

**UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION**

WESCO, INC., and WESCO, INC.
CAFETERIA PLAN AND
EMPLOYEE BENEFIT PLAN, on
behalf of themselves and a class of all others
similarly situated,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF
MICHIGAN

Defendant.

Civil Action No.: 2:25-cv-11712

Judge: Hon. Susan K. DeClercq

Magistrate Judge: David R. Grand

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 12(b)(1) 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.

In accordance with Local Rule 7.1(a), BCBSM’s counsel, Mark J. Zausmer, in good faith sought concurrence in the relief requested in this motion from counsel for Plaintiffs, Perrin Rynders, via e-mail during the week of July 7, 2025 and a teleconference on July 14, 2025. BCBSM’s counsel explained the nature of the motion and the legal basis for the motion. Plaintiffs’ counsel opposed the requested relief.

Dated: July 14, 2025

Respectfully submitted,

ALLEN OVERY SHEARMAN STERLING
US LLP

By: s/ Daniel Lewis

Daniel Lewis (Adm. in E.D. MI, NY Reg. 4084810)

Jeffrey D. Hoschander (Adm. in E.D. MI, NY Reg. 4496337)

599 Lexington Avenue

New York, NY 10022

Telephone: +1.212.848.4000

Facsimile: +1.202.508.8100

daniel.lewis@aoshearman.com

jeff.hoschander@aoshearman.com

Todd M. Stenerson (P51953)
1101 New York Avenue, NW
Washington, DC 20005
Telephone: +1.202.508.8093
Facsimile: +1.202.661.7484
todd.stenerson@aoshearman.com

ZAUSMER, P.C.

By: s/ Mark J. Zausmer
Mark J. Zausmer (P31721)
Michael A. Schwartz (P74361)
Nathan S. Scherbarth (P75647)
Jason M. Schneider (P79296)
32255 Northwestern Hwy., Ste. 225
Farmington Hills, MI 48334
Telephone: +1.248.851.4111
Facsimile: +1.248.851.0100
mzausmer@zausmer.com
mschwartz@zausmer.com
nscherbarth@zausmer.com
jschneider@zausmer.com

Attorneys for Defendant

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

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STATEMENT OF ISSUES PRESENTED

Whether the Court should dismiss Plaintiffs’ complaint for lack of standing and subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1) and for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) because Plaintiffs’ claims were released, or, in the alternative, because Plaintiffs’ claims are barred by the three-year statute of limitations applicable to breach of fiduciary duty claims under the Employee Retirement Income Security Act of 1974 (“ERISA”), or, in the alternative because Plaintiffs fail to plead facts sufficient to state a plausible claim.

Answer: Yes.

CONTROLLING OR MOST APPROPRIATE AUTHORITY

Ashcroft v. Iqbal, 556 U.S. 662 (2009)

Bell Atl. v. Twombly, 550 U.S. 544 (2007)

Intel Corp. Inv. Policy Comm. v. Sulyma, 589 U.S. 178 (2020)

Taylor v. Visteon Corp., 149 F. App'x 422 (6th Cir. 2005)

INTRODUCTION

In 2003, Blue Cross Blue Shield of Michigan (“BCBSM”) and Plaintiff Wesco Inc., on behalf of its self-insured employee benefit healthcare plan, the Wesco, Inc. Cafeteria Plan and Employee Benefit Plan (the “Plan”), entered into an Administrative Services Contract (“ASC”). Under the ASC, BCBSM processed claims submitted by health care providers for services rendered to the Plan. As part of this relationship, BCBSM, in 2018, as part of its claim processing services, adopted a “Shared Savings Program” (“SSP”) to combat excessive charges submitted by providers not contracted with BCBSM for health services rendered to Plaintiffs’ employees. To administer this program, BCBSM charged 30% of any recoveries. Plaintiffs terminated the ASC in December 2022.

The Complaint should be dismissed for lack of standing and subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1) and for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) for three reasons.

First, Plaintiffs lack standing because their claims have been released. At the end of the parties’ relationship, they entered into a clear and unambiguous release that applies to “any and all” claims arising from the parties’ contractual relationship. The broad language in the release necessarily encompasses the claims asserted here. This Court therefore lacks subject matter jurisdiction over

Plaintiffs' claims. Moreover, the Court also should dismiss the claims because they have been released, even apart from the question of standing.

Second, Plaintiffs' claims are time-barred. All the SSP recoveries alleged in the Complaint were paid more than three years ago. Plaintiffs received monthly invoices and other supporting data demonstrating precisely what claims were processed and paid, and they received information about any recoveries under the SSP. If there was a legitimate dispute about the SSP recoveries, Plaintiffs could have raised it years ago.

Third, the Complaint fails to allege facts that—even if proven—would constitute a breach of fiduciary duty or prohibited transaction. The Complaint does not identify any SSP recovery that resulted from a known processing issue. Instead, the Complaint generally alleges the presence of processing errors and then speculates this *may* have led to SSP recoveries. Such speculative, generalized accusations do not satisfy the required pleading standards. Further, the types of processing errors identified in the Complaint cannot form the basis of a breach of fiduciary duty claim. And the Complaint, in any event, does not plead facts showing any standard of care for claims processing, much less that BCBSM did not meet that standard.

The Court should dismiss this case in its entirety.

BACKGROUND

Plaintiff Wesco sponsors the Plan (together with Wesco, “Plaintiffs”), a self-funded employee benefit healthcare plan. ECF No. 1, PageID.4 ¶¶ 15–16.¹ Wesco contracted with BCBSM to provide to the Plan “administrative services associated with processing and paying medical claims.” *Id.* at PageID.9 ¶ 39. Plaintiffs allege that each putative Class member contracted with BCBSM to provide claims administration services to their self-funded benefit healthcare plans under the same or similar terms. *Id.* at PageID.13 ¶¶ 57, 122.

Wesco and BCBSM signed an ASC² to govern the services that BCBSM would provide to the Plan. *Id.* at PageID.9 ¶ 40. Wesco and BCBSM negotiated

¹ Solely for purposes of this motion to dismiss, Defendant cites to and relies on the allegations in the Complaint. But Defendant does not concede the accuracy of any such allegations and specifically reserves its rights to contest the truth of any allegations.

² BCBSM attaches to this motion as Exhibits A and B the operative ASC and relevant amendment between BCBSM and Plaintiff Wesco, given that Plaintiffs rely upon and incorporate the parties’ contracts into the Complaint. *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.”) (internal citation and quotation omitted); *Jiangbo Zhou v. Lincoln Elec. Co.*, No. 1:20-CV-00018, 2020 WL 2512865, at *4 (S.D. Ohio May 15, 2020) (“[T]he Sixth Circuit has taken a liberal view of what matters fall within the pleadings for purposes of Rule 12(b)(6).”) (citing *Armengau v. Cline*, 7 F. App’x 336, 344 (6th Cir. 2001)); *see* ECF No. 1, Page ID.9-10 ¶¶ 40–42 (“Under the ASC, BCBSM had discretionary authority

and renewed or amended the ASC annually. *Id.* at Page ID.9 ¶ 41. Plaintiffs' Complaint raises two causes of action under ERISA: (i) BCBSM allegedly engaged in prohibited transactions in violation of 29 U.S.C. § 1106, and (ii) BCBSM allegedly breached its fiduciary duties in connection with those transactions. *See id.* at PageID.34-40 ¶¶ 139–58.

First, Plaintiffs allege that BCBSM engaged in prohibited transactions under ERISA through its SSP. *See id.* at PageID.34-36 ¶¶ 139–49. The SSP is a cost-savings program that combats excessive charges submitted by providers not contracted with BCBSM for health services rendered to Plaintiffs' employees. *Id.* at PageID.21-22 ¶¶ 92–94. For those services, with the Plaintiffs' express written agreement, BCBSM retained 30% of the amount saved. *Id.* at PageID.22 ¶ 95. If the SSP did not save any amount, no fee was charged to the customer. *See id.* at PageID.22, 33, 35 ¶¶ 93–95, 135, 143.

Plaintiffs allege that BCBSM enrolled self-funded plan customers in the SSP rather than fix its claims processing system that “regularly” pays providers for claims that contain errors. ECF No. 1, PageID.19-20 ¶ 85. Plaintiffs claim that

and control over management and administration of the Plan, was responsible for interpreting the Plan's terms, calculating benefits, deciding whether to grant or deny claims on Wesco's and its Plan's behalf, and ultimately paying providers from Plan assets.”).

these errors include “duplicate bills, unbundled claims, upcoded claims or claims with the incorrect code billed,” which Plaintiffs allege are “non-exclusive examples of known errors presently existing in BCBSM’s claims processing systems for its self-funded plan customers.” *Id.* at PageID.19-20 ¶¶ 85–86.

Plaintiffs allege that BCBSM developed the SSP to “profit” from these processing errors and otherwise purposely overpaid providers so that BCBSM could then recover the payments through the SSP. *Id.* at PageID.22-23 ¶¶ 96, 99.

Second, Plaintiffs allege that BCBSM breached its fiduciary duties by mismanaging claims payments and then receiving fees by recovering those payments through the SSP. *See id.* at PageID.37-40 ¶¶ 150–58. Plaintiffs claim that the “known” processing errors in the BCBSM system resulted in BCBSM overpaying providers using Plan assets and Class members’ plan assets so that it could profit from recoveries under the SSP. *Id.* at PageID.19-22 ¶¶ 85–86, 89, 92–93. Plaintiffs acknowledge that BCBSM informed them about the SSP system but now claim that BCBSM “failed to fully inform and disclose all relevant and material information” about the SSP. *Id.* at PageID.21, 28 ¶¶ 91, 114.

Wesco terminated this relationship with BCBSM in December 2022. *Id.* at Page ID.9 ¶ 41. Pursuant to the ASC contract provisions, in May 2025, following the 24-month Termination Assistance Period, BCBSM issued a final settlement and refund to Wesco. *See* Exhibit A at Art. IV § B.6; Exhibit C (“ASC Refund

Summary” issuing refund for \$81,853 to Plaintiffs). The parties expressly agreed in the ASC that this final payment would “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” the ASC. Exhibit A at Art. IV § B.6.

Similarly, the parties agreed in the ASC Refund Summary that this final payment would “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 Group and BCBSM and arising under the” ASC. Exhibit C.³

³ In addition to the ASC, the Court can consider the release in connection with this motion to dismiss because the Complaint, in the proposed class exclusion, specifically refers to releases of BCBSM from claims relating to the SSP and because Plaintiffs’ membership in the proposed class, *i.e.*, their standing to bring the claims asserted in the Complaint, are clearly “central.” *See Carrier*, 673 F.3d at 441 (“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.”) (internal citation and quotation omitted).

LEGAL STANDARD

The motion to dismiss for failure to state a claim is “one important mechanism for weeding out meritless [ERISA] claims.” *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 425 (2014). “[A] complaint does [not] suffice if it tenders ‘naked assertion[s]’ devoid of ‘further factual enhancement.’” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (internal citations omitted). This “demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation” or “labels and conclusions.” *Id.* Instead, the “[f]actual allegations must be enough to raise a right to relief above the speculative level[.]” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). Accordingly, a complaint must “possess enough heft” to establish “something beyond the mere possibility” of a violation. *Id.* at 557–58.

Moreover, while ERISA’s statutes of limitation and repose are affirmative defenses, a court can dismiss a complaint as untimely when those defenses are apparent from the face of the complaint. *See Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 547–48 (6th Cir. 2012).

ARGUMENT

I. THE COMPLAINT SHOULD BE DISMISSED BECAUSE PLAINTIFFS’ CLAIMS HAVE BEEN RELEASED

A plaintiff must have standing to bring claims on behalf of a class. *See Fox v. Saginaw Cnty., Michigan*, 67 F.4th 284, 300 (6th Cir. 2023); *Norman v. FCA US, LLC*, 696 F. Supp. 3d 359, 375 (E.D. Mich. 2023) (dismissing class action

complaint where plaintiffs lacked standing). It also is axiomatic that a federal district court lacks subject matter jurisdiction over released claims. *Stanley v. George Washington Univ.*, 394 F. Supp. 3d 97, 106–07 (D.D.C. 2019), *aff'd*, 801 F. App'x 792 (D.C. Cir. 2020) (dismissing ERISA class action where plaintiff signed agreement releasing claims).

Here, Plaintiffs seek to represent a class of “All Self-Funded Plans and their Plan Sponsors from whom BCBSM has collected any SSP fees.” ECF No. 1, PageID.29 ¶ 122. Excluded from this class are “Self-funded Plans and their Plan Sponsors that have settled or released claims against BCBSM alleging violations of ERISA for BCBSM’s SSP fees.” *Id.* at PageID.30 ¶ 125. Plaintiffs lack standing and their claims should be dismissed for two reasons.

First, Plaintiffs are excluded from the class they propose because, as discussed above, the ASC provided for a mutual release upon the final payment between the parties and because the parties executed releases that apply to “*any and all claims* that are known, unknown, . . . and owing between the parties and *arising under this Contract.*” Exhibit A at Art. IV § B.6 (emphasis added); *see* Exhibit C.⁴ In other words, Plaintiffs fall into the very exclusion they used to

⁴ Plaintiffs further assented to the mutual release contained in Exhibit C by accepting the refund of \$81,853. *See* Exhibit D (wire transfer confirmation for final payment). *Michaelian v. Lawsuit Fin., Inc.*, No. 17-13321, 2019 WL 1281953, at *8 (E.D. Mich. Mar. 20, 2019) (“While a signature ordinarily shows

define their proposed class and are therefore not members of the class on whose behalf they seek to bring claims. *See Gilvin v. FCA USA, LLC*, No. 1:18-CV-107, 2019 WL 4941847, at *3 (S.D. Ohio Oct. 8, 2019) (“It is axiomatic that a plaintiff must be a member of the class defined in the complaint for the class to be legally viable.”), *report and recommendation adopted, Gilvin v. FCA US, LLC*, No. 1:18-cv-107, 2019 WL 6117306 (S.D. Ohio 2019); *see also Fox*, 67 F.4th at 300 (holding that plaintiff “may not pursue this class action” when he lacked standing).

Second, the release agreements cover claims for fees under the SSP, and the Court thus lacks subject matter jurisdiction over Plaintiffs’ claims. *Stanley*, 394 F. Supp. 3d at 106, 110–11 (“The Court lacks subject matter jurisdiction over released claims.”) (citing *Aulenback, Inc. v. Fed. Highway Admin.*, 103 F.3d 156, 161 (D.C. Cir. 1997)). Michigan state law governs the scope of the releases. *Dotson v. Arkema, Inc.*, No. 08-CV-13118, 2009 WL 499149, at *4–5 (E.D. Mich. Feb. 26, 2009), *aff’d*, 397 F. App’x 191 (6th Cir. 2010). “Under Michigan law, ‘[t]he scope of a release is controlled by the language of the release, and where ... the language is unambiguous, [courts] construe it as written.’” *Taylor v. Visteon*

assent, a valid and enforceable agreement can exist without a signature [such that parties] may be bound by the terms of an unsigned contract when their actions demonstrate assent to the agreement.”) (quoting *Select Rehab., LLC v. Sana Health, Inc.*, No. 17-13734, 2018 WL 2009578, at *3–4 (E.D. Mich. Apr. 30, 2018)).

Corp., 149 F. App'x 422, 424 (6th Cir. 2005) (quoting *Adair v. State*, 680 N.W.2d 386, 399 (Mich. 2004); *see also Gortney v. Norfolk & W. Ry. Co.*, 549 N.W.2d 612, 614 (Mich. Ct. App. 1996)).

The phrase “any and all claims” used in the releases is broad. *Dresden v. Detroit Macomb Hosp. Corp.*, 553 N.W.2d 387, 390 (Mich. Ct. App. 1996); *see also Ankerman v. Am. Equity Mortg., Inc.*, No. 1:08-CV-1103, 2009 WL 1212820, at *2–3 (W.D. Mich. Apr. 30, 2009) (granting motion to dismiss claims where contract released “any and all claims” arising from the loan documents). The releases apply to Plaintiffs’ claims which are based on services under the ASC, *i.e.*, claims processing and the SSP—and thus necessarily arise under the ASC. *See supra* Background; ECF No. 1, PageID.2, 9-10, 13 ¶¶ 2, 4–5, 40, 42, 57. Because Plaintiffs released their claims against BCBSM, in the ASC and final settlement, the Court lacks subject matter jurisdiction and should dismiss the complaint. *Stanley*, 394 F. Supp. 3d at 110–11 (class action dismissed for lack of subject matter jurisdiction because claims were released).

In any event, courts dismiss ERISA claims, including breach of fiduciary duty claims, where, as here, an agreement clearly and unambiguously releases “any and all” claims. *See, e.g., Taylor*, 149 F. App'x at 425, 427 (affirming dismissal of ERISA breach of fiduciary duty claims where plaintiff agreed to waive “any and all rights or claims of any kind” in settlement agreement); *see also Halvorson v.*

Boy Scouts of Am., No. 99-5021, 2000 WL 571933, at *2 n.2, *3 (6th Cir. 2000) (affirming grant of summary judgment for defendants on ERISA claims where plaintiff released “any and all other liabilities and claims”); *Scott v. Ameritech Publ’g, Inc.*, No. 12-CV-12469, 2015 WL 14075290, at *4 (E.D. Mich. Mar. 18, 2015) (denying motion to re-open case where “any and all claims” were released).⁵

II. PLAINTIFFS’ CLAIMS ARE UNTIMELY

Breach of fiduciary duty and prohibited transaction claims under ERISA must be brought within six years after the alleged breach or violation occurred. 29 U.S.C. § 1113(1). This is referred to as ERISA’s statute of repose. *Intel Corp. Inv. Pol’y Comm. v. Sulyma*, 589 U.S. 178, 180 (2020). This period is shortened to three years, however, when a plaintiff has “actual knowledge of the breach or violation.” 29 U.S.C. § 1113(2). This is referred to as ERISA’s statute of limitations. *Intel Corp.*, 589 U.S. at 181. To satisfy the actual knowledge requirement, the plaintiff only needs to have “knowledge of the facts or

⁵ As discussed above, the ASC and releases are incorporated into the Complaint and can be considered for purposes of this motion to dismiss. *See supra* n.2. If the Court finds that the release is outside the scope of the pleadings and converts this motion into one for summary judgment, *see Lockhart v. Gainwell Techs. LLC*, No. 2:23-cv-12335, 2024 WL 3909558, at *2 (E.D. Mich. Aug. 22, 2024), Plaintiffs’ Complaint should still be dismissed because there is no genuine dispute of material fact as to whether Plaintiffs’ claims survive considering the release, and BCBSM is therefore entitled to judgment as a matter of law.

transaction that constituted the alleged violation; it is not necessary that the plaintiff also have actual knowledge that the facts establish a cognizable legal claim under ERISA in order to trigger the running of the statute.” *Diederichs v. FCA US LLC*, No. 23-CV-11287, 2024 WL 5168087, at *6 (E.D. Mich. Dec. 19, 2024) (quoting *Wright v. Heyne*, 349 F.3d 321, 330 (6th Cir. 2003)).

The Complaint, which was filed on June 9, 2025, alleges that BCBSM breached its fiduciary duties under ERISA by improperly compensating itself under the SSP each time BCBSM obtained a cost-savings for Plaintiffs. *See, e.g.*, ECF No.1, PageID.1-4 ¶¶ 1, 5, 12; *id.* at PageID.18 ¶ 76; *id.* at PageID.26 ¶ 110 (listing examples of shared savings payments that Plaintiffs claim were improper). Each SSP recovery is its own individual claim that must comply with the relevant statutes of limitation and repose. *See* ECF No. 1, PageID.36 ¶ 148. Moreover, the continuing violation doctrine cannot apply here because Plaintiffs’ claims challenge specific transactions. *See Cassell v. Vanderbilt Univ.*, 285 F. Supp.3d 1056, 1068 n.8 (M.D. Tenn. 2018) (noting that the continuing violation doctrine does not apply to prohibited transaction claims). The doctrine also does not apply to the three-year statute of limitations because of knowledge on the part of the plaintiff. *See Clarke v. Pilkington N. Am., Inc.*, No. 21-12119, 2022 WL 4483817, *2–4 (E.D. Mich. Sept. 27, 2022).

The Complaint itself establishes that Plaintiffs' SSP recovery claims are barred by ERISA's three-year statute of limitations. In this regard, Plaintiff acknowledges that the program was disclosed to plan sponsors, including Wesco. ECF No. 1, PageID.28 ¶ 114. In addition, Wesco had knowledge of specific recoveries on behalf of the Plan because they are listed in the Complaint. *Id.* at PageID.26 ¶ 110. Indeed, this allegation had to have been based on monthly invoices and other data Plaintiffs received, including information about any recoveries under the SSP. *See, e.g.*, Exhibits E–P (monthly Wesco invoices).⁶ Wesco, as the sponsor of the Plan, had a duty to monitor BCBSM's recoveries and thus can be presumed to have reviewed that information when it was received. *See* ECF No. 1, PageID.15 ¶ 68; *see also In re AEP ERISA Litig.*, 327 F. Supp. 2d 812, 832 (S.D. Ohio 2004) (explaining that plan sponsor must “ensure that [BCBSM's] performance [was] in compliance with the terms of the plan and statutory standards”) (quoting 29 C.F.R. § 2509.75–8).

The ASC was terminated in December 2022, and each of the SSP recoveries identified in the Complaint occurred more than three years before the Complaint

⁶ The monthly invoices are incorporated into the Complaint and can be considered by the Court for purposes of the motion to dismiss because Plaintiffs offer four alleged “[e]xample[.]” payments. *See* ECF No. 1, PageID.26 ¶ 110; *supra* n.2.

was filed. *See* Exhibits E–P. Wesco’s claims asserted in the Complaint are thus untimely. *See, e.g., Clarke*, 2022 WL 4483817, at *2–3, *6 (dismissing ERISA claims because statute of limitations defense was apparent from face of complaint).

At a minimum, claims related to any alleged payments made before June 9, 2019, are barred under ERISA’s statute of repose because those claims must be but were not brought within six years of the alleged breach. *Intel Corp.*, 589 U.S. at 180. Such claims should be dismissed for this additional reason.

III. THE COMPLAINT SHOULD BE DISMISSED BECAUSE IT DOES NOT PLEAD BREACHES OF FIDUCIARY DUTY OR PROHIBITED TRANSACTIONS

Under ERISA, a fiduciary is prohibited—with various exemptions—from dealing with Plan assets for his own interest or account. 29 U.S.C. § 1106(b)(1). Plaintiffs claim that the SSP recoveries were prohibited transactions under ERISA because each recovery was “calculated off [BCBSM’s] own mismanagement of Plaintiffs and Class members’ assets” and “the more improper adjudications or other errors BCBSM performed or allowed on the front end, the more fees BCBSM collected on the back end.” *See* ECF No. 1, Page ID.35 ¶¶ 143–44. But Plaintiffs failed to proffer any allegations establishing that any SSP recoveries on behalf of the Plan were the result of an intentional overpayment or a processing error.

Instead, Plaintiffs allege that there were a variety of processing errors that could have occurred and then speculate that the errors could have been the basis of one of their SSP recoveries. For example, the Complaint alleges that “BCBSM’s internal claims processing systems for its self-funded plans regularly pay claims that have the following errors, among others: duplicate bills, unbundled claims, upcoded claims or claims with the incorrect code billed, claims for medically unlikely services, and claims that do not adhere to standard payment guidelines[.]” *See id.* at PageID.19-20 ¶ 85. The Complaint asserts that BCBSM should not allow such alleged errors or pay such claims. *See id.* at PageID.20 ¶ 86. But Plaintiffs fail to allege any facts tying any such alleged errors to the Plan, let alone to any SSP recoveries or payments with respect to the Plan. Moreover, statements of what BCBSM “should” and “should not” do, without more, are insufficient to establish a breach of fiduciary duty. *Twombly*, 550 U.S. at 557–58 (something beyond the “mere possibility” of a violation is required to state a claim).

Elsewhere, Plaintiffs allege that “BCBSM knowingly uses its internal claims-processing systems to regularly mis-adjudicate, mismanage, and/or otherwise cause its self-funded customers to pay improper claims—or to allow those errors to occur—costing BCBSM’s self-funded customers and their plans (including Plaintiffs and the Class members) hundreds of thousands (if not millions) of dollars.” ECF No.1, PageID.18 ¶ 79. But Plaintiffs do not allege any

specific instances of mismanagement with respect to the Plan. Instead, the Complaint points to Plaintiffs' counsel's own litigation expert report in a different case, *see id.* at PageID.19 ¶ 84, and speculates that all self-funded plans experienced improper payments, *see id.* at PageID.21 ¶¶ 87–88. But Plaintiffs never allege that any improper payments were made using Plan funds, much less that any led to an SSP recovery.

Further, any claim that BCBSM breached its fiduciary duty cannot be based on alleged processing errors because the Complaint does not allege that there were any such claims processing errors with respect to Wesco. Such claims also would fail because the Complaint does not allege facts showing how claims processing errors constitute a breach of fiduciary duty.

Indeed, the Complaint does not allege facts about the supposed standard a prudent fiduciary would have to meet for claims processing, let alone facts showing how BCBSM allegedly fell short of that standard. Instead, the Complaint baldly alleges based on a purported expert report from another case that “BCBSM’s internal claims processing systems for its self-funded plans regularly pay claims that have [various enumerated] errors[.]” *See, e.g.*, ECF No.1, PageID.19-20 ¶ 85. But the fiduciary duty of care “requires prudence, not prescience,” *DeBruyne v. Equitable Life Assurance Soc’y of U.S.*, 920 F.2d 457, 465 (7th Cir. 1990) (internal citation omitted), and merely pointing to processing

errors is not sufficient to allege a breach of fiduciary duty, *see Senior Lifestyle Corp. v. Key Benefit Adm'rs, Inc.*, No. 1:17-cv-02457, 2020 WL 2039928, at *13 (S.D. Ind. Apr. 28, 2020) (“[T]here is no evidence that KBA acted imprudently when it paid the erroneous claims.”).

Accordingly, the Complaint fails to plead a breach of fiduciary duty under ERISA. *See, e.g., id.; see also Iqbal*, 556 U.S. at 678 (noting that “the-defendant-unlawfully-harmed-me” allegation is insufficient to plead a claim).

CONCLUSION

For the foregoing reasons, the Court should dismiss the Complaint in its entirety, with prejudice.

Dated: July 14, 2025

Respectfully submitted,

ALLEN OVERY SHEARMAN STERLING
US LLP

By: s/ Daniel Lewis

Daniel Lewis (Adm. in E.D. MI, NY Reg. 4084810)

Jeffrey D. Hoschander (Adm. in E.D. MI, NY Reg. 4496337)

599 Lexington Avenue

New York, NY 10022

Telephone: +1.212.848.4000

Facsimile: +1.202.508.8100

daniel.lewis@aoshearman.com

jeff.hoschander@aoshearman.com

Todd M. Stenerson (P51953)

1101 New York Avenue, NW

Washington, DC 20005

Telephone: +1.202.508.8093
Facsimile: +1.202.661.7484
todd.stenerson@aoshearman.com

ZAUSMER, P.C.

By: s/ Mark J. Zausmer
Mark J. Zausmer (P31721)
Michael A. Schwartz (P74361)
Nathan S. Scherbarth (P75647)
Jason M. Schneider (P79296)
32255 Northwestern Hwy., Ste. 225
Farmington Hills, MI 48334
Telephone: +1.248.851.4111
Facsimile: +1.248.851.0100
mzausmer@zausmer.com
mschwartz@zausmer.com
nscherbarth@zausmer.com
jschneider@zausmer.com

Attorneys for Defendant

Exhibit A



Index Only Cover Sheet

Imaging & Support Services Cover Sheet

DEPARTMENT NAME:	Group PHI & Contracts
MAIL CODE:	514F
SCAN FORM TYPE:	Primary Index Only – Group PHI & Contracts
DATE SUBMITTED:	02/09/2016

Indexing Information

Customer ID: 270574

Group Type: ASC

Document Type: ASC_CONTRACTS

Document Year: 2015

e104851 07:18:25



"We don't claim to support. We do."

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CID-270574
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Administrative Services Contract -MOS Monthly Cap Program

WESCO Inc.

RECEIVED
7/16/25

This Contract commences on December 1, 2015 (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 WESCO Inc. with offices at 1460 Whitehall Road, Muskegon, MI 49445 ("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-

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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 – MOS Monthly Cap 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 Part C - 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. "Estimated Outstanding Liability (EOL)" means an estimate of the Group's future liability, including but not limited to, IBNR Claims which will be paid by BCBSM on behalf of the Group during the Transition Assistance Period and which is the Group's obligation to pay pursuant to the provisions of this Contract.
- M. "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.
- N. "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.
- O. "Monthly Cap" means the monthly amount as determined by BCBSM that Group will pay during the term of this Contract, subject to settlement and reconciliation in any given month as determined by BCBSM for each Contract year.
- P. "PPACA" means the Patient Protection and Affordable Care Act, as amended, Public Law 111-148 of 2010, *et seq.*, and regulations promulgated thereunder.
- Q. "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.
- R. "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.
- S. "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 make 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 actual 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. \$20,000 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 actual 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 actual 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 actual 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 shall obtain BCBSM's consent to the use of any independent third party auditor that Group wishes to perform the audit, such consent not to be unreasonably withheld. 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 actual 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. BCBSM agrees to release the claim information provided that Group and its third-party representatives receiving such information sign a confidentiality agreement containing reasonable and appropriate terms.
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, Advance Deposits, Monthly Cap, other 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 actual 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 full payment to BCBSM within ten (10) business days after the date of BCBSM's monthly invoice. Such invoice shall include the lesser of (1) BCBSM's administrative fees, additional administrative compensation, if any, stop-loss fees (if applicable), amounts that BCBSM determines are necessary to maintain the Advance Deposit, if any, hospital advance, Amounts Billed, and any other amounts owed by Group pursuant to this Contract; or (2) the Monthly Cap. BCBSM may add any amount that is greater than the Monthly Cap in any one particular month to any subsequent invoice where the amount due is less than the Monthly Cap, but in no event will such invoice be greater than the Monthly Cap set forth in Schedule A, except any deficit at the end of the plan year is due with payment of the final invoice for the Contract period. BCBSM may cease to process Claims retroactive to the last date for which full payment was made.

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 (2%) 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.

C. Interest.

Pursuant to the instructions in Schedule A, Group shall make payments 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.

Sixty (60) 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. Settlements.

1. Annual Settlements. Group shall receive its Annual Settlement approximately one hundred twenty (120) days after the end of each Contract Year. Amounts owed to Group or BCBSM shall be identified in the Annual Settlement and included in the next monthly invoice.

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.

F. 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 material 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 first day of the 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.

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 twenty-four (24) months after the TAP Effective Date, Group shall make monthly payments in the same manner as prior to the TAP Effective Date, however, Group shall pay the fixed administrative fee only for the first two months after the date of termination. AAC, if any, will continue to be paid for the TAP. After six months from the TAP Effective Date, BCBSM shall offset any Amounts Billed against the Advance Deposit and 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 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 rolling twelve-month average of the 90-day T-Bill 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 Calculation and Notifications of EOL. Within ninety (90) days after the expiration of the Transition Assistance Period, BCBSM will prepare a final settlement of the EOL 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 actual 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 EOL 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.

BCBSM agrees to indemnify, defend and hold Group harmless from any claims directly resulting from BCBSM's grossly negligent performance or failure to perform any obligation or duty specifically delegated to BCBSM in 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.

<p>If to Group:</p> <p>Current address shown on BCBSM Group Header</p>	<p>If to BCBSM:</p> <p>Blue Cross Blue Shield of Michigan 600 Lafayette East, Mail Code B612</p>
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E. Bankruptcy.

Neither BCBSM nor any other BCBS Plan shall have any obligation to continue paying Claims in the event of Group's bankruptcy or other insolvency. BCBSM, in its sole discretion, may continue paying Claims in such instance. Detroit, Michigan 48226-2998

F. 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.

G. 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.

H. 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.

I. 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.

J. 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.

K. Surcharges and Taxes.

The Federal government or various states may impose health related surcharges or taxes with respect to medical services or Claims to cover the cost of, but not by way of limitation, indigent care or graduate medical education. Group acknowledges that such surcharges or taxes may be added to the cost of Claims or separately invoiced to Group. Group shall pay such surcharges or taxes.

L. Advisors.

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

M. 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.

N. 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.

O. 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.

P. 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.

Q. 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.

R. 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.

S. 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.

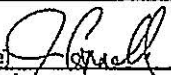
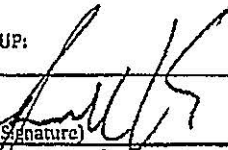
Neither party has executed this Contract in reliance on any representations, warranties, or statements other than those expressly set forth herein.

T. 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: <u>Anthony P. Connelly</u> (Print)	Name: <u>Russell Kapa</u> (Print)
Title: <u>SVP, Varsity Group Business</u>	Title: <u>HR DIRECTOR</u>
Date: <u>02/02/16</u>	Date: <u>1/22/16</u>

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

ASC MOS Monthly Cap Program - January 2015

16

2/5/2016 10:54 AM

Exhibit B

600 E. Lafayette Blvd.
Detroit, MI 48226-2998
bcbsm.com



December 21, 2021

WESCO
1460 Whitehall Road
Muskegon, MI 49445

▶ Please Sign and Return

Re: Schedule A and Stop Loss Extension through 12/31/21

Dear Russell:

This letter documents the agreement between Blue Cross Blue Shield of Michigan ("BCBSM") and WESCO INC. CID 270574("Group") to extend the term of the enclosed Schedule A and Stop Loss Exhibit to the administrative services contract through December 31, 2021.

Please indicate Group's acceptance of this extension by signing below.

Sincerely,

Griffin Cobean

Griffin Cobean
Sales Manager
West Shore Sales

Group Signer:

INSTRUCTION FOR GROUP:

← Insert ink or digital signature here and update Group Signer information below

M L H


Group Signer Name

Title *Co-President, WESCO*

Signed Date

12/22/21

Enclosure

 <p>Blue Cross Blue Shield Blue Care Network of Michigan</p> <p><small>Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association</small></p>	<h2 style="margin: 0;">GROUP SIGNATURE PAGE</h2> <p style="margin: 5px 0 0 0;">For Effective 12/01/2020 – 11/30/2021</p>
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**Between Blue Cross Blue Shield of Michigan and
WESCO INC (CID - 270574)**

Group and Blue Cross Blue Shield of Michigan agree to sign the specified documents checked-off below ("Documents") via this Group Signature Page. Also included are the 2020 Exhibit 1 to Schedule A (Value-Based Provider Reimbursement), the 2020 Schedule B BlueCard Disclosures, and the 2020 Stop Loss Policy (if applicable).

Each party's Signature is the legal equivalent of a manual / handwritten signature on the specified Documents. By providing their Signatures below, the parties are legally bound by the terms and conditions in the Documents. Group agrees that no certification authority or other third-party verification is necessary to validate Group's Signature, and that the lack of such certification or third-party verification will not in any way affect the enforceability of Group's Signature or the Documents.

Documents Included:

- ASC Contract Amendment
- Schedule A**
 - Exhibit 1 to Schedule A
 - Exhibit 2 to Schedule A
- **Schedule B**
 - Exhibit 1 to Schedule B

Stop-Loss Insurance

- **Stop-Loss Policy**
- Stop-Loss Exhibit**

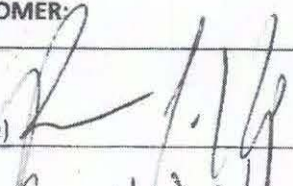
REQUIRES GROUP SELECTION (Specific Stop Loss Only)	
Group is electing Specific Stop-Loss	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<i>"Run-Out" Coverage:</i>	
<small>Policyholder Initials:</small>	rk

- Amendment to Stop-Loss Insurance**

Upon signature by the parties, this page will be electronically attached to the Documents and stored for reference and record. Group may review this documentation by requesting a copy from their BCBSM salesperson.

BLUE CROSS BLUE SHIELD OF MICHIGAN:

GROUP CUSTOMER:

By: (Signature) DocuSigned by: Jeff Connolly 5C17E52FE0EB42B...	By: (Signature) 
Name: (Print) Jeff Connolly	Name: (Print) Russell W. Kopp
Title: SVP & President, WMUP	Title: Senior Director Professional Services
Date: 1/4/2021	Date: 12/21/20

Blue Cross Blue Shield of Michigan
SCHEDULE A – Renewal Term (Effective 12/01/2020 thru 11/30/2021)
Administrative Services Contract (ASC)

- 1. **Group Name** WESCO INC
- 2. **Customer ID** 270574
- 3. **ASC Funding Arrangement** Weekly Wire

4. **Line(s) of Business and Products**

Line of Business	Applicable
Facility	X
Facility Foreign	
Facility Domestic	
Professional	X
Prescription Drugs	X
Dental	X
Vision	X
Hearing	

Products	Applicable
Flexlink	

5. **Administrative Fees**

The below administrative fees cover the Lines of Business and Products checked in Section 4 above, unless otherwise indicated.

A. Fixed Administrative Fees	Admin Fee Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Admin Fee	Effective Start Date	Effective End Date
i. 2020 Base Admin Fee	\$53.88	257	\$13,847.16	12/01/2020	11/30/2021

B. **Variable Administrative Fees – Not Applicable**

- 6. **Data Feeds – Not Applicable**
- 7. **Hospital Advance - Not Applicable**
- 8. **Advanced Deposit Monthly Cap Amount – Not Applicable**
- 9. **BCBSM Account**

1840-09397-3	Comerica	0720-00096
Wire Number	Bank	American Bank Association

10. **Late Payment / Interest Charges**

- A. Late Payment Charge 2%
- B. Health Care Provider Interest Charge 12%

11. Buy-Ups

Program	Pricing Method	Unit Price	Unit Volume	Amount	Effective Start Date	Effective End Date
Online Visits	PCPM	\$0.20	257	\$51.40	12/01/2020	11/30/2021

12. Shared Savings Programs

BCBSM has implemented programs to enhance the savings realized by its customers. As stated below, BCBSM will retain as administrative compensation a percent of the recoveries or cost avoidance. Administrative compensation retained by BCBSM through the Shared Savings Program will be available through reports obtained on eBooksHelf:

Program:	BCBSM Retention of:	
A. Pre-Payment Forensic Billing Review:	30%	Cost avoidance of improper hospital billing identified by third party vendor(s) through forensic pre-payment billing review.
B. Advanced Payment Analytics:	30%	Recoveries of claims overpayments identified by third party vendor(s) using proprietary data mining analytics and enhanced reviews.
C. Subrogation:	30%	Recoveries of claims overpayments from subrogation efforts.
D. Provider Credit Balance Recovery:	30%	Recoveries of claims overpayments obtained by third party vendor(s) through enhanced review of hospital patient accounting systems.
E. Non-Participating Provider Negotiated Pricing:	30%	Cost avoidance for out-of-network, non-participating Claims equal to the difference between the amount that would have been paid pursuant to the Group's benefit design (before Enrollee cost-share is applied) and the amount actually paid for such Claims (before Enrollee cost-share is applied) as a result of third-party vendor negotiations or benchmark-based pricing.
F. Rebate Service Fee for Medical Prescription Drugs:	10%	Medical benefit drug rebates on Claims incurred in the renewal term net of the Rebate Administrator Fee. The Rebate Administrator Fee is 5.25% of gross rebates for medical benefit drug Claims.
G. Rebate Service Fee for Pharmacy Prescription Drugs:	10%	Pharmacy benefit rebates on Claims incurred in the renewal term net of the Rebate Administrator Fee charged and retained by the Rebate Administrator. The Rebate Administrator Fee is (i) 3% of gross rebates for BCBSM clinical formulary, custom formulary, and custom select formulary drug Claims, including specialty drug Claims and (ii) 8.2% of gross rebates for Part D formulary drug Claims, including Part D specialty drug Claims.

13. Traditional Prescription Drug Pricing and Administrative Compensation

BCBSM has negotiated pricing for prescription drugs with its pharmacy benefit manager (“PBM”). Group acknowledges and agrees the amount BCBSM pays PBM for a prescription drug may be more or less than the amount Group pays BCBSM for such prescription drug. Enrollee coinsurance will be calculated based on the amount Group pays BCBSM for the prescription drug.

In addition to any other administration compensation paid to BCBSM by Group, BCBSM shall retain as administrative compensation as follows for the above Traditional Prescription Drug Pricing arrangement (“Traditional Rx Drug Pricing Admin Fee”):

- a. Up to one (1) percentage point of the aggregated AWP discount BCBSM receives from its PBM for drugs classified by BCBSM as retail (excluding mail order) brand drugs; and
- b. Up to four (4) percentage points of the aggregated AWP discount BCBSM receives from its PBM for drugs classified by BCBSM as retail or mail order generic drugs.

BCBSM’s actual Traditional Rx Pricing Admin Fee depends on Group’s prescription drug utilization, drug mix, pharmacy choice, and a pharmacy’s usual and customary charges. BCBSM will credit Group with any amount that was collected during the Contract Year that exceeds the amounts specified in (a) and (b) above. The amount retained by BCBSM as administrative compensation will be reported to the Group.

Group agrees to timely incorporate language into Group’s Summary Plan Description or equivalent document that any Enrollee cost-sharing that is calculated as a percentage will be based upon the amount Group pays BCBSM for the prescription drug.

14. 3rd Party Rx Vendor Fee

If Group’s prescription drug benefits are administered by a third-party vendor, BCBSM will charge Group an administrative fee of \$5.00 per contract per month due to the additional costs and resources necessary for BCBSM to effectively manage and administer the medical benefit without administering the prescription drug benefit.

15. 3rd Party Stop-Loss Vendor Fee

If Group obtains stop-loss coverage from a third-party stop-loss vendor, BCBSM will charge an additional fee of \$8.00 per contract per month due to the additional costs and resources necessary for BCBSM to effectively manage Group’s benefits.

16. Agent Fees

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 BCBSM, please refer to that agreement for fees and details.

17. Medicare Contracts

If Group has Medicare contracts that are being separated from the current funding arrangement, all figures within the current funding arrangement will be adjusted.

18. Compensation Agreement with Providers

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 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.

BCBSM Quality Programs may also include risk sharing arrangements with certain provider entities ("PE"), e.g., physician organizations, facilities, health systems, or any combination thereof, that have contracted with BCBSM for upside and downside risk for a performance year. The PE's performance will be measured by comparing its total cost of care trend for attributed members to BCBSM's statewide total cost of care trend which may be equated to a per member per month amount. BCBSM will calculate each PE's performance approximately 11 months after the end of a performance year.

If the PE's performance results in a payment of additional reimbursement, Group may be invoiced an additional amount based on its attributed membership to that PE. If the PE's performance results in a return of reimbursement, Group may receive a credit based on its attributed membership to that PE. BCBSM will provide Group with supporting documentation for such amounts. Invoice or credit to Group will occur in conjunction with BCBSM's customer savings refund process as set forth in the administrative services contract.

Notwithstanding the above, in the first year of the program (2020), BCBSM will not invoice Group for any additional reimbursement earned by a PE. Moreover, reimbursement returned to BCBSM will be used to offset any additional reimbursement earned by a PE in the following year. BCBSM will not retain any amounts resulting from such risk sharing arrangements.

See Exhibit 1 to Schedule A and Schedule B to ASC for additional information.

19. Out-of-State Claims

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 to Schedule A for additional information.



EXHIBIT TO THE STOP-LOSS COVERAGE POLICY

Policyholder: **WESCO INC**

Customer ID: **270574** Policy Period: **12/01/2020** through **11/30/2021**

The specifications below shall become effective on the first day of the Policy Period specified above and shall continue in full force and effect until the earliest of the following: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Exhibit is superseded in whole or in part by a later executed Exhibit.

A. AGGREGATE STOP-LOSS INSURANCE

Group did not purchase Aggregate Stop-Loss Insurance.

B. SPECIFIC STOP-LOSS INSURANCE

- | | |
|---|--|
| 1. Claims Covered | Renewal of Existing Coverage: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period. |
| 2. Lines of Business Covered | Medical Claims covered by Stop-Loss Policy |
| 3. Specific (Individual) Attachment Point (per Coverage Unit) | \$145,000 |
| 4. Aggregating Specific Deductible | N/A |
| 5. Monthly Premium (per Coverage Unit) | \$111.65 |
| 6. Number of Coverage Units | 257 |
| 7. "Run-Out" Coverage | <p>To elect "Run-Out" Coverage, Group must check the appropriate box on the Group Signature Page.</p> <p><i>"Run-Out" Coverage applies to claims incurred on or after the Original Effective Date of Policy and paid during the Run-Out Period.</i></p> |

C. ADDITIONAL PROVISIONS TO SPECIFIC STOP-LOSS INSURANCE

SECOND YEAR RATE CAP & NO-NEW LASER

The Company will not change the Specific Premium rate in Item B.5 for the Second Year Policy Period by more than the percentage noted, as long as the Attachment Point remains the same in item B.3 and Aggregating Specific Deductible remains the same in item B.4 per Coverage Unit. The Company will not apply additional lasers in the Second Year Policy Period, referenced in this Section.

Rate Cap:	50%
Second Year Policy Period:	12/01/2021
through	11/30/2022

Exhibit C

Blue Cross and Blue Shield of Michigan ASC Refund Summary



Group: Wesco Inc
Group #: 270574

Explanation for Credit: Final Post Termination Settlement

Ending ASC Balance as of August 31, 2023	(\$20,000)
Claims and Claims Adjustments	(\$2,984)
Administrative Fee	\$0
BCBSM Payment Integrity Share	(\$385)
2023 Customer Savings Refund	(\$8,299)
Pharmacy Rebates	(\$47,537)
Payments Made by Group	\$0
Balance held through December 31, 2024	(\$79,205)
Estimated Outstanding Liability	\$0
Interest Due through Month Day, Year	(\$2,648)
Refund Check Amount	(\$81,853)

Pursuant to the Term and Termination Assistance Article of the Administrative Services Contract, the payment to Group or to BCBSM in the amount shown above 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 Group and BCBSM and arising under the Administrative Services Contract.

Exhibit D

Payment Reference	1026491	Supplier or Party	WESCO INC	Processing Status	Formatted
Paper Document Number	699345	Payee	WESCO INC	Bank Account	XXXXXX0214
Payment Amount	81,853.00	Supplier Number	1000760571	IBAN	
Discount Taken	0.00	Payee Site	MUSKEGON	Bank Name	PNC BANK OHIO
Amount Withheld	0.00	Address	1460 WHITEHILL RD, , Muskegon, MI,	BIC	



Payment File Register

Report Date 05/08/2025
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Payment Date	US, 49445 05/09/2025	Payment Method	Cash Concentration or Disbursement
Maturity Date		Payment Business Unit	Blue Cross Blue Shield of Michigan and Blue Care Network

Invoice Business Unit	Reference Number	Sequence Number	Sequence Name	Unique Remittance Identifier	Document Date	Due Date	Gross Amount to Be Paid	Discount Amount	Withheld Amount	Payment Amount
Blue Cross Blue Shield of Michigan and Blue Care Network	FINAL EOL SETTLEMENT	2134304	BCBSM_ST D_INV		05/07/2025	05/07/2025	81,853.00	0.00	0.00	81,853.00

Exhibit E



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: DECEMBER 2019

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
ADVANCED PAYMENT ANALYTIC	007021637	0000		MEDICAL	[REDACTED]	[REDACTED]		03/01/2019	12/20/2019	296.00	88.80	207.20
								ADVANCED PAYMENT ANALYTIC TOTAL		296.00	88.80	207.20
SUBROGATION	007021637	0000		MEDICAL	[REDACTED]	[REDACTED]	[REDACTED]		10/14/2019	1,496.32	448.90	1,047.42
		0000		MEDICAL	[REDACTED]	[REDACTED]	[REDACTED]		10/16/2019	1,490.06	447.02	1,043.04
		0002		MEDICAL	[REDACTED]	[REDACTED]	[REDACTED]		10/21/2019	2,500.00	750.00	1,750.00
		0002		MEDICAL	[REDACTED]	[REDACTED]	[REDACTED]	09/21/2019	12/06/2019	1,358.87	407.66	951.21
		0002		MEDICAL	[REDACTED]	[REDACTED]	[REDACTED]		10/28/2019	14,256.02	4,276.81	9,979.21
		0007		MEDICAL	[REDACTED]	[REDACTED]	[REDACTED]	07/03/2019	12/13/2019	1,294.79	388.44	906.35
								SUBROGATION TOTAL		22,396.06	6,718.83	15,677.23
								Total All Shared Savings Program		22,692.06	6,807.63	15,884.43

*Administrative Compensation **Credit for claim re-pays

Exhibit F



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: FEBRUARY 2020

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
SUBROGATION	007021637	0007		MEDICAL	██████████	██████████		06/05/2019	10/18/2019	887.10	266.13	620.97
							SUBROGATION TOTAL			887.10	266.13	620.97
							Total All Shared Savings Program			887.10	266.13	620.97

*Administrative Compensation **Credit for claim re-pays

Exhibit G



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: MARCH 2020

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
ADVANCED PAYMENT ANALYTIC	007021637	0000		MEDICAL	[REDACTED]	[REDACTED]		03/01/2019	01/24/2020	-206.31	-61.89	-144.42
ADVANCED PAYMENT ANALYTIC TOTAL										-206.31	-61.89	-144.42
Total All Shared Savings Program										-206.31	-61.89	-144.42

*Administrative Compensation **Credit for claim re-pays

Exhibit H



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: APRIL 2020

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
ADVANCED PAYMENT ANALYTIC	007021637	0000		MEDICAL	[REDACTED]	[REDACTED]		03/01/2019	04/17/2020	-89.69	-26.91	-62.78
ADVANCED PAYMENT ANALYTIC TOTAL										-89.69	-26.91	-62.78
Total All Shared Savings Program										-89.69	-26.91	-62.78

*Administrative Compensation **Credit for claim re-pays

Exhibit I



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: JUNE 2020

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
ADVANCED PAYMENT ANALYTIC	007021637	0002		MEDICAL	██████	██████████		02/10/2020	07/03/2020	106.53	31.96	74.57
		0007		MEDICAL	██████	██████████		11/12/2019	06/19/2020	160.41	48.12	112.29
ADVANCED PAYMENT ANALYTIC TOTAL										266.94	80.08	186.86
SUBROGATION	007021637	0000		MEDICAL	██████	██████████	██████		05/01/2020	1,573.09	471.93	1,101.16
		0007		MEDICAL	██████	██████████		06/19/2019	04/24/2020	334.86	100.46	234.40
		0007		MEDICAL	██████	██████████		07/23/2019	04/24/2020	79.40	23.82	55.58
SUBROGATION TOTAL										1,987.35	596.21	1,391.14
Total All Shared Savings Program										2,254.29	676.29	1,578.00

*Administrative Compensation **Credit for claim re-pays

Exhibit J



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: SEPTEMBER 2020

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
ADVANCED PAYMENT ANALYTIC	007021637	0002		MEDICAL	██████	██████		05/15/2020	09/04/2020	628.52	188.56	439.96
		0007		MEDICAL	██████	██████		05/07/2020	09/04/2020	140.55	42.17	98.38
ADVANCED PAYMENT ANALYTIC TOTAL										769.07	230.73	538.34
SUBROGATION	007021637	0002		MEDICAL	██████	██████		09/21/2019	07/31/2020	395.76	118.73	277.03
		0002		MEDICAL	██████	██████		09/21/2019	09/18/2020	64.51	19.35	45.16
SUBROGATION TOTAL										460.27	138.08	322.19
Total All Shared Savings Program										1,229.34	368.81	860.53

*Administrative Compensation **Credit for claim re-pays

Exhibit K



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: SEPTEMBER 2021

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
ADVANCED PAYMENT ANALYTIC	007021637	0000		MEDICAL	██████	██████████		12/20/2019	09/30/2021	75,105.49	22,531.65	52,573.84
ADVANCED PAYMENT ANALYTIC TOTAL										75,105.49	22,531.65	52,573.84
Total All Shared Savings Program										75,105.49	22,531.65	52,573.84

*Administrative Compensation **Credit for claim re-pays

Exhibit L



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: OCTOBER 2021

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
ADVANCED PAYMENT ANALYTIC	007021637	0007		MEDICAL	██████	██████████		04/16/2019	08/06/2021	45.51	13.65	31.86
							ADVANCED PAYMENT ANALYTIC TOTAL			45.51	13.65	31.86
CREDIT BALANCE AUDIT	007021637	0000		MEDICAL	██████	██████████		10/03/2020	10/22/2021	101.06	30.32	70.74
							CREDIT BALANCE AUDIT TOTAL			101.06	30.32	70.74
Total All Shared Savings Program										146.57	43.97	102.60

*Administrative Compensation **Credit for claim re-pays

Exhibit M



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: FEBRUARY 2022

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
SUBROGATION	007021637	0002		MEDICAL	██████████		██████████		12/06/2021	5,053.24	1,515.97	3,537.27
							SUBROGATION TOTAL			5,053.24	1,515.97	3,537.27
							Total All Shared Savings Program			5,053.24	1,515.97	3,537.27

*Administrative Compensation **Credit for claim re-pays

Exhibit N



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: MARCH 2022

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
SUBROGATION	007021637	0007		MEDICAL	██████		██████		12/13/2021	5,000.00	1,500.00	3,500.00
							SUBROGATION TOTAL			5,000.00	1,500.00	3,500.00
HOSPITAL CREDIT BALANCE	007021637	0000		MEDICAL	██████	██████		02/18/2021	02/25/2022	142.00	42.60	99.40
		0000		MEDICAL	██████	██████		04/01/2021	02/25/2022	142.00	42.60	99.40
							HOSPITAL CREDIT BALANCE TOTAL			284.00	85.20	198.80
							Total All Shared Savings Program			5,284.00	1,585.20	3,698.80

*Administrative Compensation **Credit for claim re-pays

Exhibit O



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: APRIL 2022

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
HOSPITAL CREDIT BALANCE	007021637	0000		MEDICAL	██████	██████████		02/18/2021	07/16/2021	229.76	68.93	160.83
								HOSPITAL CREDIT BALANCE TOTAL		229.76	68.93	160.83
								Total All Shared Savings Program		229.76	68.93	160.83

*Administrative Compensation **Credit for claim re-pays

Exhibit P



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ASC Shared Savings Value Report - Invoice Detail

WESCO INC

007021637

For Month: MAY 2022

Shared Savings Program	Group Number	Division	Department ID	Claim Type	SSN	ICN (Claim ID)	Check Number	Date of Service	Claim Finalized or Check Date	Recovered, Avoided, Check or (Re-Paid) Amount	BCBSM Share of Savings*	Net Group Savings
SUBROGATION	007021637	0000		MEDICAL	██████		██████		03/11/2022	9,136.33	2,740.90	6,395.43
							SUBROGATION TOTAL			9,136.33	2,740.90	6,395.43
ADVANCED EDITING	007021637	0007		MEDICAL	██████	██████		04/14/2022	04/22/2022	68.44	20.53	47.91
							ADVANCED EDITING TOTAL			68.44	20.53	47.91
							Total All Shared Savings Program			9,204.77	2,761.43	6,443.34

*Administrative Compensation **Credit for claim re-pays

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION**

WESCO, INC., and WESCO, INC.
CAFETERIA PLAN AND EMPLOYEE
BENEFIT PLAN, on
behalf of themselves and a class of all others
similarly situated,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF
MICHIGAN,

Defendant.

Civil Action No.: 2:25-cv-11712

Judge: Hon. Susan K. DeClercq

Magistrate Judge: David R. Grand

**INDEX OF EXHIBITS TO
DEFENDANT’S BRIEF IN SUPPORT OF ITS MOTION TO DISMISS
PLAINTIFF’S COMPLAINT FOR FAILURE TO STATE A CLAIM**

Exhibit No.	Description
A	Administrative Services Contract (“ASC”)
B	2021 Extension to ASC
C	ASC Refund Summary
D	Wire Confirmation for Wesco Final Settlement
E	December 2019 ASC Shared Savings Value Report Invoice
F	February 2020 ASC Shared Savings Value Report Invoice

G	March 2020 ASC Shared Savings Value Report Invoice
H	April 2020 ASC Shared Savings Value Report Invoice
I	June 2020 ASC Shared Savings Value Report Invoice
J	September 2020 ASC Shared Savings Value Report Invoice
K	September 2021 ASC Shared Savings Value Report Invoice
L	October 2021 ASC Shared Savings Value Report Invoice
M	February 2022 ASC Shared Savings Value Report Invoice
N	March 2022 ASC Shared Savings Value Report Invoice
O	April 2022 ASC Shared Savings Value Report Invoice
P	May 2022 ASC Shared Savings Value Report Invoice