Parts, Exhibits and Addenda attached hereto and incorporated herein by reference.

G. "Contract Year" means the period from the Effective Date to the first Renewal Date, or the period from one Renewal Date to the next Renewal Date. If termination occurs other than at the end of a Contract Year, Contract Year means that period from the Effective Date or the most recent Renewal Date through the date of termination.

H. "Coverages" means the health care benefits set forth in Universal Group Application or Part C of the Group Enrollment and Coverage Agreement, which is incorporated into this Contract.

I. "Employee" means the following which are eligible and enrolled for Coverage under the terms of the Plan or as required by law: (i) employees as designated by Group; (ii) retirees and their surviving spouses as designated by the Group; and (iii) COBRA beneficiaries.

J. "Enrollee" means an individual that Group enrolled as an employee, spouse or dependent in the Plan pursuant to Article II.B, either as an Employee or as a dependent of an Employee.

K. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, 29 USC 1101, *et seq*, and regulations promulgated thereunder.

L. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, Public Law 104-191 of 1996, *et seq*, and regulations promulgated thereunder.

M. "IBNR Claims" means Claims which are incurred during the term of this Contract, including during the Transition Assistance Period, but have not been reported to the Group as Amounts Billed or paid and which remain the Group's liability.

N. "PPACA" means the Patient Protection and Affordable Care Act, as amended, Public Law 111-148 of 2010, *et seq*, and regulations promulgated thereunder.

O. "Quality Programs" refer to BCBSM programs funded with value-based provider reimbursement. Quality Programs are governed by separate agreements with health care providers and are designed to improve health care outcomes and control health care costs.

P. "Renewal Date" means the date one year after the Effective Date, and the same date of every subsequent year. The Renewal Date may be changed by mutual agreement of BCBSM and Group.

Q. "Transition Assistance Period (TAP)" means a period of twenty-four (24) months after Termination has been effectively demanded under Article IV, during which BCBSM shall provide those services, and Group shall perform those obligations, set forth in Article IV, Section B.

ARTICLE II
GENERAL RESPONSIBILITIES

A. Claims Administrator Status.

If the Plan is governed by ERISA, based on Group's disclosure of ERISA status in this Contract, Group hereby delegates to BCBSM the responsibility and discretionary authority as claims administrator to makes final benefit determinations and plan interpretations necessary to make those benefit determinations. BCBSM's claims administrator responsibilities extend only to the full and fair review of claims and administrative appeals as set forth in ERISA §433. By assuming these specifically delegated responsibilities as claims administrator, BCBSM does not thereby assume any other duty of the Group as Plan Administrator or any other fiduciary function Group performs on behalf of its Plan. Any determination or interpretation made by BCBSM pursuant to its claim determination authority is

binding on the Enrollee, Group, and BCBSM unless it is demonstrated that the determination or interpretation was arbitrary and capricious. Group retains all other fiduciary responsibilities and duties under ERISA not specifically delegated to BCBSM in this Contract.

BCBSM shall not be responsible for Group's failure to meet any of its financial obligations or Plan Administrator responsibilities with respect to the Plan.

B. **Eligibility and Enrollment.**

Prior to the Effective Date, Group shall notify BCBSM of all Enrollees that will be covered by the Plan. During the term of this Contract, following agreed upon procedures, Group shall notify BCBSM of all changes in Plan enrollment. Until BCBSM has been properly notified of changes to Group's Plan enrollment, BCBSM shall continue to process Claims for Enrollees as listed on BCBSM's computer membership programs. Group represents and warrants that any eligibility and status changes it requests are compliant with and permissible under applicable state and federal law, including the PPACA; and, agrees that it will only request eligibility and status change requests that are compliant with and permissible under applicable state and federal law, including the PPACA.

C. **Claims Processing.**

During the term of this Contract, requests for payment from Michigan providers will be directly submitted to BCBSM and shall be processed according to BCBSM's standard operating procedures for Claims. Requests for payment from out-of-state providers may, depending on the type of request for payment, be directly submitted to the appropriate out-of-state BCBS Plan and shall be processed pursuant to the BlueCard Program as set forth in Schedule B.

D. **Disputed Claims.**

Group shall notify BCBSM in writing of any Claim that Group disputes within 60 days of Group's access to a paid Claims listing. BCBSM shall investigate such Claims and respond to Group within a reasonable time period. Upon BCBSM's request, Group shall execute any reasonably necessary documents that will allow BCBSM to recover any amounts that may be owed by a third party with respect to such disputed Claim. If BCBSM recovers any amount from a third party or if BCBSM determines that the disputed Claim is not Group's financial responsibility or is incorrect, then BCBSM shall give Group a credit for the recovered or corrected amount (reduced by any stop loss credits given by BCBSM relating to such disputed Claim).

E. **Subrogation.**

BCBSM shall be subrogated to all of Group's, the Plan's, or an Enrollee's rights with respect to any Claim, however, BCBSM is not obligated to institute or become involved in any litigation concerning such Claim. BCBSM will use reasonable efforts to identify Claims in which the Group may have a subrogation or reimbursement interest. BCBSM will evaluate information provided by the Enrollee and other sources to determine whether a subrogation or reimbursement interest exists. BCBSM will not be obligated to undertake any such recovery litigation unless mutually agreed to by BCBSM and Group in writing. Absent written agreement, should Group elect to pursue such recovery litigation, BCBSM agrees to cooperate in Group's recovery efforts. BCBSM will remit to Group the funds recovered from third parties, less any expenses BCBSM has incurred in the recovery effort, including any attorney fees. BCBSM may assign or subcontract a portion of its duties under this provision of the Contract to third parties. Group will assist BCBSM or its assignee or subcontractor as reasonably necessary for BCBSM, its assignee, or subcontractor to carry out its duties under this provision.

Group authorizes BCBSM to act on behalf of Group and/or the Plan in any health care class action litigation of which BCBSM has knowledge, including but not by way of limitation, drug manufacturer and product liability litigation. BCBSM will take reasonable steps to notify Group of such class action litigation. Group will notify BCBSM if Group desires to independently pursue such litigation and BCBSM will reasonably cooperate with Group. As part of BCBSM's subrogation duties, BCBSM will use reasonable efforts to identify Claims that may be included in such class action litigation. BCBSM may institute and participate in such class action litigation, however, Group acknowledges that

BCBSM is not obligated to do so unless BCBSM and Group otherwise agree in writing. Group will reasonably cooperate with BCBSM with respect to any such litigation. BCBSM may assign or subcontract a portion of its duties under this provision to third parties. Group authorizes BCBSM to settle or compromise any litigation and BCBSM will remit to Group any funds recovered, less any expenses that BCBSM has incurred in participation of such class action litigation.

F. **Litigation.**

If a third party initiates a claim, suit, or proceeding against the Plan, Group, or BCBSM relating to benefits payable under the Plan or any of the administrative services subject to this Contract ("Litigation"):

1. Each party shall provide prompt written notice of the Litigation to the other party if served with such Litigation.

2. Group may, with BCBSM's consent, request that BCBSM select counsel and defend litigation. BCBSM retains the right to deny this request and enforce Group's obligation to defend the Litigation.

3. Whenever Group or BCBSM is a party in any Litigation, regardless of who is obligated to defend the litigation, Group and BCBSM each reserve the right, at its own cost and expense, to retain counsel to protect its own interests.

4. Regardless of who is obligated to defend the litigation, Group and BCBSM shall reasonably cooperate with each other to provide all relevant information and documents within their respective control that are not subject to a privilege or confidentiality obligation; and to reasonably assist each other to defend, settle, compromise, or otherwise resolve the Litigation. Whenever either party is served with any Litigation, the party served shall take all steps necessary to prevent a default in the Litigation prior to determining which party will defend such Litigation.

5. BCBSM shall have full authority to settle or compromise such Litigation, without Group's specific consent, unless:

   a. $50,000 or more is at issue in the Litigation;
   b. State tax issues or mandated benefit issues are part of the Litigation and Group has requested BCBSM to defend the Litigation; or
   c. Settlement of the Litigation could have a material adverse impact on Plan costs or administration.

   If Group's consent to settle or compromise Litigation is required, such consent shall not be unreasonably withheld. If Group withholds consent for any reason and the final resolution of the Litigation is equal to or greater than a settlement or compromise proposed by BCBSM, Group shall pay BCBSM the additional cost of any subsequent settlement, compromise or judgment including all of BCBSM's reasonable attorney fees and costs for proceeding with the Litigation.

6. When Group is obligated to defend the Litigation, Group shall have full authority to settle or compromise such Litigation without BCBSM's consent, unless BCBSM has notified Group that the Litigation may have a material adverse impact on BCBSM.

   If BCBSM's consent to settle or compromise Litigation is required, such consent shall not be unreasonably withheld. If BCBSM withholds consent for any reason and the final resolution of the Litigation is equal to or greater than a settlement or compromise proposed by Group, BCBSM shall pay the additional cost of any subsequent settlement, compromise or judgment including all of Group's reasonable attorney fees and costs for proceeding with the Litigation.

7. When BCBSM defends the Litigation, the cost and expenses of such defense shall be paid by BCBSM. The cost and expenses of such defense shall include reasonable attorney fees and other reasonable litigation costs, however, any settlement or payment of amounts that are the financial responsibility of Group, including but not limited to Claims, (via judgment, award, etc.) shall be paid by Group.

8. Subject to paragraph 7 above, when the Group defends the Litigation, the cost and expenses of such defense shall be paid by Group. The cost and expenses of such defense shall include reasonable attorney fees and other reasonable litigation costs and any settlement or payment for benefits or Claims shall be paid by Group.

G. Group Audits.

Group, at its own expense, shall have the right to audit Claims incurred under this Contract; however, audits shall not occur more frequently than once every twelve months and shall not include Claims from previously audited periods or Claims paid prior to the last 24 months. Both parties acknowledge that Claims with incurred dates over two years old may be more costly to retrieve and that it may not be possible to recover over-payments for these Claims; however, BCBSM shall use best efforts to retrieve such Claims.

All audits shall be conducted pursuant to BCBSM corporate policy and other requirements at the time of the audit. The parties acknowledge staffing constraints may exist in servicing concurrent Group initiated audits. Therefore after notice from Group requesting an audit, BCBSM will have 60 to 90 days, depending on scope and sample size, to begin gathering requested documentation and to schedule the on-site phase of the audit.

Sample sizes shall not exceed 200 Claims and shall be selected to meet standard statistical requirements (i.e., 95% Confidence Level; precision of +/- 3%). Group shall reimburse BCBSM for Claims documentation in excess of 200 Claims at $50 per Claim.

Following the on-site activity and prior to disclosing the audit findings to Group, the auditor shall meet with BCBSM Management and present the audit findings. BCBSM, depending upon the scope of the audit, shall be given a reasonable period of time to respond to the findings and provide additional documentation to the Auditor before the Auditor discloses the audit findings to the Group.

BCBSM shall have no obligation to make any payments in connection with audit findings to Group unless there has been a recovery from the provider, Enrollee, or third-party carrier as applicable. No adjustments or refunds shall be made on the basis of the auditor's statistical projections of sampled dollar errors. An audit error will not be assessed if the Claim payment is consistent with BCBSM policies and procedures, or consistent with specific provisions contained in this Contract or other written Group instructions agreed to by BCBSM.

Prior to any audit, Group and BCBSM must mutually agree upon any independent third party auditor that Group wishes to perform the audit. Additionally, prior to audit, Group and any third party auditor shall sign all documents BCBSM believes necessary for the audit which will, at a minimum, provide for: the scope of the audit; the costs for which BCBSM is to be reimbursed by Group; the protection of confidential and proprietary information belonging to BCBSM, and of any patient specific information; and the indemnification and hold harmless of BCBSM from any claims, actions, demands or loss, including all expenses and reasonable attorney fees, arising from any suit or other action brought by an individual or provider to the extent caused by Group or its auditor.

Group shall provide BCBSM with a copy of any internal audit or review of the services performed under any agreement with BCBSM.

H. **Disclosures.**

Group shall disclose the following to Enrollees in writing:

1. BCBSM services being provided.
2. BCBSM does not insure any Enrollees.
3. Group is responsible for the payment of Claims.
4. Group is responsible for changes in Plan benefits.
5. Group is responsible for enrollment.

I. **Health Care Provider Interest.**

Group acknowledges that various states including Michigan have enacted prompt payment legislation with respect to the payment of Claims that may require the payment of interest to providers under circumstances dictated by statute. BCBSM will invoice the Group for any interest required by statute and Group shall pay such interest. Additionally, out-of-state Claims may be inclusive of any interest owed by statute or required by the terms of provider contracts with the out-of-state BCBS Plan. Out-of-state Claims are reported and billed to Group as submitted to BCBSM by the out-of-state BCBS Plan.

J. **Confidentiality.**

The terms of this Contract and the items set forth below are confidential and shall not be disclosed or released to a third party without the prior written consent of BCBSM, unless required by law.

1. Claim Information
   Enrollee personal or individually identifiable health information.

2. Provider Proprietary Information
   Health care provider names, addresses, tax identification numbers, and financial amounts paid to such providers.

3. BCBSM and Other BCBS Plan Proprietary Information
   BCBSM's or any other BCBS Plan's methods of reimbursement, amounts of payments, discounts and access fees; BCBSM's administrative fees and, if applicable, stop loss fees; those processes, methods, and systems developed for collecting, organizing, maintaining, relating, processing and transacting comprehensive membership, provider reimbursement and health care utilization data.

K. **Amounts Billed.**

1. Claims:

The Claims billed to Group include both service-based and value-based reimbursement to health care providers. Group acknowledges that BCBSM's negotiated reimbursement rates include all reimbursement obligations to providers including provider obligations and entitlements under BCBSM Quality Programs. Service-based reimbursement means the portion of the negotiated rate attributed to a particular health care service. Value-based reimbursement is the portion of the negotiated reimbursement rate attributable to BCBSM Quality Programs, as described in the Exhibit to Schedule A.

BCBSM negotiates provider reimbursement rates and settles provider obligations on its own behalf, not Group. Through this contract, Group receives the benefit of BCBSM provider rates, but it has no entitlement to a particular rate or to unbundle the service-based or value-based components of Claims. BCBSM does not retain any portion of Claims as compensation. All amounts collected from Group in Claims are used to satisfy provider obligations. Group agrees to pay Claims as defined herein.

Out-of-state Claims processed through the BlueCard Program, shall be calculated according to the BlueCard Program policies and procedures, as set forth in Schedule B.

2. Additional Administrative Compensation:

Group shall pay Additional Administrative Compensation ("AAC") as set forth in Schedule A unless the Group has elected a Full Fixed Administrative Fee in lieu of AAC. AAC is calculated as a percentage of BCBSM discounts on Michigan hospital Claims with a cap and floor as set forth in Schedule A.

3. Health Care Provider Interest:

See Article II.I.

4. Taxes and Surcharges:

State and Federal governments may impose surcharges or taxes on Claims. The State of Michigan imposes a tax on all Michigan Claims for Michigan residents. Tax rates are governed by applicable law.

Such surcharges or taxes, where imposed by law, may be invoiced to Group or billed and reported to Group in Claims. Group agrees to pay all such surcharges or taxes.

5. Pharmacy Benefits Services:

If Group elects BCBSM pharmacy benefits, Amounts Billed shall include pharmacy Claims and any claims processing, pharmacy fees, and rebate processing fees set forth in Schedule A.

6. Amounts Billed shall also include any fee or charge identified in Group's Schedule A, including but not limited to Group's Administrative Fee.

L. **Coordination with Medicare.**

Group shall timely notify BCBSM whether Medicare is the primary payer for Claims of any Enrollee. BCBSM shall change such Enrollee's eligibility record within 15 business days of BCBSM's receipt of Group's notice. Group shall indemnify and hold harmless BCBSM for any claim, demand, judgment, penalty or other liability that arises out of Group's failure to provide timely notice to BCBSM.

M. **Pharmacy Benefits.**

To the extent Group has engaged BCBSM to administer prescription drug claims for its Plan, BCBSM or its subcontractor shall process all prescription drug claims according to Group's benefit design and BCBSM's participating pharmacy contracts.

Group acknowledges that payments to participating pharmacies may include prescription drug costs, dispensing fees, and incentive fees for dispensing a generic drug or compounding a prescription drug.

Group authorizes BCBSM to act and serve as Group's exclusive agent for the purpose of negotiating with and obtaining rebates from pharmaceutical manufacturers. Group understands and agrees that BCBSM may directly contract with pharmaceutical manufacturers or BCBSM may contract with various subcontractors that have contracts with pharmaceutical manufacturers. BCBSM's rebate administrators retain a portion of the total rebates collected from drug manufacturers as a rebate administration fee. BCBSM will pass on to Group rebates net of rebate administration fees. If BCBSM receives rebate adjustments or de minimis amounts of unidentifiable rebates that cannot practicably be tied to particular claims, BCBSM will proportionally allocate those rebate amounts to customers with pharmacy benefits.

Pharmacy administration fees and rebate administration fees are set forth in Schedule A.

ARTICLE III
FINANCIAL RESPONSIBILITIES

A. **Group Responsibilities.**

Group shall be liable for all risks, financial obligations, Amounts Billed, fees, and interest set forth in this Contract, including Schedules A, B, and C. Group shall also be liable for any statutory court costs and attorney's fees awarded by a court to Enrollees, and all other liabilities which BCBSM may assume or which might otherwise attach with respect to the administration of Coverages pursuant to this Contract, including Schedules A, B, and C. Group shall make full payment and satisfaction to BCBSM for all amounts resulting from such risks, financial obligations, and liabilities.

B. **Scheduled Payments by Group.**

Group shall make payments of amounts due and owing as set forth on Schedule A, including, but not by way of limitation, (1) administrative fee per Employee and additional administrative compensation, if any; (2) the hospital advance; and (3) Amounts Billed.

C. **Interest.**

Pursuant to the instructions in Schedule A, Group shall pay the Estimated Weekly Payment to a designated BCBSM bank account, which funds other BCBSM accounts. To the extent any of those bank accounts are interest bearing, BCBSM retains any interest earned and will not pay or credit any interest to Group. Additionally, banks holding BCBSM accounts may retain float interest earned on transactions with the funds in those accounts.

D. **Schedule A Renewals.**

Thirty (30) days prior to each Renewal Date, BCBSM shall send Group a Schedule A for the new Contract Year with all pricing terms, including BCBSM's administrative fee, applicable AAC, interest rates, and any new Michigan hospital advance. Such Schedule A may specify the pricing terms for a single Contract Year or, with the agreement of BCBSM and Group, may specify the pricing terms for multiple Contract Years. The renewal term Schedule A as received by the Group shall be considered fully executed and effective on the Renewal Date unless the Group notifies BCBSM prior to the Renewal Date that the contract will not be renewed.

E. **Group's Weekly Wire and Other Payments.**

Group shall make weekly payments of all amounts due to BCBSM within one business day of the payment day set forth in the Schedule A. In addition, Group shall pay to BCBSM any separately invoiced amounts within fifteen (15) days of invoice or settlement receipt. If Group's payment for any amount payable under this Contract is more than one business day late, Group shall pay a late fee of the lesser of two percent of any outstanding amount due or the maximum amount permitted by law. In addition, BCBSM may cease to process Claims retroactive to the last date for which full payment was made.

F. **Settlements.**

1. Annual Settlements. Group shall receive its Annual Settlement approximately one hundred twenty (120) days after the end of each Contract Year, which may include a reconciliation of the administrative fee based on BCBSM's enrollment records for the Contract Year at the time the reconciliation is performed. Because reconciliation of Group's hospital Claims depends on BCBSM's final settlement with the hospitals, a separate settlement process called CSR, explained below, captures that reconciliation.

   If the Group has an arrangement whereby it pays AAC, the total AAC reported to Group with the Annual Settlement equals the total amount of AAC collected from Group during the year in Amounts Billed less any AAC that was refunded to Group pursuant to a stop-loss insurance policy

with BCBSM. If the total AAC exceeds the maximum AAC set forth in Schedule A, BCBSM shall return the excess AAC to Group. If the total AAC is less than the minimum AAC set forth in Schedule A, Group shall pay BCBSM the shortfall. Neither Group nor BCBSM shall pay any interest on these payments/refunds.

2. Customer Savings Refund. Customer Savings Refund (CSR) is the annual report reconciling Group's Amounts Billed during the 12-month period 7/1 – 6/30 with any of the following items settled during the same period: (1) retroactive adjustments made in the Michigan Hospital Settlement (MHS), explained below, (2) drug rebates received pursuant to Group's Pharmacy Benefits arrangement, (3) class action recoveries, and (4) any other settlements from litigation and provider audits for which claim readjudication is not practicable.

   If a refund is due, Group will receive a CSR payment in the year following the close of the CSR period. In the case of a liability resulting from the MHS, the liability will be reported to Group in the year following the close of the CSR period. A liability will accumulate with interest and be offset against future CSR payments. BCBSM may in its sole discretion elect not to offset any MHS liability against some or all drug rebates.

   MHS liabilities will continue to accumulate from year to year unless Group elects to pay the liability or CSR payments in subsequent years exceed the amount of Group's outstanding MHS liability. BCBSM may in its sole discretion invoice Group for some or all of Group's CSR liability, which invoice shall be paid within thirty (30) days of receipt by Group.

   The MHS is designed to reconcile amounts BCBSM paid to a hospital during a year with the total amount of reimbursement due to the hospital. Pursuant to separate agreements between BCBSM and Michigan hospitals, BCBSM makes periodic estimated payments to each hospital based on expected claims for all BCBSM customers. At the end of the contract year with the hospital, BCBSM settles the amount the hospital received in payments with actual claims experience, hospital reward and incentive payments under Quality Programs, and hospital obligations to Quality Programs. The MHS will result in a gain or loss applied to Group's CSR.

   Group will not receive a CSR or incur adjusted liability attributable to a particular hospital until after the finalization of the MHS for a particular hospital. Group's refund or liability attributable to a particular hospital gain or loss, respectively, is proportionate to Group's utilization for that hospital.

G. **Changes in Enrollment or Coverages – Effect on Pricing Terms.**

If there is more than a 10 percent (10%) change in the number of Enrollees from the number stated in Schedule A during any month of the Contract Year or a change in Coverages, BCBSM may immediately revise any affected pricing terms in the Schedule A to reflect such changes in Enrollment and/or Coverages. Any revisions will be effective beginning with the next month following thirty (30) day notification by BCBSM to the Group. The revised Schedule A will be treated as executed by Group and effective as of the date it is received by Group.

ARTICLE IV
TERMINATION AND TERMINATION ASSISTANCE

A. **Termination & Notice.**

1. With or Without Cause. Either party may with or without cause provide notice of intent to terminate this Contract by giving written notice to the other party. For the ninety (90) days following such written notice, each Party's obligations and entitlements will remain unaltered. At the conclusion of this ninety (90) day notice period, no claims with service dates following the conclusion of the ninety (90) day notice period will be approved and the Transition Assistance Period ("TAP") will begin, which will conclude 24 months later, at which time the contract will be terminated.

2. Nonpayment, Partial Payment, Insolvency, or Bankruptcy. Notwithstanding any other Contract provisions, if Group fails to timely pay any amounts owed or becomes insolvent or files for bankruptcy protection, BCBSM may at its option, after giving five (5) days notice in writing, cause the contract to immediately enter the TAP.

3. Termination within the First Contract Year. If Group gives notice of termination of the Contract before the end of the first Contract Year or if BCBSM terminates the contract under paragraph (2.) before the end of the first Contract Year, Group's total administrative fee liability to BCBSM shall be twelve months of administrative fees at the rate stated in Schedule A in order to compensate BCBSM for the costs of setting up and implementing the arrangement. Group's termination liability for administrative fees shall be determined using the average monthly enrollment prior to termination times twelve months, and shall be net of administrative fees paid prior to termination.

B. Transition Assistance Period.

Once written notice of termination has been given under Section A of this Article and the notice period has expired, the parties will continue to perform, and this Contract will continue, with respect to each party's obligations related to the wind-down of this Contract as set forth in this Section for the TAP. Upon the expiration of the TAP, this Contract shall terminate. The date on which the applicable notice period has expired following a termination trigger and on which the TAP commences will be called the "TAP Effective Date."

1. End of Coverage. Notwithstanding any other provisions contained herein, neither BCBSM nor any BCBS Plan shall have any obligation for payment for any health care services which are incurred after the TAP Effective Date.

2. Obligation to Pay. Notwithstanding any other provisions contained herein, Group's obligation to pay amounts incurred under the Contract shall survive during the TAP, and Group shall continue to timely pay all amounts owed. All Claims incurred prior to the TAP Effective Date, but not paid before that date, shall be processed by BCBSM or other BCBS Plans pursuant to the terms and conditions in this Contract and separate agreements with providers. Group agrees that it shall have no right to have any Claims incurred before the TAP Effective Date processed by a replacement carrier or administrator.

   BCBSM retains the right to cease paying Claims if, during the TAP, Group fails to timely pay BCBSM for Amounts Billed and/or if Group is insolvent and/or files for bankruptcy protection. Group represents and warrants that it understands that it will be solely liable for any Claims BCBSM does not pay as a result of Group's failure to make timely payment to BCBSM, and Group will indemnify, defend, and hold BCBSM harmless for any Litigation or other adversary proceeding brought by an Enrollee whose claim was not paid by BCBSM as a result of Group's failure to timely pay BCBSM. This paragraph is independent of BCBSM's rights under Art. IV.A.2.

3. Claim Payments. For the first three (3) months following the TAP Effective Date, Group shall make weekly payments in the same manner as prior to the TAP Effective Date; however, Group shall pay the fixed administrative fee for only the first two months after the TAP Effective Date. AAC, if any, will continue to be paid for the TAP. For the next twenty-one (21) months, BCBSM will invoice Group each month and Group shall make payments to BCBSM. After six months from the TAP Effective Date, BCBSM shall offset any Amounts Billed against the Michigan hospital advance.

4. Settlement-Last Contract Year. Within one hundred eighty (180) days following the TAP Effective Date, BCBSM shall prepare a settlement statement for the last Contract Year. Such settlement statement shall include any compensation to BCBSM, including administrative fees.

5. Interest. If the total amount of the estimated Amounts Billed included in the weekly payments made during the first three (3) month period following termination exceed the actual Amounts Billed during the period, BCBSM will pay the Group interest at the then rate for short term government treasury bonds (STIGB), which is currently calculated as a rolling twelve-month

average of the 90-day T-Bill yield rate on the average monthly balance of any excess. The total amount of any excess will be included in the settlement for the last Contract Year.

6. Final Settlement. Within ninety (90) days after the expiration of the Transition Assistance Period, BCBSM will prepare a final settlement and will refund any positive balance or invoice Group for any negative balance. Any negative balance will be due within ten (10) days of the date of invoice. The payment to Group or to BCBSM as provided in the immediately preceding sentence shall fully and finally settle, release, and discharge each party from any and all claims that are known, unknown, liquidated, non-liquidated, incurred-but-not-reported, adjustments, recoupments, receivables, recoveries, rebates, hospital settlements, and other sums of money due and owing between the parties and arising under this Contract.

7. Group Duty to Notify/Indemnity. Group shall notify BCBSM if, as a result of its insolvency or other status, another party is required by law to receive any refunds, payments, or returned funds from BCBSM under this Article IV. Group shall indemnify, defend, and hold BCBSM harmless for any liability, including attorney fees, resulting from Group's failure to notify BCBSM under this paragraph.

C. **Conversion to Underwritten Group.**

If Group converts from a self-funded group to a BCBSM underwritten group, Group shall continue to be obligated for any balance due and Group shall timely pay the amounts due and owing under this Contract in addition to any premium payments as a BCBSM underwritten group.

ARTICLE V
GENERAL PROVISIONS

A. **Entire Agreement.**

This entire Contract, including Schedules, represents the entire understanding and agreement of the parties regarding matters contained herein. This Contract supersedes any prior verbal or written agreements and understandings between the parties and shall be binding upon the parties, their successors or assigns.

B. **Indemnity.**

Group agrees to indemnify, defend and hold BCBSM harmless from any claims resulting from Group's breach of any term of this Contract and/or breach of any obligation or duty not expressly delegated to BCBSM in this Contract, including, but not limited to, Group's obligation to manage enrollment, to disclose Plan information to Enrollees, to respond to requests for Plan documents, and to read and understand the terms of this Contract.

The indemnity and hold harmless provisions of this Contract shall survive the termination of the Contract.

C. **Service Mark Licensee Status.**

BCBSM is an independent licensee of BCBSA and is licensed to use the "Blue Cross" and "Blue Shield" names and service marks in Michigan. BCBSM is not an agent of BCBSA and, by entering into this Contract, Group agrees that it made this Contract based solely on its relationship with BCBSM or its agents. Group agrees that BCBSA is not a party to this Contract, has no obligations under this Contract, and that no BCBSA obligations are created or implied under this Contract.

D. **Notices.**

Unless otherwise provided in this Contract, any notice required shall be given in writing and sent to the other party either by hand-delivery, electronic mail message to designated representative of the

other party, or postage pre-paid US first class mail at the following address or such other address as a party may designate from time to time.

If to Group:	If to BCBSM:
Current address shown on BCBSM Group Header	Blue Cross Blue Shield of Michigan 600 Lafayette East, Mail Code B612 Detroit, Michigan 48226-2998

E. Amendment.

This Contract may be amended only by a written agreement duly executed by authorized representatives of each party provided, however that this Contract may be amended by BCBSM upon written notice to Group in order to facilitate compliance with applicable law including changes in regulations, reporting requirements or data disclosure as long as such amendment is applicable to all BCBSM groups that would be similarly affected by the legal change in question. BCBSM will provide thirty (30) calendar days notice of any such amendment and regulatory provision, unless a shorter notice is necessary in order to accomplish regulatory compliance.

Upon request by Group BCBSM will consult with Group regarding the regulatory basis for any amendment to this Contract as a result of regulatory requirements.

F. Severability.

The invalidity or nonenforceability of any provision of this Contract shall not affect the validity or enforceability of any other provision of this Contract.

G. Waiver.

The waiver by a party of any breach of this Contract by the other party shall not constitute a waiver as to any subsequent breach.

H. Law.

This Contract is entered into in the State of Michigan and, unless preempted by federal law, shall be construed according to the laws of Michigan. Group agrees to abide by all applicable state and federal law. Group agrees that, where applicable, the federal common law applied to interpret this Contract shall adopt as the federal rule of decision Michigan law on the interpretation of contracts..

I. HIPAA.

1. Group Certification.

Group certifies that it is the Plan Sponsor and Plan Administrator, performs Plan administration functions, needs access to Enrollee protected health information to carry out such administration functions, and has amended the Plan documents to comply with the requirements of 45 CFR 164.504(f)(2). BCBSM is therefore authorized to provide Group with the minimum necessary Enrollee protected health information for Group to perform its plan administration functions.

2. Business Associate Agreement.

The parties shall enter into a business associate agreement.

J. Force Majeure.

Neither BCBSM nor Group shall be deemed to have breached this Contract or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Contract if

prevented from doing so by acts of God or the public enemy, fires, floods, storms, earthquakes, riots, strikes, boycotts, lock-outs, wars and war-operations, restraints of government, power or communication line failure, judgment, ruling, order of any federal or state court or agency of competent jurisdiction, change in federal or state law or regulation subsequent to the execution of this Contract, or other circumstances beyond the party's reasonable control for so long as such "force majeure" event reasonably prevents performance.

K. **Group Disclosure of Other Coverage Vendors.**

Group agrees that, to the extent that BCBSM does not administer all of Plan's "essential health benefits," as that term is defined by the PPACA, Group shall identify for BCBSM all those vendors ("Vendors") that are also providing or administering essential health benefits to the Plan's participants, the benefits the Vendors are providing to them, the number of participants receiving such benefits, and the cost sharing arrangements for such benefits.

In addition, Group shall cause its officers, directors, employees, and representatives and Vendors' officers, directors, employees and representatives to fully and timely cooperate with BCBSM and provide it with the necessary information for BCBSM to ensure its compliance and that of the Plan with PPACA to the extent BCBSM is obligated to do so by law or by contract. This information includes, but is not limited to, social security numbers or other forms of government identification numbers of each Plan participant and beneficiary.

Group is solely responsible to ensure Group's maximum out-of-pocket amount is in compliance with PPACA. If BCBSM agrees to assist Group in determining whether Group's maximum out-of-pocket amount is in compliance with PPACA, then Group authorizes all Vendors to, and shall inform the Vendors in Group's contract with them that they must, effective on the beginning of the Group's first plan year on or after January 1, 2014, disclose to BCBSM on a daily basis (or some other regularly scheduled period as determined by BCBSM) all claims data for the essential health benefit(s) of Plan participants and beneficiaries that they possess.

L. **Other Data Requirements.**

Group agrees to provide to BCBSM all data reasonably necessary for BCBSM to comply with the requirements of PPACA or other applicable federal or state laws. Such data includes, but is not limited to, all Enrollee data needed to comply with any reporting or other requirements of PPACA, *e.g.*, the employer's share of any premium and social security or tax identification numbers. Group certifies that if it fails to provide all the data requested and if it has provided such information to BCBSM in response to a previous request, then Group shall be deemed to have certified to BCBSM that such information previously supplied remains correct and can be relied upon.

Group and Group's Vendors will maintain relevant books, records, policies, procedures, internal practices, and/or data logs relating to this Contract in a manner that permits review for a period of seven (7) years or (ten (10) years in the case of Medicare/Medicaid transactions) after the expiration of this Contract. With reasonable notice and during usual business hours, BCBSM, or its designated third party (with appropriate confidentiality obligations), may audit those relevant books, records, policies, procedures, internal practices, and/or data logs of Group and/or its Vendors, as necessary, to verify calculations related to the imposition of any taxes and fees under PPACA or other federal or state laws and to ensure compliance with this Contract and any applicable federal and state laws. Group shall cooperate with BCBSM in all reasonable respects in connection with such audits.

BCBSM's failure to detect, failure to notify Group of detection, or failure to require Group's remediation of any unsatisfactory practices does not relieve Group of its responsibility to comply with this Contract or applicable law, does not constitute acceptance of such practice, and does not constitute a waiver of BCBSM's enforcement rights under this Contract or applicable law.

If Group conducts, or contracts to have conducted, an internal audit or review of the services performed under any agreement with BCBSM, Group shall provide BCBSM with a copy of such audit or review within thirty (30) days of BCBSM's written request. This also applies to audits/reviews performed by or at the request of any federal or state regulatory agencies of BCBSM services. The

selection of an independent auditor by Group to conduct an internal audit of Group does not preclude BCBSM from conducting an audit in accordance with the terms contained herein.

The provisions of this Section shall survive the termination of this Contract.

M. **Grandfather Status; Women's Preventative Care Religious Exemption.**

Group acknowledges and agrees that unless a written certificate of grandfather status and indemnity in form and substance satisfactory to BCBSM was previously provided to BCBSM by Group or, for a Group new to BCBSM as of January 1, 2013, was provided to and accepted by BCBSM concurrently with the signing of this Contract, Group will be considered non-grandfathered for all purposes.

In addition, Group acknowledges that the health care coverages provided to its Enrollees will include recommended women's preventive health services without cost sharing (as required by PPACA) unless the Plan (i) is a grandfathered group health plan that has not provided such coverage or (ii) qualifies as either an exempt group health plan or one eligible for the temporary safe harbor under PPACA and has provided a certificate to that effect in form and substance satisfactory to BCBSM.

N. **Summary of Benefits and Coverage.**

Group is solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to the Plan, or for creation or disclosure of compliant SBCs. BCBSM disclaims any liability or responsibility for any non-compliance by Plan with SBC rules and regulations relating to creation, disclosure or other requirements.

O. **Plan Year.**

Group's Plan Year, as that term is defined in PPACA, is the one year period beginning on the Effective Date and ending one year (or less) later on the last day of the month immediately preceding the month in which the Effective Date falls ("Effective Date Month"). Each Plan Year thereafter shall begin on the first day of the Effective Date Month and end one year later.

If Group's Plan Year that is not consistent with that reflected in the preceding paragraph, Group will promptly notify BCBSM in writing. Group will notify BCBSM at least six months in advance of any change in the Plan Year.

P. **Knowing Assent.**

Group acknowledges that it has had full opportunity to consult with such legal and financial advisors as it has deemed necessary or advisable in connection with its decision knowingly to enter into this Contract. Group acknowledges that it is its obligation as Plan Fiduciary to determine whether the financial arrangements set forth in this Contract and Schedules are an appropriate Plan expense and for the exclusive benefit of the Plan. Group acknowledges that it has had any questions about this Contract posed to BCBSM fully answered to Group's satisfaction.

Neither party has executed this Contract in reliance on any representations, warranties, or statements other than those expressly set forth herein.

Q. **Group Health Plan Type; Attestation.**

Is Groups' Plan governed by ERISA? ☒ Yes, ☐ No.

Group attests that, to the best of its knowledge, this response is correct and acknowledges that BCBSM will rely on this response to determine requirements applicable to Group and the performance of this Contract.

AGREED AND ACCEPTED.

BCBSM:	GROUP:
By: (Signature)	By: (Signature)
Name: (Print) Jeffrey L. Connelly	Name: MARK VAN HAASEN (Print)
Title: SVP, Young Group Business	Title: V.P. - HUMAN RESOURCES
Date: 01/05/16	Date: 12/16/15

By: (Signature)	By: (Signature)
Name: (Print)	Name: (Print)
Title:	Title:
Date:	Date:

1/22/2016 DRAFT

ASC Weekly Invoiced Program – CID# 275980

6026S503481

Exhibit B

REGISTER OF ACTIONS

CASE NO. 19-001808-CD

PARTY INFORMATION

		Lead Attorneys
Defendant	Blue Cross Blue Shield of Michigan	
Plaintiff	Wegner, Dennis	Mary K. Deon *Retained* (248) 494-7444(W)

EVENTS & ORDERS OF THE COURT

OTHER EVENTS AND HEARINGS

02/07/2019	Complaint, Filed
02/07/2019	Service Review Scheduled
02/07/2019	Status Conference Scheduled
02/07/2019	Case Filing and Jury Trial Fee - Paid
05/20/2019	*CANCELED* Status Conference (8:00 AM) (Judicial Officer Snow, Martha M.) *Case Disposed/Order Previously Entered* *05/06/2019 Reset by Court to 05/13/2019* *05/09/2019 Reset by Court to 05/06/2019* *05/13/2019 Reset by Court to 05/20/2019*
05/20/2019	Non-Service Dismissal, Signed and Filed (Judicial Officer: Kenny, Timothy M.)

FINANCIAL INFORMATION

	Plaintiff Wegner, Dennis			
	Total Financial Assessment			260.00
	Total Payments and Credits			260.00
	Balance Due as of 11/08/2019			0.00
02/07/2019	Transaction Assessment			260.00
02/07/2019	eFiling	Receipt # 2019-10529	Shelton & Deon Law Group, PLLC	(260.00)

Exhibit C

CPS-275980
1154B

Amendment to Administrative Services Contract

52YAGIIS
71115

This amendment ("Amendment") to the Administrative Services Contract, effective on your 2018 Renewal Date ("Contract"), is between Blue Cross Blue Shield of Michigan ("BCBSM") and the undersigned group ("Group"), as the plan sponsor and administrator of its group health care plan.

In consideration of their mutual promises, the Contract will be amended as follows:

1. The Subscription section of Article II—Group Responsibilities—is amended by adding the following sentence at the end of the first paragraph:

   On and after the effective date of the new Shared Savings Program, which shall not be sooner than January 1, 2018, BCBSM will retain as administrative compensation a percentage of all funds recovered through subrogation efforts as set forth in Schedule A.

2. The Pharmacy Rebates section of Article II—Group Responsibilities is deleted in its entirety and replaced with the following:

   Pharmacy Benefits.

   To the extent Group has engaged BCBSM to administer prescription drug claims for its Plan, BCBSM or its subcontractor shall process all prescription drug claims according to Group's benefit design and BCBSM's participating pharmacy contracts.

   Group acknowledges that payments to participating pharmacies may include prescription drug costs, dispensing fees, and incentive fees for dispensing a generic drug or compounding a prescription drug.

   Group understands and agrees that BCBSM may directly contract with pharmaceutical manufacturers or BCBSM may contract with various subcontractors that have contracts with pharmaceutical manufacturers ("Rebate Administrators"). Because of such contracts with Rebate Administrators, Group agrees that Group will not submit, either directly or indirectly through a third party, prescription drug claims to any pharmaceutical manufacturers for rebates. The Rebate Administrators retain a portion of the gross rebates collected from drug manufacturers as a claims processing and rebate administration fee ("Rebate Administrator Fee"). In addition, notwithstanding anything to the contrary in this Contract, BCBSM retains a portion of the rebates as administrative compensation ("BCBSM Rebate Service Fee"). The Rebate Administrator Fee and BCBSM Rebate Service Fee are set forth in Schedule A. If, pursuant to BCBSM's agreement with a Rebate Administrator, the Rebate Administrator Fee changes during a Contract Year, such change shall be effective and automatically incorporated in Group's Schedule A following 30 days' notice by BCBSM to Group. BCBSM will pass on to Group rebates net of any fees set forth in the Schedule A. If BCBSM receives rebate adjustments or de minimis amounts of unidentifiable rebates that cannot practicably be tied to particular claims, BCBSM will proportionally allocate these rebate amounts to customers with pharmacy benefits.

3. Except as set forth in this Amendment, all other terms and conditions of the Contract shall remain in full force and effect. If there is a conflict between the terms of this Amendment and the Contract, the terms of this Amendment shall prevail.

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Signatures

BCBSM:	GROUP:
By: (Signature) Jeffrey L. Connolly	By: (Signature) Mark Van Faasen
Name: (Print) GVP & Prog. M.M	Name: (Print) MARK VAN FAASEN
Title: Jeffrey L. Connolly	Title: VP HUMAN RESOURCES
Date: 12/12/17	Date: 12/5/17

FLINT GROUP 71409

Exhibit D

1151B

Blue Cross Blue Shield of Michigan
SCHEDULE A-Renewal Term (Effective 1/1/2018 - 12/31/2018)
Administrative Services Contract (ASC)

1. Group Name: S2 YACHTS
2. Group Number: 71315
3. Initial ASC Effective Date: 1/1/2006
4. ASC Funding Arrangement: Weekly Invoice

5. Line(s) of Business:

- [X] Facility
- [X] Professional
- [X] Prescription Drugs
- [ ] Dental
- [ ] Vision

6. Administrative Fees: The below administrative fees cover the Lines of Business checked in Section 5 above, unless otherwise indicated.

Option 1: Administrative Fee (Full Fixed)

	Cost Per Hospital Covered Contract	Estimated Monthly Contracts	Estimated Monthly Premium
A. Administrative Fee	$69.95	618	$43,229
B. Additional Wellness Fees	Not Applicable	0	$0
C. Prescription Drug Accumulator Fee	Not Applicable	0	$0
D. Online Visit Fee	$0.20	618	$124
E. Third-Party Stop-Loss Vendor Fee	Not Applicable	0	$0
F. Other Fees	Not Applicable	0	$0
TOTAL	$70.15	618	$43,353

7. Hospital Advance $104,830

8. This Schedule A does not include any fees payable by Group to an Agent. If Group has an Agent Fee Processing Agreement on file with Blue Cross, please refer to the agreement for fees and details.

9. Late Payment Fees: If Group's payment is more than one business day late, Group shall pay a late fee of the lesser of two percent (2%) of any outstanding amount due or the maximum amount permitted by law.

10. Blue Cross Account: [redacted]

11. Amounts billed for out-of-state claims may include BlueCard access fees and any value-based provider reimbursement negotiated by a Host Blue with out-of-state providers. See Schedule B to ASC and Exhibit 1 for additional information.

12. If your group contains Medicare contracts and they are being separated from the current funding arrangement, all figures within the current funding arrangement will be adjusted

13. The Group acknowledges that BCBSM or a Host Blue may have compensation arrangements with providers in which the provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and member management fees. Often the compensation amount is determined after the medical service has been performed and after the Group has been invoiced. The Claims billed to Group include both service-based and value-based reimbursement to health care providers. Group acknowledges that BCBSM's negotiated reimbursement rates include all reimbursement obligations to providers including provider obligations and entitlements under BCBSM Quality Programs. Service-based reimbursement means the portion of the negotiated rate attributed to a particular health care service. Value-based reimbursement is the portion of the negotiated reimbursement rate attributable to BCBSM Quality Programs, as described in Exhibit 1 to Schedule A. BCBSM negotiates provider reimbursement rates and settles provider obligations on its own behalf, not Group. Group receives the benefit of BCBSM provider rates, but it has no entitlement to a particular rate or to unbundle the service-based or value-based components of Claims. See Exhibit 1 to Schedule A and Schedule B to ASC for additional information.

14. BCBSM will charge an additional administrative fee if an ASC customer obtains stop-loss coverage from a third-party stop-loss vendor. This additional fee will be $6.00 per contract per month.

15. If you have a Consumer-Directed Health (CDH) spending account, you may be billed a separate fee for the applicable contracts.

16. If there is more than a 10 percent (10%) change in the number of Enrollees from the number stated above during any month of the Contract Year or a change in Coverages, BCBSM may immediately revise any affected pricing terms in this Schedule A to reflect such changes in Enrollment and/or Coverages. Any revisions will be effective beginning whith the next invoice following thirty (30) days notification by BCBSM to the Group. The revised Schedule A will be treated as executed by Group and effective as of the date it is received by Group.

17. Shared Savings: BCBSM has implemented a program to enhance the savings realized by its customers through additional pre-payment and post-payment recovery efforts. As stated below, BCBSM will retain as administrative compensation 30% of the recoveries or cost avoidance identified below:

    A. Pre-Payment Forensic Billing Review. Cost avoidance of improper hospital billing identified by third party vendor(s) through forensic pre-payment billing review.

    B. Advanced Payment Analytics. Recoveries of claims overpayments identified by third party vendor(s) using proprietary data mining analytics and enhanced reviews .

    C. Subrogation. Recoveries of claims overpayments from subrogation.

    D. Provider Credit Balance Recovery. Recoveries of claims overpayments obtained by third party vendor(s) through enhanced review of hospital patient accounting systems.

    Administrative compensation retained by BCBSM through the Shared Savings Program will be itemized on Group's invoices, with detail available to the Group in a report entitled Shared Savings Value Report. Group will be notified of the Effective Date of each component of the Shared Savings Program at least 30 days in advance ("Notice"). The Shared Savings Program is Effective as of the later of the Renewal Date or the date stated in the Notice received by Group disclosing the Effective Date of each component of the Shared Savings Program.

18. The rebate administration fee and claims processing fee charged and retained by the Rebate Administrator is (i) 3.8% of gross rebates for BCBSM clinical formulary, custom formulary, custom select formulary, including specialty drug Claims and (ii) 8.2% of gross rebates for part D formulary drug Claims, including Part D specialty drug Claims ("Rebate Administrator Fee").
Additionally, BCBSM will retain 10 percent of pharmacy rebates on Claims incurred in the renewal term net of the above Rebate Administrator Fee. The amount of rebates retained by BCBSM as administrative compensation will be identified as a BCBSM Rebate Service Fee and reported to Group.

    BCBSM guarantees, on a per contract per month ("PCPM") basis, the Group's prescription drug rebates reported on the 2018 Customer Service Refund (CSR) will be at least 50% more than the rebates reported on the 2016 CSR, as calculated below.

    (A) Group's 2018 PCPM Prescription Drug Rebate = (2018 CSR Prescription Drug Rebates) / (total actual pharmacy ASC contract count for April 2017 through March 2018)

    (B) PCPM Rebate Guarantee = (2016 CSR Prescription Drug Rebates) / (total actual pharmacy ASC contract count for April 2015 through March 2016) x 1.5

    If (A) is less than (B), BCBSM will pay Group the PCPM difference multiplied by the total actual pharmacy ASC contract count for April 2017 through March 2018.

    Pursuant to Rebate Administrator's Inflation Protection Program, the Rebate Administrator's contracts with pharmaceutical manufacturers for inflation protection payments ("IPP") to off-set increases to certain brand drugs. The Rebate Administrator will pay a predetermined portion of the IPP that it receives to BCBSM as set forth in the contract between the Rebate Administrator and BCBSM. The Rebate Administrator contracts for IPP on its own behalf and may realized positive margin between amounts paid to BCBSM and amounts received from pharmaceutical manufacturers. BCBSM will distribute Group's share of the IPP that it receives from the Rebate Administrator based on the total IPP received by BCBSM divided by the total number of brand drug claims multiplied by the number of Group's brand drug claims. IPPs will be distributed to Group through the CSR process.

    The rebate administration fee charged and retained by Rebate Administrator is up to 5.5% of gross rebates for medical benefit drug Claims.

Blue Cross:

BY: _____
Blue Cross Vice President (Signature)

DATE: 12/12/17

Prepared by:
Martin Case Blue Cross Underwriting

S2 YACHTS

BY: _____
(Signature)

NAME: MARK VAN FRASEN
(Print)

TITLE: VP HUMAN RESOURCES

DATE: 12/5/17