UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

WESCO, INC., WESCO, INC. CAFETERIA PLAN AND EMPLOYEE BENEFIT PLAN, FRANKENMUTH BAVARIAN INN, INC., FRANKENMUTH BAVARIAN INN, INC. EMPLOYEE HEALTH BENEFIT PLAN & TRUST, OPUS PACKAGING GROUP INC., and OPUS PACKAGING GROUP HEALTH INSURANCE 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 PLAINTIFFS' AMENDED 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 Plaintiffs' Amended Complaint (ECF No. 23). 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 Plaitniffs, Perrin Rynders, in person on August 11, 2025. BCBSM's counsel explained the nature of the motion and the legal basis for the motion. Plaintiffs' counsel opposed the requested relief.

Dated: August 11, 2025

Respectfully submitted,

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UNITED STATES DISTRICT COURT
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WESCO, INC., WESCO, INC. CAFETERIA PLAN AND EMPLOYEE BENEFIT PLAN, FRANKENMUTH BAVARIAN INN, INC., FRANKENMUTH BAVARIAN INN, INC. EMPLOYEE HEALTH BENEFIT PLAN & TRUST, OPUS PACKAGING GROUP INC., and OPUS PACKAGING GROUP HEALTH INSURANCE 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 BRIEF IN SUPPORT OF ITS MOTION TO DISMISS PLAINTIFFS' AMENDED COMPLAINT FOR FAILURE TO STATE A CLAIM

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STATEMENT OF ISSUES PRESENTED

1. Whether the Court should dismiss Plaintiffs' Amended Complaint for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) because Plaintiffs' claims are barred by the three-year statute of limitations applicable 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.

2. Whether the Court should, in the alternative, dismiss the Wesco Plaintiffs' claims for lack of standing and subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1) because the Wesco Plaintiffs' claims were released.

Answer: Yes.

CONTROLLING OR MOST APPROPRIATE AUTHORITY

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

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

Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross Blue Shield of Mich., No. 24-1367, 2025 WL 2104569 (6th Cir. July 28, 2025)

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

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

Blue Cross Blue Shield of Michigan ("BCBSM") respectfully submits this brief in support of its Motion to Dismiss the Amended Complaint filed by Plaintiffs under Rule 12(b)(6) for failure to state a claim and, as to Wesco and the Wesco Plan, also under Rule 12(b)(1) for lack of standing.[1]

INTRODUCTION

BCBSM entered into an Administrative Services Contract ("ASC") with each of the Sponsors on behalf of the related Plans. Under each ASC, BCBSM processed claims submitted by health care providers for services rendered to the relevant Plan. In 2018, as part of these relationships and in connection with its claim processing services, BCBSM 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.

All of this was clearly disclosed to Plaintiffs. They nevertheless rely on this program as the linchpin for their fanciful theory that BCBSM has been concealing

[1] Plaintiffs are Wesco, Inc. ("Wesco"), Frankenmuth Bavarian Inn, Inc. ("Bavarian Inn"), Opus Packaging Group Inc. ("Opus") (each of Wesco, Bavarian Inn, and Opus, a "Sponsor," and collectively, the "Sponsors"), Wesco, Inc. Cafeteria Plan and Employee Benefit Plan ("Wesco Plan"), Frankenmuth Bavarian Inn, Inc. Employee Health Benefit Plan & Trust ("Bavarian Inn Plan"), and Opus Packaging Group Health Insurance Plan ("Opus Plan") (each of the Wesco Plan, Bavarian Inn Plan, and Opus Plan, a "Plan," and collectively, the "Plans").

for years that it intentionally overpays claims through various mistakes it supposedly overlooks when processing claims for the Plans so that it can recover a portion of that overpayment for itself through the SSP. The Amended Complaint then seeks to spin this speculation into prohibited transaction and breach of fiduciary duty claims under ERISA. These claims should be dismissed for multiple independent reasons.

First, all of Plaintiffs' claims are time-barred. The Sixth Circuit's recent decision in *Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross Blue Shield of Mich.*, No. 24-1367, 2025 WL 2104569 (6th Cir. July 28, 2025), makes this clear. There, the Sixth Circuit held that ERISA's three-year statute of limitations barred a claim that BCBSM breached its fiduciary duty by not applying required rates for claims processed over several years because BCBSM had disclosed, more than three years before the plaintiff filed the complaint, that it could not apply the rates. Here too, BCBSM disclosed the SSP and its terms more than three years ago: to Wesco and Bavarian Inn upon its implementation in 2018 and to Opus when Opus entered into the ASC in February 2022.

Second, the Amended Complaint fails to allege facts that—even if proven—would constitute a breach of fiduciary duty or prohibited transaction. The Amended Complaint does not identify any SSP recovery that resulted from the supposed processing issues identified in the Amended Complaint. Instead,

Plaintiffs allege the general presence of processing errors and then speculate that this *may* have led to SSP recoveries. Even more speculative—indeed nonsensical—Plaintiffs allege that BCBSM allowed these processing errors to continue because a third-party reviewing claims under the SSP might later recover a portion, and thereby entitle BCBSM to related fees. The Amended Complaint does not plead a single *fact* supporting this accusation and falls far short of meeting the particularity requirements of Rule 9(b), which apply because Plaintiffs allege—albeit baselessly—that BCBSM engaged in "systematic fraud."

Additionally, Wesco and the Wesco Plan lack standing because their claims have been released. At the end of Wesco's relationship with BCBSM, it released "any and all" claims arising from the parties' contractual relationship, which necessarily encompasses the claims asserted here.

The Court should dismiss this case in its entirety.

BACKGROUND

A. The ASCs Between BCBSM and Plaintiffs

Wesco, Bavarian Inn, and Opus each sponsors their respective self-funded employee benefit healthcare plan—i.e., the Plans—and are obligated as a fiduciary for such Plan. ECF No. 23, PageID.253-255 ¶¶ 15, 22, 29.[2] Each entered into an

[2] Solely for purposes of this motion to dismiss, BCBSM cites to and relies on the allegations in the Amended Complaint. BCBSM does not concede the accuracy

ASC on behalf of their respective Plan to engage BCBSM to provide "administrative services associated with processing and paying medical claims." *Id.* at PageID.257 ¶ 41.

Wesco entered its ASC in 2003 and renewed it until termination in 2022; Bavarian Inn entered its ASC in March 2016[3] (or 2019, according to the Amended Complaint) and renewed it through at least August 2025; and Opus entered its ASC in February 2022 and renewed it until termination in early 2025. *Id*. at PageID.260-261 ¶¶ 55–57.[4] Plaintiffs also allege that each putative class member

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of any such allegations and specifically reserves its rights to contest the truth of any allegations.

[3] The ASC, entered into in 2016, contradicts the allegation that Bavarian Inn entered into its ASC in 2019. *See* Exhibit A, 2016 Bavarian Inn ASC. As discussed below in note 4, the Court can consider the ASC because it is incorporated into the Amended Complaint. But even if this event happened in 2019, when the Amended Complaint alleges Bavarian Inn entered into its ASC, the claims would still be time-barred.

[4] BCBSM attaches to this motion as Exhibits A–J the operative ASCs, relevant amendments, and schedules between BCBSM and Plaintiffs given that Plaintiffs rely on and incorporate the parties' contracts into the Amended 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. 23, Page ID.261 ¶ 58 ("Under each of the Class Representatives' ASCs, BCBSM

contracted with BCBSM to provide claims administration services to their self-funded benefit healthcare plans under the same or similar terms. *Id.* at PageID.260, 283 ¶¶ 53, 147–48.

B. The SSP

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.274 ¶¶ 113. As part of BCBSM's administrative services, BCBSM contracted with third parties for a variety of cost-containment programs, both pre- and post-claims payment, to identify potential savings for the group health plan. *See Tiara Yachts, Inc. v. Blue Cross Blue Shield of Mich.*, 138 F.4th 457, 469 (6th Cir. 2025). Rather than spreading SSP fees over the millions of claims payments, and with the Plaintiffs' express written agreement, BCBSM retained 30% of the amounts saved. ECF No. 23 at PageID.274 ¶ 114. If the SSP did not save any amount, no fee was charged to Plaintiffs. *See id.* at PageID.274, 287, 289 ¶¶ 112–14, 160, 168.

Plaintiffs acknowledge that BCBSM disclosed the SSP to plan sponsors, including Plaintiffs. *Id.* at PageID.277, 280 ¶¶ 126, 134. Indeed, BCBSM plainly disclosed the SSP and its terms to Wesco and Bavarian Inn upon the SSP's

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had discretionary authority and control over management and administration of each Class Representative's respective Plan[.]").

implementation in 2018, to and to Opus upon its entry into an ASC in February 2022. *See* Exhibit C (Wesco ASC Schedule A); Exhibit E (Bavarian Inn ASC Amendment dated 2018); Exhibit F (Bavarian Inn Schedule A); Exhibit I (Opus ASC Schedule A).

C. The Wesco Plaintiffs' Termination and Release

The Wesco Plaintiffs terminated their relationship with BCBSM in December 2022. ECF No. 23 at Page ID.260 ¶ 55. Under the ASC applicable to the Wesco Plaintiffs, in May 2025, following the 24-month Termination Assistance Period, BCBSM issued a final settlement and refund to them. *See* Exhibit B at Art. IV § B.6; Exhibit K ("ASC Refund Summary").

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 B 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 K.[5]

D. Plaintiffs' Amended Complaint

Plaintiffs' Amended 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* ECF No. 23 at PageID.288-294 ¶¶ 164–83.

First, Plaintiffs allege that BCBSM engaged in prohibited transactions under ERISA through its SSP. *See id.* at PageID.288-290 ¶¶ 164–74. Plaintiffs allege that BCBSM enrolled self-funded plan customers in the SSP rather than fix its claims processing system, which, according to Plaintiffs, BCBSM allegedly knows "regularly" pays providers for claims that contain errors. *Id.* at PageID.271-272 ¶ 101. Plaintiffs allege that these errors include "duplicate bills, unbundled claims, upcoded claims or claims with the incorrect code billed" and are "non-exclusive

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[5] As discussed below, courts lack subject matter jurisdiction over released claims. *See infra* Argument § III. The Court thus can consider the ASC Refund Summary in connection with this motion to dismiss under Rule 12(b)(1). *Rogers v. Stratton Indus., Inc.*, 798 F.2d 913, 915–16 (6th Cir. 1986). The Court also can consider the ASC Refund Summary because the Wesco Plaintiffs' membership in the proposed class, *i.e.*, their standing to bring the claims asserted in the Complaint, is clearly "central" to the claims asserted in the Amended Complaint. *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).

examples of known errors presently existing in BCBSM's claims processing systems for its self-funded plan customers." *Id.* at PageID.271-272 ¶¶ 101–02. Plaintiffs speculate that BCBSM intentionally 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.275 ¶¶ 115, 118.

Second, Plaintiffs allege that BCBSM breached its fiduciary duties by mismanaging claims payments and then receiving fees from SSP recoveries. *See id.* at PageID.291-294 ¶¶ 175–83. Plaintiffs claim that BCBSM allows the "known" processing errors to continue so that it can profit from recoveries under the SSP. *Id.* at PageID.271-274 ¶¶ 101–02, 108, 111–12.

In this regard, the Amended Complaint alleges BCBSM employed a system known as "flip logic," which enabled full reimbursement of certain providers. *Id.* at PageID.270-271 ¶¶ 97–98. When individual beneficiaries seek care from certain out-of-territory providers with whom BCBSM and its partners have no relationship ("non-participating providers"), there is no negotiated rate. *See, e.g.*, Exhibit G at 17–18 (Bavarian Inn Schedule B); Exhibit J at 14–15 (Opus Schedule B). This means that the individual beneficiary—i.e., the patient—may receive a bill from that provider for the balance of the amount that is not covered by the Plan. To protect such beneficiaries from this "balance billing," the group benefit plans

specifically permit BCBSM to reimburse the non-participating provider for the full amount charged so that the provider does not then try to collect anything from the member. *See, e.g.*, Exhibit G at 17–18 (Bavarian Inn Schedule B); Exhibit J at 14–15 (Opus Schedule B). The Amended Complaint does not allege how the use of "flip logic" to implement this negotiated-for benefit breaches the ASC or could trigger a recovery under the SSP. Indeed, the benefit is entirely in the interests of the Plans' beneficiaries.

LEGAL STANDARD

A 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). 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). This "demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation" or "labels and conclusions." *Iqbal*, 556 U.S. at 678. Accordingly, a complaint must "possess enough heft" to establish "something beyond the mere possibility" of a violation. *Twombly*, 550 U.S. at 557–58.

Those standards are heightened here because the Amended Complaint sounds in fraud. Indeed, Plaintiffs allege—albeit baselessly—that "BCBSM has engaged in systematic fraud." ECF No. 23, PageID.281 ¶ 137.[6] Therefore, Plaintiffs must satisfy the heightened standard under Rule 9(b) and the Amended Complaint must include particularized allegations supporting their claims, including pleading the who, what, where and when details of their claims with specificity. *See Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 551 (6th Cir. 2012) (quoting *Bennett v. MIS Corp*., 607 F.3d 1076, 1100 (6th Cir. 2010)) ("Rule 9(b) . . . requir[es] plaintiffs to allege the time, place, and content"); *see also In re Gen. Motors ERISA Litig*., No. 05-71085, 2006 WL 897444, at *16 (E.D. Mich. Apr. 6, 2006) (recognizing the applicability of Rule 9(b) to allegations sounding in fraud where the defendant allegedly lied "in the context of a fiduciary duty claim").

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[6] *Compare Tiara Yachts, Inc.*, 138 F.4th at 467 (allegations did not sound in fraud where plaintiff did not "allege that it relied on any misrepresentations related to the SSP in continuing to do business with BCBSM" or allege that BCBSM "concealed the claims it was overpaying in the first place"), *with, e.g.*, Amended Complaint, ECF No. 23, PageID.281 ¶ 137 ("BCBSM has engaged in systematic fraud . . . concealing its overpayments upon which SSP fees were based . . . and misrepresenting the SSP . . . when it actually is . . . a ruse BCBSM uses to fleece its self-funded customers").

ARGUMENT

I. 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 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)). 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*, 676 F.3d at 547–48.

Here, it is apparent from the face of the Amended Complaint that Plaintiffs had actual knowledge of the alleged prohibited transactions and breaches of

fiduciary duty related to the SSP well over three years before this action was filed. The Amended Complaint should thus be dismissed in its entirety because it is untimely.

A. Plaintiffs' SSP Prohibited Transaction and Fiduciary Duty Claims Are Time-Barred

The Amended Complaint alleges that the SSP violated ERISA's prohibited transaction rules and that BCBSM breached its fiduciary duties in connection with the SSP. BCBSM disclosed the SSP to Wesco and Bavarian Inn by the time it implemented the SSP in 2018 (or 2019 for Bavarian Inn according to the Amended Complaint), and to Opus in February 2022. *See supra* Background § B; Exhibits A–J. Plaintiffs thus learned about the SSP more than three years before this action was filed and are thus barred by the three-year ERISA statute of limitations. 29 U.S.C. § 1113(2).

The Sixth Circuit's recent decision in *Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross Blue Shield of Michigan* is instructive. There, the plaintiff allegedly asked BCBSM in 2009 to ensure that it receive Medicare-Like Rate ("MLR") discounts when its claims were processed. 2025 WL 2104569, at *2. At that time, BCBSM said it could not adjust its entire system to calculate such rates but that it would provide rates close to the MLR by providing a discount for services at a specific hospital. *Id*. The plaintiff filed a lawsuit in 2014 asserting, among other things, breach of fiduciary duty claims under ERISA based on

allegations that BCBSM overpaid claims by not taking advantage of the MLR discounts, claiming it did not know the "full extent" of BCBSM's conduct until 2013, after it had a chance to conduct an audit. *Id*.

In affirming dismissal of the ERISA claims as untimely, the Sixth Circuit held that the plaintiff's "own allegations establish that in 2009, it had actual knowledge of Blue Cross's refusal to pursue MLR." *Id*. at *6. Significantly, "[t]hat knowledge forecloses any argument that the [plaintiff] was unaware of [BCBSM's] failure to pursue MLR before 2013." *Id*. In reaching this conclusion, the Sixth Circuit rejected the plaintiff's argument that BCBSM's purported breach was continuing because BCBSM never allegedly offered any assurances it would seek MLR discounts. *Id*. at *6.

Here too, Plaintiffs had "actual knowledge" of all of the relevant facts. Plaintiffs had such knowledge from when BCBSM disclosed the SSP, either in amendments or Schedule As to existing ASCs, or upon first entering the ASC. *See supra* Background § B; Exhibits A–J. Because each disclosure to each Plaintiff occurred more than three years ago, their claims are untimely. At a minimum, SSP recoveries that occurred more than three years ago, such as the specific recoveries

listed in the Amended Complaint at paragraph 129, should be excluded. *See, e.g.*, Exhibits L–W (monthly Wesco invoices).[7]

B. The "Fraud or Concealment" Exception Does Not Apply

Plaintiffs also cannot extend the limitations period by attempting to assert that ERISA's "fraud or concealment" exception applies. Under that standard, the Amended Complaint must "state with particularity" the omissions or misrepresentations that BCBSM made, including the time, place, and content of any misrepresentations. *See Cataldo*, 676 F.3d at 551 (citing *Bennett*, 607 F.3d at 1100); *Tiara Yachts, Inc.*, 138 F.4th at 467 (to qualify for fraud or concealment exception to ERISA's statute of limitations a plaintiff "need[s] to adequately plead fraud"). As discussed below, the Amended Complaint does not allege at all—much less with the requisite particularity—how or when BCBSM misrepresented the SSP.

Plaintiffs have also not alleged facts to support that they acted with diligence in identifying any violations—as they must to rely on the "fraud or concealment" exception. *Cf. Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Mich.*, 751 F.3d 740, 749 (6th Cir. 2014) ("[A]n ERISA plaintiff's failure to discover a fiduciary

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[7] The monthly invoices are incorporated into the Amended 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. 23, PageID.26 ¶ 129; *supra* note 4.

violation must not have been attributable to a lack of due diligence on his part."). Nor could they because the SSP was disclosed to each. *See Dublin Eye Assocs. P.C. v. Mass Mut. Life Ins. Co.*, 590 F. App'x 463, 465–66 (6th Cir. 2014) (affirming plaintiff's claim as time barred when "[a] reasonably diligent plaintiff would have discovered the basis" for claims from reviewing received forms).

C. Plaintiffs' Claims Are Untimely Under ERISA's Six-Year Statute of Repose

At a minimum, the Wesco and Bavarian Inn Plaintiffs' claims related to any alleged payments made before June 9, 2019, or July 28, 2019, respectively, are barred under ERISA's statute of repose because those claims must be—but were not—brought within six years of the alleged breach. 29 U.S.C. § 1113(1); *Intel Corp.*, 589 U.S. at 180. Such claims should be dismissed for this additional reason.

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

The Amended Complaint does not come close to meeting the plausibility requirements set forth in *Iqbal* and *Twombly*, much less the heightened pleading requirements of Rule 9(b).

A. The Allegations Fail to Support a Claim Based on SSP Recoveries

Plaintiffs baselessly claim that BCBSM engaged in prohibited transactions and breached its fiduciary duties through an orchestrated fraud using the SSP.

They allege that BCBSM "[m]ismanag[ed] the Plans and Class plan assets through making or causing to be made improper claim payments (e.g., overpayments) in order to extract excessive fees from the Plans and Class plan assets through its SSP," ECF No. 23, PageID.293 ¶ 182, and "engaged in systematic fraud and/or concealment to further its self-dealing" allegedly by "(1) refusing to provide Plaintiffs with their full set of claims data necessary to understand the SSP and fees BCBSM collected pursuant to the SSP; [(2)] concealing its overpayments upon which SSP fees were based; and (3) misrepresenting the SSP as a 'savings' or 'cost-containment' program, when it actually is the opposite." *See id.* at PageID.281 ¶ 137.

Not one of these conclusory assertions in the Amended Complaint is supported by particularized factual allegations that meet the heightened pleading standard applicable under Rule 9(b). When a complaint sounds in fraud, plaintiffs must "allege the time, place, and content of the alleged misrepresentations on which he or she relied; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud." *Sanderson v. HCA-The Healthcare Co.*, 447 F.3d 873, 877 (6th Cir. 2006) (internal citation omitted). "General allegations that raise the mere possibility of fraud will not do; instead, the complaint must provide the factual predicates necessary to convince [a court] that the underlying fraud in all likelihood occurred." *Greer v. Strange Honey Farm,*

LLC, 114 F.4th 605, 615 (6th Cir. 2024) (citation modified). Plaintiffs' allegations lack all of these required details and thus do not satisfy the requirements of Rule 9(b). Nor do they even satisfy the lesser plausibility standard under *Iqbal* and *Twombly*.

First, Plaintiffs' allegations that there were a variety of processing errors that later were the subject of SSP recoveries fail under Rule 9(b) because Plaintiffs at most identify a variety of errors and then speculate that such errors could have occurred with respect to their Plans and further speculate that such errors could have been the basis of one of their SSP recoveries.

For example, the Amended 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[.]" ECF No. 23, PageID.271 ¶ 101. Missing but required under Rule 9(b) are particularized facts tying such alleged errors to the Wesco, Bavarian Inn, or Opus Plans and then to SSP recoveries or payments with respect to the Plans. Indeed, the SSP applied more broadly than seeking to recover potential overpayments, and also manifestly covered items such as cost avoidance for out-of-network claims and rebate service fees for prescription drugs. *See, e.g.*, Exhibit I § 12 (Opus Schedule A).

Allegations that there were SSP recoveries without tying any—not one—to an alleged processing error of the type identified "generally" in the Amended Complaint are insufficient to establish a breach of fiduciary duty under Rule 8, much less Rule 9(b). *Twombly*, 550 U.S. at 557–58 (something beyond the "mere possibility" of a violation is required to state a claim).

Second, not a single particularized factual allegation supports Plaintiffs' speculation that BCBSM "knowingly" misadjudicates claims to increase recoveries under the SSP. ECF No.23, PageID.270 ¶ 95. Instead of pointing to anything BCBSM ever said or did with respect to the SSP, the Amended Complaint points to a litigation expert report filed by Plaintiffs' counsel in a different case, *see id.* at PageID.271 ¶ 100, and speculates that all self-funded plans experienced improper payments, *see id.* at PageID.272-273 ¶¶ 103–04. The report of someone hired by Plaintiffs' counsel as an expert in a different case addressing claims payments for a different plan cannot even substitute for particularized allegations that any improper payments were made with respect to the Plans, much less substitute for particularized allegations that any alleged misadjudication of claims was "knowing."

Third, although the Amended Complaint alleges generally that BCBSM "impedes" access to data by rejecting requests for claims data and supposedly refused requests for data made by Wesco, *id*. at PageID.281-280 ¶¶ 135–36, the

Amended Complaint does not particularize when Wesco allegedly made a request and for what specific data, and what BCBSM said in response. The Amended Complaint also is devoid of any allegations that Bavarian Inn or Opus even made a similar request for (unspecified) data like Wesco apparently did on some (unspecified) date. Rule 9(b) requires such detail. *See Sanderson*, 447 F.3d at 877 (internal citation omitted) ("Rule 9(b) requires that the plaintiff specify the 'who, what, when, where, and how' of the alleged fraud."); *see also In re Calpine Corp. ERISA Litig.*, No. C 03-1685 SBA, 2005 WL 3288469, at *7 (N.D. Cal. Dec. 5, 2005) (finding allegations of misleading information in press releases "too vague" to satisfy Rule 9(b) when plaintiff failed to identify the misleading statements or allege facts to show why they were false or misleading).

Fourth, the assertion in the Amended Complaint that BCBSM somehow "conceal[ed] its overpayments" is entirely conclusory. ECF No. 23, PageID.281 ¶ 137. Indeed, under the ASC Plaintiffs received claims data and had a right to request an audit of that data. *See* Exhibit H at Art. II §§ C–D, G. And yet, nowhere in the Amended Complaint is there a particularized allegation connecting specific data that allegedly was missing to an explanation for how it precluded Plaintiffs from understanding how *their* claims were being processed. ECF No. 23. Nor do Plaintiffs allege that they attempted to but were not permitted to exercise their respective audit rights.

Finally, no particularized allegations support Plaintiffs' claim that BCBSM misrepresented the SSP as a "savings program" when it allegedly was not. Based on the same disclosures made to Plaintiffs, the Sixth Circuit had no trouble concluding that the SSP was not concealed and that a self-funded plan was aware of the program. *See Tiara Yachts, Inc.*, 138 F.4th at 467 (referring to the plaintiff's concession that "BCBSM was up front about collecting 30% of the savings from the SSP and allowed [plaintiff] to challenge or audit claims"). Moreover, as noted above, not a single allegation ties a single SSP recovery to an alleged overpayment. Nor is there any analysis in the Amended Complaint showing that the amount of BCBSM's alleged payments under the SSP exceeded recoveries such that it was not in fact a "savings program" for the Plans.

Accordingly, the Amended Complaint's conclusory prohibited transaction and breach of fiduciary duty allegations related to the SSP fail under *Twombly* and *Iqbal*—and even more so under Rule 9(b). *See*, *e.g.*, *Iqbal*, 556 U.S. at 678 (noting that "the-defendant-unlawfully-harmed-me" allegation is insufficient to plead a claim); *Sanderson*, 447 F.3d at 877–78 (affirming dismissal for failure to comply with Rule 9(b) where allegations in the complaint were "limited to speculation and unsupported conclusion" and lacked "specific information" about the filed claims at issue).

B. The Allegations Fail to State a Claim for Breach of Fiduciary Duty From Processing Errors

Any claim that BCBSM breached its fiduciary duty cannot be based on alleged processing errors, apart from the SSP, because the Amended Complaint does not include allegations, particularized or not, that there were any such claims processing errors with respect to *Plaintiffs*. Such claims also would fail because the Amended Complaint does not allege facts showing how claims processing errors constitute a breach of fiduciary duty. 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 insufficient 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.").

Moreover, Plaintiffs' vague challenge to the full reimbursement of certain providers at charged rates is the opposite of a breach of fiduciary duty. The ASC permits this practice, which protects individual beneficiaries (patients) from surprise billing. *See supra* Background § D. To be sure, Plaintiff Sponsors pay more when reimbursement is higher, but that is not a breach of fiduciary duty to the Plans or their beneficiaries—the patients—who clearly benefit from this practice.

III. THE WESCO PLAINTIFFS' CLAIMS HAVE BEEN RELEASED

A federal district court lacks subject matter jurisdiction over released claims. *Wolschlager v. Law Offices of Mitchell D. Bluhm & Assocs., LLC*, 366 F. Supp. 3d 888, 891–92 (W.D. Mich. 2017) (court dismissed claims for lack of subject matter jurisdiction because named plaintiff settled claims); *see also Pettrey v. Enter. Title Agency, Inc.*, 584 F.3d 701, 703 (6th Cir. 2009) (a settlement "moots an action" because it means a plaintiff no longer has a "legally cognizable interest in the outcome of the litigation").

The Wesco ASC provided for a mutual release upon the final payment between the parties, and 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 B at Art. IV § B.6; *see* Exhibit K.[8]

Michigan 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

[8] The Wesco Plaintiffs further assented to the mutual release contained in Exhibit K by accepting the refund of $81,853. *See* Exhibit X (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 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.") (internal quotations omitted).

controlled by the language of the release, and where . . . the language is unambiguous, [courts] construe it as written.'" *Taylor v. Visteon Corp.,* 149 F. App'x 422, 424 (6th Cir. 2005) (internal citation omitted); *see also Gortney v. Norfolk & W. Ry. Co.,* 549 N.W.2d 612, 614 (Mich. Ct. App. 1996).

Here, 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 the Wesco Plaintiffs' claims—which are based on services under the ASC, *i.e.*, the SSP and related claims processing—and thus necessarily arise under the ASC. *See supra* Background; ECF No. 23, PageID.250-251, 260, 265 ¶¶ 2, 4–5, 54–55, 73.

Because the Wesco Plaintiffs completely and fully released their claims against BCBSM, the Court lacks subject matter jurisdiction and should dismiss the Wesco Plaintiffs' claims. In any event, courts dismiss ERISA 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).[9]

CONCLUSION

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

Dated: August 11, 2025

Respectfully submitted,

ALLEN OVERY SHEARMAN STERLING US LLP

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[9] The ASCs and Wesco release are incorporated into the Amended Complaint and can be considered for purposes of this motion to dismiss. *See supra* note 4. The Court also has discretion to consider documents outside the pleadings when evaluating a motion under Rule 12(b)(1). *Rogers*, 798 F.2d at 916.

ZAUSMER, P.C.

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Attorneys for Defendant

Exhibit D

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

Blue Cross Blue Shield Blue Care Network of Michigan

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,

GriffinCobean

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 Lott

Group Signer Name
Title Co-President, Wesco

12/22/21

Signed Date

Enclosure

Blue Cross Blue Shield Blue Care Network of Michigan. Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association	**GROUP SIGNATURE PAGE** For Effective 12/01/2020 – 11/30/2021

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 "Run-Out" Coverage:*	X Yes ☐ No
Policyholder Initials:	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)	[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%

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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.

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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.

Blue Cross Blue Shield Blue Care Network of Michigan

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	To elect "Run-Out" Coverage, Group must check the appropriate box on the **Group Signature Page**. *"Run-Out" Coverage applies to claims incurred on or after the Original Effective Date of Policy and paid during the Run-Out Period.*

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 O

Blue Cross Blue Shield of Michigan

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 V

Blue Cross Blue Shield of Michigan

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	[redacted]	[redacted]		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 E

CID - 100340

Amendment to Administrative Services Contract

FRANKENMUTH BAVARIAN INN INC.
007000359

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

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

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

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

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

   Pharmacy Benefits.

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

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

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

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

Signatures

BCBSM: **GROUP:** FRANKENMUTH BAVARIAN INN INC.

By: (Signature)	By: (Signature) Vernon J Schiefer
Name: (Print) ~~Sandy Fester~~	Name: (Print) Vernon J. Schiefer
Title: Vice President Middle & Small Group	Title: Corporate Accountant
Date: 12/12/17	Date: 11-30-2017

Exhibit F

CID - 100340

SCHEDULE A-Renewal Term (Effective March 2018 through February 2019)
Administrative Services Contract (ASC)
Blue Cross Blue Shield of Michigan

1. Group Name: FRANKENMUTH BAVARIAN INN INC.
2. Group Number: 007000359
3. Contract Effective Date: March 01, 1994
4. ASC Funding Arrangement: Quarterly Settled Monthly Wire
5. Line(s) of Business:

[X] Facility
[ ] Facility Foreign
[ ] Facility Domestic
[X] Professional
[X] Prescription Drugs
[ ] Dental
[ ] Vision

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

		Administrative Fee Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Administrative Fee
A.	Administrative Fee (Full Fixed)	$45.83	140	$6,416
B.	Additional Wellness Fees	not applicable	not applicable	not applicable
C.	Online Visits	not applicable	not applicable	not applicable
D.	Prescription Drug Accumulator Fee	not applicable	not applicable	not applicable
E.	Third-Party Stop Loss Vendor Fee	not applicable	not applicable	not applicable
	Total Administrative Fee	$45.83	140	$6,416

7. 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.

8. Late Payment Charges/Interest:
   A. Late Payment Charge 2%
   B. Yearly Statutory Interest Charge (Simple Interest) 12%
   C. Provider Contractual Interest
   If Group's payment is more than one business day late, Group shall pay a late fee of the lesser of two percent (2%) of any outstanding amount due or the maximum amount permitted by law.

9. BCBSM Account: 1840-09397-3 (Wire Number) Comerica (Bank) 0720-00096 (American Bank Assoc)

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

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

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

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

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

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

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

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

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

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

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

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

16. If there is more than a 10 percent (10%) change in the number of Enrollees from the number stated above during any month of the Contract Year or a change in Coverages, BCBSM may immediately revise any affected pricing terms in this Schedule A to reflect such changes in Enrollment and/or Coverages. Any revisions will be effective beginning with the next invoice 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.

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

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

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

C. Subrogation. Recoveries of claims overpayments from subrogation.

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

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

BCBSM:

BY: _____ (Signature)

NAME: Sandy Fester (Print)

TITLE: Vice President Middle & Small Group

DATE: 12/12/17

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

THE GROUP:

BY: Vernon J. Schiefer (Signature)

NAME: Vernon L. Schiefer (Print)

TITLE: Corporate Accountant

DATE: 11-30-2017

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

Exhibit G

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Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

2023 ASC Group - Customer Signature Page(s)

Effective for 03/01/2023 – 02/29/2024

Between Blue Cross Blue Shield of Michigan and

FRANKENMUTH BAVARIAN INN INC. (CID - 100340)

Group customer agrees to sign the specified documents listed below ("Documents"). BCBSM countersignatures will be captured via a separate Signature Page and appended to these Documents. Copies of these fully-executed Documents will be shared with all parties upon completion. By providing their signatures, all parties are legally bound by the terms and conditions in the Documents referenced.

Documents Included:

- **Schedule A**
  - Exhibit 1 to Schedule A
  - Exhibit 2 to Schedule A
- **Schedule B**
  - Exhibit 1 to Schedule B
- **Stop-Loss Coverage**
  - Stop-Loss Policy
  - Stop-Loss Exhibit
  - Amendment to Stop-Loss Coverage

Requires Group Selection:

Specific Stop-Loss Run-Out Coverage				
Group is electing "Run-Out" Coverage for their Specific Stop-Loss	Yes	☒	No	☐

AGREED AND ACCEPTED.

GROUP CUSTOMER:

By: (Signature)	Vern Schiefer
Name: (Print)	Vern Schiefer
Title:	Corporate Accountant
Date:	3/31/2023

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Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Cover Sheet for BCBSM 2023 ASC Contractual Documents

FRANKENMUTH BAVARIAN INN INC. (CID - 100340)

The following documents are included for review and agreement between Group Customer and Blue Cross Blue Shield of Michigan.

Documents Included:

- **Schedule A**
  - Exhibit 1 to Schedule A
  - Exhibit 2 to Schedule A
- **Schedule B**
  - Exhibit 1 to Schedule B
- **Stop-Loss Coverage**
  - Stop-Loss Policy
  - Stop-Loss Exhibit
  - Amendment to Stop-Loss Coverage

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Blue Cross Blue Shield of Michigan
SCHEDULE A – Renewal Term (Effective 03/01/2023 thru 02/29/2024)
Administrative Services Contract (ASC)

1. **Group Name** FRANKENMUTH BAVARIAN INN INC.
2. **Customer ID** 100340
3. **ASC Funding Arrangement** Monthly Wire

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

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

5. **Administrative Fees**

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

A. Fixed Administrative Fees	Amount Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Admin Fee	Effective Start Date	Effective End Date
i. 2023 Base Admin Fee	$48.29	132	$6,374.28	03/01/2023	02/29/2024

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

6. **Data Feeds – *Not Applicable***

7. **Advance Deposit – *Not Applicable***

8. **Advance Deposit Monthly Cap / Level Payment Amount – *Not Applicable***

9. **BCBSM Account**

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

10. **Late Payment / Interest Charges**

Late Payment Charge	2.00%
Health Care Provider Interest Charge	12.00%

11. **Buy-Ups – *Not Applicable***

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. Hospital Bill Review	30%	Cost avoidance of improper hospital billing by line-by-line reviews of each inpatient claim's itemized bill to identify

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		defects and improprieties before the bill is paid.
B. Advanced Payment Analytics	30%	Recoveries of overpayments using proprietary data mining analytics as a second pass review along with continual monitoring enabling up-to-date policy compliance.
C. Subrogation	30%	Recoveries of money already paid through Blue Cross benefits that is the responsibility of non-health insurance carrier.
D. Hospital Credit Balance	30%	Recoveries of claims through enhanced reviews of hospital patient accounting systems and identified credit balances from overpayments.
E. Advanced Editing	30%	Cost avoidance through applied advanced algorithms and extensive analytic reviews of professional and outpatient facility Claims for adherence to medical, clinical and national coding guidelines.
F. 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.
G. Home Infusion Therapy Medical Drugs	30%	The difference between BCBSM's 2021 home infusion therapy ("HIT") network pricing and the improved negotiated pricing administered through a third party HIT vendor.
H. 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.
I. Rebate Service Fee for Pharmacy Prescription Drugs	10%	Pharmacy benefit manufacturer rebates on Claims incurred in the renewal term.

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13. Pharmacy Pricing Arrangement

A. Traditional Prescription Drug Pricing and Administrative Compensation

Group acknowledges and agrees the amount BCBSM pays its contracted pharmacy benefit manager ("PBM") for a prescription drug may be more or less than the amount Group pays BCBSM for such prescription drug, and BCBSM may retain the difference as administrative compensation as specified below, when the amount is less.

BCBSM shall retain the following administrative compensation ("Traditional Rx Drug Pricing Admin Fee"):

a. Up to two (2) percentage points of the aggregated Average Wholesale Price ("AWP") discount BCBSM receives from its PBM for drugs classified by BCBSM as retail or 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.

c. $0.10 of the dispensing fee for 30-day supplies of retail prescription drugs.

The actual Traditional Rx Drug Pricing Admin Fee paid by Group to BCBSM shall depend on Group's aggregated AWP discount referenced above, which is based 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 Traditional Rx Drug Pricing Admin Fee retained by BCBSM 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.

B. Pharmacy Monitoring Fee (PMF) Pricing – *Not Applicable*

14. Additional Pharmacy Services and/or Programs

A. 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.

B. High-Cost Drug Discount Optimization Program – *Not Applicable*

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

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provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and care coordination 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.

See Schedule B to ASC and Exhibit 1 to Schedule A 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.

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Exhibit 1 to the Schedule A:
Value-Based Provider Reimbursement

As in prior years, the Claims billed to Group include amounts that BCBSM reimburses health care providers including reimbursement tied to value. BCBSM has adopted a provider payment model that includes both fee-based and value-based reimbursement. BCBSM does not unbundle Claims and does not retain any portion of Claims as compensation. Provider reimbursement is governed by separate agreements with providers, BCBSM standard operating procedures, and BCBSM Quality Programs, which are subject to change at BCBSM's discretion. BCBSM shall provide Group with at least sixty (60) days' advance written notice of any additions, modifications, or changes to BCBSM Quality Programs describing the change and the effective date thereof.

BCBSM negotiates provider reimbursement rates on its own behalf and makes those rates available to customers through its products and networks. The reimbursement rates can, and often do, vary from provider to provider. Providers may qualify for higher reimbursement rates for satisfying requirements of certain BCBSM Quality Programs, including, but not limited to:

A. **Pay-for-Performance.**
Hospitals earn reimbursement for improving quality, cost efficiency and population health. This program recognizes both mid-to-large sized and small rural short-term acute care hospitals for quality improvements such as lower re-admission rates, participating in a statewide health information exchange, and performance in a varied portfolio of collaborative quality initiatives to address many of the most common and costly areas of surgical and medical care in Michigan.

B. **Value-Based Contracting.**
Hospitals earn reimbursement for improving quality, cost efficiency and population health. Hospitals work with physicians to provide cost-efficient care for a shared patient population, and earn rewards based on improved outcomes across that population.

C. **Collaborative Quality Initiatives ("CQIs").**
CQIs address many of the most common and costly areas of surgical and medical care in Michigan. In each CQI, hospitals and physicians across the state collect, share and analyze data on patient risk factors, processes of care and outcomes of care, then design and implement changes to improve patient care.

D. **Physician Group Incentive Program.**
The Physician Group Incentive Program connects approximately 40 physician organizations (representing about 20,000 physicians) statewide to collect data, share best practices and collaborate on initiatives that improve the health care system in Michigan. Participating physician organizations are evaluated and rewarded on transformation of health care delivery, quality metric performance, and performance enablement – all efforts designed to improve the overall value of care delivered while reducing total cost of care.

E. **Patient-Centered Medical Home ("PCMH").**
In our PCMH model of care, patients get the right care at the right time in the right setting. Since 2009, Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home designation program has fueled statewide movement of primary care into a team-based, proactive model of efficient, cost-effective care centered around the patient.

F. **Provider-Delivered Care Management.**
PCMH-designated practices increasingly provide personalized care management services for patients with chronic conditions or multiple, ongoing health needs. Patient care teams are assembled according to each patient's needs, and may include nurses, nutritionists, counselors, psychologists, respiratory therapists, asthma educators, certified diabetes educators, social workers, pharmacists and community health workers. Services are coordinated with the care patients are already receiving from their doctor.

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G. Blueprint for Affordability.

The Blueprint for Affordability program combines quality outcomes with a shared financial risk contract that enables providers to manage the health of their patient population and their total cost of care. BCBSM contracting arrangements may also include risk sharing with certain provider entities ("PE"), e.g., physician organizations, physician hospital organizations, health systems, or any combination thereof, that have contracted with BCBSM for upside and downside financial risk.

Providers may receive reward and incentive payments from BCBSM Quality Programs funded through an allocation from provider reimbursement. Such allocations may be to a pooled fund from which value-based payments to providers are made. If a provider's performance results in a payment of additional reimbursement, the reward payment is made from the pooled funding. For Blueprint for Affordability, if the PE's performance results in a return of reimbursement, the amount at risk is returned to the pooled fund to offset a portion other provider gains. BCBSM will not retain any amounts resulting from BCBSM Quality Programs.

As explained in the Blue Card Program disclosure (Schedule B to ASC), an out-of-state Blue Cross Blue Shield Plan ("Host Blue") may also negotiate fee-based and/or value-based reimbursement for their providers. A Host Blue may include all provider reimbursement obligations in Claims or may, at its election, collect some or all of its value-based provider (VBP) reimbursement obligations through a PaMPM benefit expense, as in, for example, the Total Care Program. All Host Blue PaMPM benefit expenses for VBP reimbursement will be consolidated on your monthly invoice and appear as "Out-of-State VBP Provider Reimbursement." The supporting detail for the consolidated amount will be available on e-Bookshelf as reported by each Host Blue Plan. Host Blues determine which members are attributed to eligible providers and calculate the PaMPM VBP reimbursement obligation based only on these attributed members. Host Blue have exclusive control over the calculation of PaMPM VBP reimbursement.

Additional information is available at *www.valuepartnerships.com* and *www.bcbs.com/totalcare*. Questions regarding provider reimbursement and BCBSM Quality Programs or Host Blue VBP reimbursement should be directed to your BCBSM account representative.

Intellectual property may be developed through BCBSM Quality Programs for subsequent license and use by BCBSM or a third party. Group specifically understands, acknowledges, and agrees that it has no rights to any intellectual property, or derivatives thereof, including, but not limited to, copyrights, patents, or licenses, developed thru BCBSM Quality Programs.

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BLUE CROSS BLUE SHIELD OF MICHIGAN
Exhibit 2 to Schedule A
For Effective 3/1/2023 – 2/28/2024

1. Group Name FRANKENMUTH BAVARIAN INN, INC
2. CID 100340

This Exhibit 2 to Schedule A modifies and/or supplements the 2023 Schedule A based on any non-standard arrangements with Group. If there is a conflict between the terms of the Schedule A and this Exhibit 2, the terms of this Exhibit 2 will control and govern the rights and obligations of the parties.

1. Additional non-standard fees and services are added under a new section, Section 20:

20. Enrollee Change

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

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Schedule B
BlueCard Disclosures
Inter-Plan Arrangements

Out-of-Area Services

Overview

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Enrollees access healthcare services outside the geographic area BCBSM serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSM for payment in accordance with the rules of the Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCBSM serves, Enrollees obtain care from Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Enrollees may obtain care from Providers in the Host Blue geographical area that do not have a contractual agreement ("Nonparticipating Providers") with the Host Blue. BCBSM remains responsible for fulfilling its contractual obligations to you. BCBSM's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that Dental Care Benefits, except when paid as medical claims / benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSM to provide the specific service or services, are not processed through Inter-Plan Arrangements.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Enrollees access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. **Liability Calculation Method Per Claim – In General**

   a. Enrollee Liability Calculation

The calculation of the Enrollee liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the Participating Provider's billed covered charges or the negotiated price made available to BCBSM by the Host Blue.

Under certain circumstances, if BCBSM pays the Healthcare Provider amounts that are the responsibility of the Enrollee, BCBSM may collect such amounts from the Enrollee.

Where Group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, Enrollees will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Nonparticipating Provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a Provider's billed charge, the Enrollee will incur no liability, other than any applicable Enrollee cost sharing.

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b. Group Liability Calculation

The calculation of Group liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSM by the Host Blue under contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Group may be liable for the excess amount even when the Enrollee's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSM may include a factor for such settlement or reconciliations as part of the fees BCBSM charges to Group.

2. Claims Pricing

The Host Blue determines a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to BCBSM by the Host Blue may be represented by one of the following:

(i) an actual price. An actual price is a negotiated payment in effect at the time a Claim is processed without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(iii) an average price. An average price is a percentage of billed charges for covered services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or an average price in its respective Provider agreements. The use of estimated or average pricing may result in a difference (positive or negative) between the price Group pays on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Enrollee and Group is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Group will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Group. If Group terminates, Group will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume / number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. The Host Blue may retain interest earned on funds held in variance accounts.

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3. BlueCard Program Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which BCBSM is obligated under the BlueCard Program to pay to the Host Blue, to the Blue Cross and Blue Shield Association (BCBSA), and/or to vendors of BlueCard Program related services. The specific Blue Card Program fees and compensation that are charged to Group and which Group is responsible related to the foregoing are set forth in Exhibit 1 to this Schedule B. BlueCard Program Fees and compensation may be revised annually from time to time as described in **section H** below.

B. Negotiated Arrangements

With respect to one or more Host Blue, instead of using the BlueCard Program, BCBSM may process your Enrollee claims for covered healthcare services through Negotiated Arrangements.

In addition, if BCBSM and Group have agreed that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in BCBSM's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Enrollees access such network(s). In negotiating such arrangement(s), BCBSM is not acting on behalf of or as an agent for Group, the Group's health care plan or Group Enrollees.

1. Enrollee Liability Calculation

Enrollee liability calculation for covered healthcare services will be based on the lower of either billed covered charges for covered services or negotiated price that the Host Blue makes available to BCBSM that allows Group's Enrollees access to negotiated participation agreement networks of specified Participating Providers outside of BCBSM's service area.

Under certain circumstances, if BCBSM pays the Healthcare Provider amounts that are the responsibility of the Enrollee, BCBSM may collect such amounts from the Enrollee.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSM may include a factor for such settlement or reconciliations as part of the fees BCBSM charges to Group.

Where Group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, Enrollees will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Nonparticipating Provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a Provider's billed charge, the Enrollee will incur no liability, other than any applicable Enrollee cost sharing.

2. Group Liability Calculation

The calculation of Group liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSM by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Group may be liable for the excess amount even when the Enrollee's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

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3. Claims Pricing

Same as in the BlueCard Program above.

4. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangement may be revised annually as described in **section H** below. In addition, the participation agreement with the Host Blue may provide that BCBSM must pay an administrative and/or a network access fee to the Host Blue, and Group further agrees to reimburse BCBSM for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Group under the Negotiated Arrangements are set forth in Exhibit 1 to this Schedule B.

C. Special Cases: Value-Based Programs

Value-Based Programs Overview

Group Enrollees may access covered healthcare services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways, including but not limited to retrospective settlements, Provider Incentives, share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to BCBSM, which BCBSM will pass directly on to Group as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Group via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the Claim, they may be billed as a Per Attributed Member Per Month (PaMPM) amount for Value-Based Programs incentives/Shared Savings settlements to Group outside of the Claim system. BCBSM will pass these Host Blue charges directly through to Group as a separately identified amount on the Group's invoices.

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The amounts used to calculate either the supplemental factors for estimated pricing or PaMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing **section A.3** above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, the Host Blue will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PaMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PaMPM price methods, described above, are calculated. If Group terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of the administrative services contract.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated / drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume / number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. The Host Blue may retain interest earned on funds held in variance accounts.

Note: Enrollees will not bear any portion of the cost of Value-Based Programs except when the Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

The Host Blue may also bill BCBSM for Care Coordinator Fees for Covered Services which BCBSM will pass on to Group as follows:

1. PaMPM billings; or
2. Individual Claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of this agreement / contract, BCBSM and Group will not impose Enrollee cost sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If BCBSM has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to Enrollees, BCBSM will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

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D. Return of Overpayments

Recoveries of overpayments from a Host Blue or its Participating Providers and Nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied so that corrections will be made, in general, on either a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from the Host Blue to BCBSM they will be credited to the Group account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments or recovery amounts. The fees of such a third party may be charged to Group as a percentage of the recovery.

Unless the Host Blue agrees to a longer period of time for retroactive cancellations of membership, the Host Blue will provide BCBSM the full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, BCBSM will request such refunds for a period of up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this agreement / contract.

E. Inter-Plan Programs: Federal / State Taxes / Surcharges / Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSM will provide prior written notice of any such surcharge, tax or other fee to Group, which will be Group liability.

F. Nonparticipating Healthcare Providers Outside BCBSM's Service Area

1. **Enrollee Liability Calculation**

a. In General

When covered healthcare services are provided outside of BCBSM's service area by Nonparticipating Providers, the amount an Enrollee pays for such services will generally be based on either the Host Blue's Nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Enrollee may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

b. Exceptions

In some exception cases, BCBSM may pay Claims from Nonparticipating Providers outside of BCBSM's service area based on the Provider's billed charge, such as in situations where an Enrollee did not have reasonable access to a Participating Provider, as determined by BCBSM in BCBSM's sole and absolute discretion or by applicable state law. In other exception cases, BCBSM may pay such Claims based on the payment BCBSM would make if BCBSM were paying a Nonparticipating Provider inside of its service area where the Host Blue's corresponding payment would be more than BCBSM's in-service area Nonparticipating Provider payment. BCBSM may choose to negotiate a payment with such a Provider on an exception basis.

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Unless otherwise stated, in any of these exception situations, the Enrollee may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph.

2. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Group and that Group will be responsible for in connection with the foregoing are set forth in Exhibit 1 to this Schedule B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in **section H** below.

G. Blue Cross Blue Shield Global Core (Formerly known as BlueCard Worldwide® Program)

1. General Information

If Enrollees are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists Enrollees with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Enrollees receive care from Providers outside the BlueCard service area, the Enrollees will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if Enrollees contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Enrollees to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit Enrollee Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Enrollee paid in full at the time of service, the Enrollee must submit a Claim to obtain reimbursement for covered healthcare services. Enrollees must contact BCBSM to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Enrollees to pay in full at the time of service. Enrollees must submit a Claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Enrollees pay for covered healthcare services outside the BlueCard service area, they must submit a Claim to obtain reimbursement. For institutional and professional claims, Enrollees should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSM, the Blue Cross Blue Shield Global Core Service Center, or online at *www.bcbsglobal.com*. If Enrollees need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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2. Blue Cross Blue Shield Global Core Program-Related Fees

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Group under the Blue Cross Blue Shield Global Core Program and that Group is responsible for relating to the foregoing are set forth in Exhibit 1 to this Schedule B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in **section H** below.

H. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, BCBSM shall provide Group with at least sixty (60) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Group right to terminate the ASC without penalty by giving written notice of termination before the effective date of the change. If Group fails to respond to the notice and does not terminate the ASC during the notice period, Group will be deemed to have approved the proposed changes, and BCBSM will then allow such modifications to become part of the ASC.

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Exhibit 1

BlueCard Program Access Fees may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in BCBSM's administrative fee, unless otherwise agreed to by Group. The BlueCard Access Fee is charged by the Host Blue to BCBSM for making its applicable Provider network available to Group's Enrollees. The BlueCard Access Fee will not apply to Nonparticipating Provider Claims. The BlueCard Access Fee is charged on a per-Claim basis and is charged as a percentage of the discount / differential BCBSM receives from the applicable Host Blue and is capped at $2,000.00 per Claim. The percentages for 2023 are:

1. 3.62% for fewer than 1,000 PPO or traditional enrolled Blue contracts;
2. 2.02% for 1,000–9,999 Blue PPO or traditional enrolled Blue contracts;
3. 1.87% for 10,000–49,999 Blue PPO or traditional enrolled Blue contracts;

For Groups with 50,000 or more Blue PPO or Traditional enrolled contracts, Blue Card Access Fees are waived and not charged to the Group. If Group's enrollment falls below 50,000 PPO enrolled contracts, BCBSM passes the BlueCard Access Fee, when charged, directly on to the Group.

Instances may occur in which the Claim payment is zero or BCBSM pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, BCBSM will pay the Host Blue's Access Fee and passes it directly on to the Group as stated above even though the Group paid little or had no Claim liability.

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Blue Cross Blue Shield of Michigan

STOP-LOSS INSURANCE POLICY

between

BLUE CROSS BLUE SHIELD OF MICHIGAN
a Nonprofit Mutual Insurer

Herein called "the Company"

and

FRANKENMUTH BAVARIAN INN INC.

Herein called "the Policyholder"

The Exhibit attached hereto and made a part of this Policy shall establish the Policyholder's Group Name, Customer ID, and the Policy Period.

In consideration of the Exhibit attached hereto and in consideration of the payment made by the Policyholder of all premiums when due as hereinafter provided, the Company agrees to make the payments herein specified, subject to the provisions and conditions of this Policy.

All definitions of the administrative services contract between the Policyholder and the Company (herein called the "Contract") shall apply equally to this Policy unless otherwise specified in this Policy or the Exhibit.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYHOLDER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE POLICYHOLDER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This Policy is exempt from the filing requirements of Section 2236 of the Insurance Code of 1956, 1956 PA 218, MCL 500.2236.

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SECTION I
DEFINITIONS

Additional definitions applicable to this Policy are contained in the Contract.

1. **"Additional Administrative Compensation" or "AAC"** has the meaning as defined in the applicable Contract.

2. **"Aggregate Attachment Point"** means the dollar amount above which Aggregate Stop-Loss Coverage will apply. The Aggregate Attachment Point is the product of (a) the average number of Coverage Units per month for the Policy Period, (b) the expected Claims per Coverage Unit for the Policy Period and (c) the attachment point percentage listed in Item A of the Exhibit to this Policy provided, however, that the Aggregate Attachment Point shall never be less than the Minimum Aggregate Attachment Point specified in Item A.4. of the Exhibit.

3. **"Aggregate Stop-Loss Coverage"** means the Amounts Billed during the Policy Period (less Specific Stop-Loss Claims, if any) that exceed the Aggregate Attachment Point. For any aggregate credits to be provided, a twelve-month Policy Period is required.

4. **"Aggregating Specific Deductible"** means a deductible, in addition to the Specific Attachment Point, that must be satisfied during the Policy Period before Amounts Billed are credited under this Policy.

5. **"Amounts Billed"** means paid Claims, including any adjusted and re-adjudicated Claims, in addition to the combined amount of BlueCard Fees and AAC, if any. AAC and/or BlueCard Fees shall only be included as "Amounts Billed" where such AAC or fees are paid in association with the types of Claims Covered and in settlement of Claims for any benefits under the Plan, and are:

   (a) In the case of new stop-loss coverage or an existing self-funded customer adding stop-loss coverage: (i) incurred and paid during the Policy Period or (ii) incurred prior to and paid during the Policy Period for which Policyholder is not reimbursed or paid by the prior stop-loss carrier, as specified on the Exhibit.

   (b) In the case of a renewal of existing stop-loss coverage, incurred on or after the Original Effective Date of Policy and paid during the Policy Period, as specified on the Exhibit. Notwithstanding the prior sentence, Amounts Billed includes Claims incurred on or after the effective date of the most recent Contract and paid during the Policy Period.

   (c) Paid during the Run-Out Period, where applicable, in accordance with the provisions of this Policy.

   Claims, AAC, and BlueCard Fees are considered "incurred" on the date the associated service or supply is furnished; Claims, AAC, and BlueCard Fees are considered "paid" on the date they are processed.

6. **"Amounts Billed"** shall not include:

   (a) AAC or BlueCard Fees associated with claims incurred prior to the Original Effective Date of Policy, except as specified on the Exhibit;

   (b) AAC or BlueCard Fees associated with claims incurred after the termination date of this Policy;

   (c) Extra-contractual damages of any nature, compensatory damages, punitive damages, or any similar damages however assessed (including as a result of settlement), or any payments made as an exception to the Plan;

7. **"BCBS Plan"** means a company that has been licensed by the Blue Cross and Blue Shield Association ("BCBSA").

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8. **"BlueCard Fees"** means the fees assessed under the national program established by BCBSA under which BCBS Plan Enrollee claims are processed by BCBS Plans when an Enrollee receives health care services outside of the area served by their BCBS Plan.

9. **"Claim"** means "Claim" as that term is defined in the Contract for the lines of business specified in Items A.2 and/or B.2 in the Exhibit.

10. **"Claims Covered"** means the coverage specified in Items A.1. and/or B.1. of the Exhibit.

11. **"Coverage Unit"** means an Employee plus such person's eligible enrolled dependents. Those dependents are not counted separately but are included within the Employee's "Coverage Unit."

12. **"Enrollee"** means "Enrollee," as that term is defined in the Contract unless the Contract provides coverage for inmates of a penal institution, in which case "Enrollee" means "Inmate," as defined in such Contract.

13. **"Effective Date of Policy"** means the Policy Period start date referenced in the Exhibit.

14. **"Employee"** means "Employee," as that term is defined in the Contract unless the Contract provides coverage for inmates of a penal institution or participants in a Trust Fund, in which case "Employee" means "Inmate" or "Participants," as defined in the relevant Contract.

15. **"Exhibit"** means the attached Exhibit to the Stop-Loss Coverage Policy or any subsequent replacement Exhibit supplied by the Company. The specifications or items of the Exhibit shall be applicable for the Policy Period indicated on the Exhibit, except that any item of the Exhibit may be changed in accordance with the provisions described in this Policy.

16. **"Final Policy Period"** means the period of time beginning on the first day of the Policy Period specified on the Exhibit and ending on the date the Policy is terminated.

17. **"Minimum Aggregate Attachment Point"** is the minimum Claims amount shown in Item A.4 of the Exhibit that must be paid by the Policyholder before Aggregate Stop-Loss Coverage is credited. The Minimum Aggregate Attachment Point is 90 percent of a) the Aggregate Attachment Point as shown in Item A.3. of the Exhibit on a per Coverage Unit basis times b) the number of Coverage Units as shown in Item A.6. of the Exhibit.

18. **"Month"** means each succeeding calendar month period beginning on the first day of the Policy Period.

19. **"Original Effective Date of Policy"** means the date the Policyholder became a Blue Cross Blue Shield of Michigan stop-loss insurance policyholder. If stop-loss coverage was terminated for any reason, the Original Effective Date of Policy means the start date of the most recent uninterrupted policy periods.

20. **"Plan"** shall mean the self-funded group health plan of the Policyholder.

21. **"Policy"** as used herein means this Stop-Loss Insurance Policy.

22. **"Policy Period"** means the period of coverage beginning and ending on the dates shown on the Exhibit.

23. **"Proof of Loss"** means evidence of the Plan's payment or liabilities of Amounts Billed by or on behalf of an Enrollee during the Policy Period.

24. **"Run-In Period"** means the period immediately prior to the initial Policy Period, if any, as specified in Item B.1. of the Exhibit.

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25. **"Run-Out Amounts Billed"** means those Amounts Billed that are incurred on or after the Original Effective Date of Policy but prior to termination and that are paid during the Run-Out Period.

26. **"Run-Out Period"** means the 24-month period immediately following the termination of this Policy.

27. **"Specific Attachment Point"** means the dollar amount above which Specific Stop-Loss Coverage will apply as shown in Item B.3 of the Exhibit.

28. **"Specific Stop-Loss Coverage"** means the Amounts Billed during the current Policy Period in excess of the Specific Attachment Point and the Aggregating Specific Deductible in Item B.4. of the Exhibit, if applicable, per Policy Period.

29. **"Stop-Loss Claims"** means the Amounts Billed for which the Company assumes responsibility and risk.

    (a) If the Amounts Billed that have accumulated during the Policy Period for any Coverage Unit exceed the amount indicated in Item B.3. and the Aggregating Specific Deductible indicated in Item B.4., if applicable, of the Exhibit to this Policy, such excess, up to the maximum amounts indicated, if any, shall be referred to in this Policy as Specific Stop-Loss Claims. A monthly review will occur to determine if such excess exists.

    (b) Specific Stop-Loss Coverage does not extend beyond the termination date of this Policy unless coverage for Run-Out Stop-Loss Insurance is elected at least twelve months prior to termination of the Contract.

    (c) If, during the Run-Out Period, Run-Out Amounts Billed exceed the Specific Attachment Point and the Aggregating Specific Deductible indicated in Item B.4., if applicable, of the Exhibit, such excess, if any, shall be referred to in this Policy as Run-Out Stop-Loss Claims and the coverage provided hereunder for such claims as Run-Out Stop-Loss Insurance.

    (d) If, during the current Policy Period, aggregate Amounts Billed less Specific Stop-Loss Claims, if any, exceed 1) the Aggregate Attachment Point and 2) Minimum Aggregate Attachment Point indicated in Item A.4. of the Exhibit to the Policy, such excess, if any, shall be referred to in this Policy as Aggregate Stop-Loss Claims.

    (e) Stop-Loss Claims may also include claims paid by the Policyholder's prior claim administrator as specified on the Exhibit.

30. **"Stop-Loss Premium"** means the Monthly or annual premium, calculated by multiplying the number of Coverage Units for a particular Month by the premium rate indicated in Items A.5. and/or B.5. of the Exhibit, that is required by the Company for the risk assumed under the Policy as indicated in Item A.1. and/or B.1. of the Exhibit. The Policyholder shall pay to the Company the Stop-Loss Premium by the date set forth on the Stop-Loss Premium invoice. If the Policyholder's payment is more than one business day late, the Policyholder shall pay a late fee in the amount as described in this Policy.

    The Stop-Loss Premium shall be subject to change by the Company (and the Aggregate Stop-Loss Attachment Point revised retroactive to the first month of the Contract Year) upon the occurrence of any of the following:

    (a) Any changes or benefit variances in the Policyholder's Plan, its administration, or the level of benefit valuation which would increase the Company's risk;

    (b) Changes imposed by governmental entities, including taxes and fees, increase expenses incurred by the Company provided that such increases shall be limited to an amount sufficient to recover such increase in expenses; or

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(c) Company determines that there has been a change in Coverages or the number of Coverage Units has changed by an amount equal to 10% or more of total enrollment from the number shown in Items A.6. and/or B.6. of the Exhibit.

Any Stop-Loss Premium changes will be effective beginning on the first day of the first full month following thirty (30) day notification by Company to Policyholder.

SECTION II
POLICY PROVISIONS

1. **STOP-LOSS CREDIT.** The Company hereby agrees to credit the Policyholder as specified in the section of this Policy entitled SETTLEMENTS against the Amounts Billed during the Policy Period which are in excess of the Aggregate Attachment Point or Specific Attachment Point. If the Policyholder selects an Aggregating Specific Deductible as part of its Policy, in addition to the Specific Attachment Point, a deductible of amount specified in Item B.4. in Amounts Billed must be met before any credit is made by the Company. This additional deductible amount may be met on behalf of one or more Enrollees and must be an accumulation of Amounts Billed in excess of those applied to the Specific Attachment Point within the Policy Period. The Company shall not be liable for, nor shall the credit be extended to, any claim or liability for extra-contractual, compensatory, or punitive damages, including interest, statutory penalties and attorney fees or any payments made as an exception to the Plan. Unless otherwise specified in the Exhibit, the Company shall not be liable for the cost of administration of a Plan, including any costs related to investigation, payment or other services provided by a third-party administrator or any other party.

2. **ENTIRETY.** This Policy, the Exhibit, and any attachments shall constitute the entire Policy between the parties for the purposes of this Policy and shall supersede any and all prior or contemporaneous Policies or understandings, either oral or in writing, between the parties with respect to the subject matter herein. This Policy shall not create any right or legal obligation between the Company and any Enrollee under the Plan.

3. **MODIFICATION.** Except for the Exhibit to this Policy, which may be changed at any time in accordance with the provisions of this Policy by notifying the Policyholder in writing of such change, no modification, amendment, change, or waiver of any provision of this Policy shall be valid unless agreed to by an officer of Company and an authorized representative of the Policyholder.

SECTION III
PREMIUM PROVISIONS

1. **PREMIUM PAYMENT.** The premium amounts to be paid to the Company as consideration for the insurance provided hereunder shall be specified on the Exhibit and the method of payment shall be set forth in the Contract.

2. **REMITTANCE.** The Company shall bill the Policyholder for the Stop-Loss Premium amount due and the Policyholder shall remit payment as set forth in the Contract. A remittance will be considered received when actually delivered into the possession or control of the Company.

3. **LATE FEE.** A late fee shall be assessed for the late remittance of any amount(s) due and payable to the Company by the Policyholder. This charge shall be an amount equal to the lesser of:

   (a) 2.0% of any outstanding amount due; or

   (b) The maximum rate permitted by state law.

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4. **NOTICE, SUBROGATION, AND PROOF OF LOSS.** The Company shall reimburse the Policyholder as specified in the section of this Policy entitled SETTLEMENTS. Payment to the Policyholder in settlement of claims hereunder shall not be construed as a waiver of, or prohibition against, the Company's right to adjudicate or make further adjustments to such settlements. The subrogation provisions of the Contract are hereby incorporated by reference except to the extent they conflict with a specific provision of this Policy.

   No action at law or in equity shall be brought to recover on this Policy more than three (3) years from the date of Termination of the Policy regardless of any "Run-Out" Coverage.

   If any time limitation of this section of the Policy is less than that permitted by the state of Michigan at the time this Policy is issued, such limitation is hereby extended to agree with the minimum permitted by such law.

   The books and records of the Policyholder which pertain to the Plan, including any Proof of Loss required by the Plan, shall be open to the Company and its representatives at all times during the usual business hours for inspection.

5. **RUN-OUT STOP-LOSS PREMIUM.** If Run-Out Stop-Loss Insurance is selected by the Policyholder (only available for Specific Stop-Loss Coverage and only if selected at least twelve months prior to termination of the Policy), the Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for the final month before termination by the Specific Stop-Loss Premium amount indicated in Item B.5. and shall be payable for the first three months after termination of the Policy. However, if the number of Coverage Units in the final month is less than the number in the month exactly one year earlier, BCBSM shall calculate the Monthly Premium using the higher count from one year earlier.

SECTION IV
SETTLEMENTS

1. **SPECIFIC STOP-LOSS SETTLEMENT.** The invoices or payment schedules provided under the Contract shall include the premium due under this Policy as well as any credits to the Policyholder for Specific Stop-Loss Claims existing at that time. To the extent that a true-up is needed to reflect corrections or adjustments based on the actual number of Employees covered at any one-time during Policy Period or for other reasons, including but not limited to recovery of claims, the Company will provide, within 120 days after the end of each Policy Period during which this Policy is in effect, an annual settlement. Any deficit or surplus resulting from this settlement will be reflected in a subsequent bill. If the Policyholder owes payment to the Company, the Company reserves the right to deduct amount(s) owed from any payment due the Policyholder as a result of the settlement.

   If this Policy is terminated prior to the expiration of the Policy Period, claim settlements for Specific Stop-Loss Claims will be made, as specified herein, for only those full Months of the Policy Period immediately preceding Policy termination. Specific Stop-Loss Coverage shall not extend beyond the termination date of this Policy.

2. **AGGREGATE STOP-LOSS SETTLEMENT.** For any Aggregate Stop-Loss Claims, the claim settlement shall be provided to the Policyholder by the Company within 120 days after the end of each Policy Period during which this Policy is in effect. If the Policyholder owes payment to the Company, the Company reserves the right to deduct amount(s) owed from any payment due the Policyholder as a result of the settlement.

3. **RUN-OUT PERIOD SETTLEMENT.** If Run-Out Stop-Loss Insurance is selected by the Policyholder (only available for Specific Stop-Loss Insurance and only if selected at least twelve months prior to termination of the Policy), credits shall be provided to the Policyholder for Run-Out Stop-Loss Claims under this Policy as part of the Run-Out process under the Policy. Within 120 days following the Run-Out Period, the Company shall prepare a settlement statement that will include a final reconciliation of all Run-Out Stop-Loss Claims.

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SECTION V
GENERAL PROVISIONS

1. **TERMINATION.** This Policy will terminate upon the earliest of the following dates:

   (a) The end of the Policy Period.

   (b) The date specified in writing by the Policyholder provided that Company is notified at least 30 days in advance of the termination date.

   (c) The date mutually agreed to in writing by both parties.

   (d) The date specified in writing by Company following Policyholder's failure to timely pay amounts due provided that Policyholder is notified at least 5 days in advance of the termination and during which Policyholder's delinquency is not cured.

   (e) The date the Plan terminates.

   (f) The date the Contract terminates.

   In the event of termination of this Policy for any reason prior to the expiration of a Policy Period, no Aggregate Stop-Loss Coverage will exist for the Final Policy Period or Run-Out Period. The Policyholder will be required to fund all claims during the Final Policy Period and Run-Out Period. The Company shall have no obligation to determine a Claim settlement for the period during which coverage was not in effect nor shall the Company refund any portion of the premium(s) to the Policyholder.

2. **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 Policy. Neither party has executed this Policy in reliance on any representations, warranties, nor statements made by the other party hereto other than those expressly set forth herein.

3. **ASSIGNMENT.** No part of this Policy, or any rights, duties, or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Company's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel from other parties shall not constitute an assignment under this Policy.

4. **GOVERNING LAW.** This Policy shall be governed by, and shall be construed in accordance with, the laws of the State of Michigan without regard to any state choice-of-law statutes, and any applicable federal law.

5. **INSOLVENCY.** The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Enrollees under a Plan.

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6. **LIABILITY.** The Company will have neither the right nor the obligation under this Policy (though such right or obligation may exist under the separate Contract) to directly pay any Enrollee or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit an Enrollee to have a direct right of action against the Company. The Company will not be considered a party to the Plan or to any supplement or amendment to it by reason of this Policy.

7. **NO WAIVER.** The failure of either the Policyholder or the Company to insist upon strict performance of any of the terms of this Policy shall not be construed as a waiver of its respective rights or remedies with respect to any subsequent breach or default in any of the terms of this Policy.

8. **NOTICES.** Unless otherwise provided in this Policy, any notice required shall be given in writing and sent to the other party either by hand-delivery, electronic message to a designated representative of the other party, or postage-pre-paid U.S. first-class mail at the following address or such other address as a party may designate from time to time:

   If to Policyholder: to the Policyholder's address as shown in the Contract

   If to the Company: Blue Cross Blue Shield of Michigan
   600 Lafayette East, Mail Code B612
   Detroit, Michigan 48226-2998

9. **OFFSET.** Policyholder must promptly refund any erroneous reimbursement or credit issued by Company upon notice to Policyholder of such error. To the extent Policyholder fails to make such refund, Company may deduct the amount erroneously credited from any future reimbursement or credit owed to Policyholder.

10. **SERVICE MARK LICENSEE STATUS.** The Company is an independent licensee of BCBSA and is licensed to use the "Blue Cross" and "Blue Shield" names and service marks in Michigan. The Company is not an agent of BCBSA and, by entering into this Policy, Policyholder agrees that it did so based solely on its relationship with the Company or its agents. Policyholder agrees that BCBSA is not a party to this Policy, has no obligations under this Policy, and that no BCBSA obligations are created or implied under this Policy.

11. **SEVERABILITY.** In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Policy, but this Policy shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

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Blue Cross Blue Shield Blue Care Network of Michigan

EXHIBIT TO THE STOP-LOSS COVERAGE POLICY

Policyholder: **FRANKENMUTH BAVARIAN INN INC.**

Customer ID: 100340 Policy Period: 03/01/2023 through 02/29/2024

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 and Prescription Drug Claims covered by Stop-Loss Policy
3.	Specific Attachment Point (per Coverage Unit)	$200,000.00
4.	Aggregating Specific Deductible	[N/A]
5.	Monthly Premium (per Coverage Unit)	$78.37
6.	Number of Coverage Units	132
7.	Run-Out Coverage	*Group may elect "Run-Out" Coverage by checking the "Yes" box on the Group Signature Page. Unless checked "Yes", Group will not have Stop-Loss Run-Out coverage.* *"Run-Out" Coverage applies to claims incurred on or after the Original Effective Date of Policy and paid during the Run-Out Period*

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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 coverage details in Items B.2, B.3, and B.4 remain the same 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:	03/01/2024
	through	02/28/2025

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Amendment to Stop-Loss Exhibit & Policy
Effective 03/01/2023 thru 2/29/2024

Policyholder Group Name:	**FRANKENMUTH BAVARIAN INN INC.**
CID Number:	100340
Effective Date of Policy:	03-01-2023

This Amendment to the Stop-Loss Exhibit & Policy modifies and/or supplements the 2023 Stop-Loss Exhibit & Policy to reflect custom arrangements with the Policyholder. If there is a conflict between the terms of the Stop-Loss Exhibit & Policy and this Amendment, the terms of this Amendment will control and govern the rights and obligations of the parties.

It is hereby agreed that the Stop-Loss Exhibit is amended as follows:

Item B.5. Monthly Premium (per Coverage Unit) is modified to add the following:

The number of current Coverage Units is 132. If the number of Coverage Units varies by +/- 10% in any month during its Coverage period, the premium rate may be revised effectively beginning with the next invoice following a thirty (30) day notification by Blue Cross Blue Shield of Michigan to the Group.

All other terms and provisions of the Stop Loss Exhibit & Policy will continue to apply.

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Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

2023 ASC Group – BCBSM Signature Page

Effective for 03/01/2023 – 02/29/2024

Between Blue Cross Blue Shield of Michigan and

FRANKENMUTH BAVARIAN INN INC. (CID - 100340)

BCBSM Executive agrees to countersign the specified documents listed below ("Documents"). Once completed, signatures will be appended to the ASC Group-signed Documents. Copies of these fully-executed Documents will be shared with all parties upon completion. By providing their signatures, all parties are legally bound by the terms and conditions in the Documents referenced.

Documents Included:

- **Schedule A**
  - Exhibit 1 to Schedule A
  - Exhibit 2 to Schedule A
- **Schedule B**
  - Exhibit 1 to Schedule B
- **Stop-Loss Coverage**
  - Stop-Loss Policy
  - Stop-Loss Exhibit
  - Amendment to Stop-Loss Coverage

AGREED AND ACCEPTED.

Blue Cross Blue Shield of Michigan:

By: (Signature)	DocuSigned by: Sandy Fester 97D1FD8C5BEC44B...
Name: (Print)	Sandy Fester
Title:	Vice President
Date:	4/5/2023

Exhibit A

Blue Cross Blue Shield of Michigan

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:	03/08/2016

Indexing Information

Customer ID:	**100340**
Group Type:	**ASC**
Document Type:	**ASC_CONTRACTS**
Document Year:	**2015**

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CM Print

Imaging Support Services

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

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CID - 100340
Territory - PV

Administrative Services Contract – Quarterly Settled Monthly Wire Program

FRANKENMUTH BAVARIAN INN INC.

This Contract commences on 3/1/2016 (the "Effective Date") and is made between Blue Cross Blue Shield of Michigan, a Michigan non-profit mutual insurance corporation, with offices at 600 Lafayette East, Detroit, Michigan 48226-2998 ("BCBSM") and FRANKENMUTH BAVARIAN Inc with offices at 713 S MAIN, FRANKENMUTH MI, 48734 ("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 – Monthly Wire 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 the Universal Group Application or Part C of the Group Enrollment and Coverage Agreement, which is incorporated into this Contract.

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

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

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

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

P. "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.

Q. "Quarterly Payment Period" means each three (3) month period, commencing on the Effective Date and continuing during the term of this Contract and includes the first three (3) months following the date initiating the Termination Assistance Period.

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 makes final benefit determinations and plan interpretations necessary to make those benefit determinations. BCBSM's claims administrator responsibilities extend only to the full and fair review of claims and administrative appeals as set forth in ERISA §433. By assuming these specifically delegated responsibilities as claims administrator, BCBSM does not thereby assume any other duty of the Group as Plan Administrator or any other fiduciary function Group performs on behalf of its Plan. Any determination or interpretation made by BCBSM pursuant to its claim determination authority is binding on the Enrollee, Group, and BCBSM unless it is demonstrated that the determination or interpretation was arbitrary and capricious. Group retains all other fiduciary responsibilities and duties under ERISA not specifically delegated to BCBSM in this Contract.

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

B. **Eligibility and Enrollment.**

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

C. **Claims Processing.**

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

D. **Disputed Claims.**

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

E. **Subrogation.**

BCBSM shall be subrogated to all of Group's, the Plan's, or an Enrollee's rights with respect to any Claim, however, BCBSM is not obligated to institute or become involved in any litigation concerning such Claim. BCBSM will use reasonable efforts to identify Claims in which the Group may have a subrogation or reimbursement interest. BCBSM will evaluate information provided by the Enrollee and other sources to determine whether a subrogation or reimbursement interest exists. BCBSM will

not be obligated to undertake any such recovery litigation unless mutually agreed to by BCBSM and Group in writing. Absent written agreement, should Group elect to pursue such recovery litigation, BCBSM agrees to cooperate in Group's recovery efforts. BCBSM will remit to Group the funds recovered from third parties, less any expenses BCBSM has incurred in the recovery effort, including any attorney fees. BCBSM may assign or subcontract a portion of its duties under this provision of the Contract to third parties. Group will assist BCBSM or its assignee or subcontractor as reasonably necessary for BCBSM, its assignee, or subcontractor to carry out its duties under this provision.

Group authorizes BCBSM to act on behalf of Group and/or the Plan in any health care class action litigation of which BCBSM has knowledge, including but not by way of limitation, drug manufacturer and product liability litigation. BCBSM will take reasonable steps to notify Group of such class action litigation. Group will notify BCBSM if Group desires to independently pursue such litigation and BCBSM will reasonably cooperate with Group. As part of BCBSM's subrogation duties, BCBSM will use reasonable efforts to identify Claims that may be included in such class action litigation. BCBSM may institute and participate in such class action litigation, however, Group acknowledges that BCBSM is not obligated to do so unless BCBSM and Group otherwise agree in writing. Group will reasonably cooperate with BCBSM with respect to any such litigation. BCBSM may assign or subcontract a portion of its duties under this provision to third parties. Group authorizes BCBSM to settle or compromise any litigation and BCBSM will remit to Group any funds recovered, less any expenses that BCBSM has incurred in participation of such class action litigation.

F. **Litigation.**

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

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

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

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

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

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

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

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

judgment including all of BCBSM's reasonable attorney fees and costs for proceeding with the Litigation.

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

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

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

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

G. **Group Audits.**

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

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

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

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

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

Prior to any audit, Group and BCBSM must mutually agree upon any independent third party auditor that Group wishes to perform the audit. Additionally, prior to audit, Group and any third party auditor shall sign all documents BCBSM believes necessary for the audit which will, at a minimum,

provide for: the scope of the audit; the costs for which BCBSM is to be reimbursed by Group; the protection of confidential and proprietary information belonging to BCBSM, and of any patient specific information; and the indemnification and hold harmless of BCBSM from any claims, actions, demands or loss, including all expenses and reasonable attorney fees, arising from any suit or other action brought by an individual or provider to the extent caused by Group or its auditor.

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

H. **Disclosures.**

Group shall disclose the following to Enrollees in writing:

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

I. **Health Care Provider Interest.**

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

J. **Confidentiality.**

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

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

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

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

K. **Amounts Billed.**

1. Claims:

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

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

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

2. Additional Administrative Compensation:

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

3. Health Care Provider Interest:

See Article II.I.

4. Taxes and Surcharges:

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

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

5. Pharmacy Benefits Services:

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

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

L. **Coordination with Medicare.**

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

M. **Pharmacy Benefits.**

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

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

Group authorizes BCBSM to act and serve as Group's exclusive agent for the purpose of negotiating with and obtaining rebates from pharmaceutical manufacturers. Group understands and agrees that BCBSM may directly contract with pharmaceutical manufacturers or BCBSM may contract with various subcontractors that have contracts with pharmaceutical manufacturers. BCBSM's rebate

administrators retain a portion of the total rebates collected from drug manufacturers as a rebate administration fee. BCBSM will pass on to Group rebates net of rebate administration fees. If BCBSM receives rebate adjustments or de minimis amounts of unidentifiable rebates that cannot practicably be tied to particular claims, BCBSM will proportionally allocate those rebate amounts to customers with pharmacy benefits.

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

ARTICLE III
FINANCIAL RESPONSIBILITIES

A. **Group Responsibilities.**

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

B. **Scheduled Payments by Group.**

During the first two Quarterly Payment Periods of this Contract, Group shall pay to BCBSM each month the "Estimated Monthly Payment" which consists of (1) the pro rata cost of the Group's estimated Amounts Billed for the Quarterly Payment Period; (2) the pro rata costs of the Group's estimated administrative charge and, if applicable, of the stop loss fees for the Contract Year; (3) the amount BCBSM determines necessary to maintain the prospective hospital reimbursement funding for the Quarterly Payment Period ("Michigan Hospital Advance"); and (4) any other amounts owed by the Group pursuant to this Contract. Thereafter, approximately thirty (30) days before each Quarterly Payment Period, BCBSM will notify Group of any adjustments in the above amounts to be paid during the next Quarterly Payment Period. The estimated amounts owed relating to Claims for each Quarterly Payment Period are based on the total of Amounts Billed during the prior available twelve (12) months, adjusted for costs and utilization.

C. **Interest.**

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

D. **Schedule A Renewals.**

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

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

Group shall make monthly wire transfer payments of all amounts due to BCBSM within one business day of the payment day set forth in the Quarterly Settlement Payment Schedule. In addition, Group

shall pay to BCBSM any separately invoiced amounts within fifteen (15) days of invoice or settlement receipt.

If Group's payment is more than one business day late, Group shall pay a late fee of the lesser of two percent (2%) of any outstanding amount due or the maximum amount permitted by law. In addition, BCBSM may cease to process Claims retroactive to the last date for which full payment was made.

F. **Settlements.**

1. Quarterly Settlements. Approximately sixty (60) days after the close of each Quarterly Payment Period, BCBSM will provide a settlement that sets forth amounts paid by Group and, to the extent known by BCBSM at that time, the Amounts Billed with respect to the covered lines of business for the immediate prior Quarterly Period.

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

   If the Group has an arrangement whereby it pays AAC, the total AAC reported to Group with the Annual Settlement equals the total amount of AAC collected from Group during the year in Amounts Billed less any AAC that was refunded to Group pursuant to a stop-loss insurance policy with BCBSM. If the total AAC exceeds the maximum AAC set forth in Schedule A, BCBSM shall return the excess AAC to Group. If the total AAC is less than the minimum AAC set forth in Schedule A, Group shall pay BCBSM the shortfall. Neither Group nor BCBSM shall pay any interest on these payments/refunds.

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

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

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

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

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

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

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

ARTICLE IV
TERMINATION AND TERMINATION ASSISTANCE

A. **Termination & Notice.**

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

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

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

B. **Transition Assistance Period.**

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

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

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

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

3. Claim Payments. For the first three (3) months following the TAP Effective Date, Group shall make monthly payments in the same manner as prior to the TAP Effective Date, except that (i) if the TAP Effective Date occurs before the end of a Quarterly Payment Period, the monthly amounts then being made will continue to be made during the first three (3) months following TAP Effective Date and (ii) Group shall pay the fixed administrative fee for only the first two months after the TAP Effective Date. AAC, if any, will continue to be paid for the TAP. Thereafter, for the next twenty-one (21) months, Group shall make monthly payments to BCBSM for Amounts Billed.

   Within ninety (90) days following the TAP Effective Date, BCBSM will prepare a settlement in the form of a quarterly settlement, for the period from the last quarterly settlement through the TAP Effective Date. Within sixty (60) days after the six-month and twelve-month periods following the TAP Effective Date, BCBSM will make new calculations of the EOL, MHS and any other settlements included in CSR, so that Group is aware of any estimated liability and continuing obligation for payment.

   If any EOL balance shows a surplus over any funds then held by BCBSM, the amount of the surplus will be refunded to Group within thirty (30) days. Any Amounts Billed during the TAP will first be charged against any funds then held by BCBSM and, after such funds are exhausted, BCBSM may invoice Group as frequently as each month for Amounts Billed.

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 monthly payments made during the first three (3) month period following termination exceed the actual Amounts Billed during the period, BCBSM will pay the Group interest at the then rate for short term government treasury bonds (STIGB), which is currently calculated as a rolling twelve-month average of the 90-day T-Bill yield rate on the average monthly balance of any excess. The total amount of any excess will be included in the settlement for the last Contract Year.

6. Final Calculation and Notifications of EOL. Within ninety (90) days after the expiration of the Transition Assistance Period, BCBSM will prepare a final 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 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.

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

C. **Service Mark Licensee Status.**

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

D. **Notices.**

Unless otherwise provided in this Contract, any notice required shall be given in writing and sent to the other party either by hand-delivery, electronic mail message to designated representative of the other party, or postage pre-paid US first class mail at the following address or such other address as a party may designate from time to time.

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

E. **Amendment.**

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

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

F. **Severability.**

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

G. **Waiver.**

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

H. **Law.**

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

I. **HIPAA.**

1. Group Certification.

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

2. Business Associate Agreement.

The parties shall enter into a business associate agreement.

J. **Force Majeure.**

Neither BCBSM nor Group shall be deemed to have breached this Contract or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Contract if prevented from doing so by acts of God or the public enemy, fires, floods, storms, earthquakes, riots, strikes, boycotts, lock-outs, wars and war-operations, restraints of government, power or communication line failure, judgment, ruling, order of any federal or state court or agency of competent jurisdiction, change in federal or state law or regulation subsequent to the execution of this Contract, or other circumstances beyond the party's reasonable control for so long as such "force majeure" event reasonably prevents performance.

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

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

In addition, Group shall cause its officers, directors, employees, and representatives and Vendors' officers, directors, employees and representatives to fully and timely cooperate with BCBSM and provide it with the necessary information for BCBSM to ensure its compliance and that of the Plan with PPACA to the extent BCBSM is obligated to do so by law or by contract. This information

includes, but is not limited to, social security numbers or other forms of government identification numbers of each Plan participant and beneficiary.

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

L. **Other Data Requirements.**

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

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

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

If Group conducts, or contracts to have conducted, an internal audit or review of the services performed under any agreement with BCBSM, Group shall provide BCBSM with a copy of such audit or review within thirty (30) days of BCBSM's written request. This also applies to audits/reviews performed by or at the request of any federal or state regulatory agencies of BCBSM services. The selection of an independent auditor by Group to conduct an internal audit of Group does not preclude BCBSM from conducting an audit in accordance with the terms contained herein.

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

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

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

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

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

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

O. **Plan Year.**

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

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

P. **Knowing Assent.**

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

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

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

Is Group's Plan governed by ERISA? ☑ Yes. ☐ No.

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

AGREED AND ACCEPTED.

BCBSM:	GROUP:
By: (Signature)	By: (Signature)
Name: (Print) John Dunn	Name: (Print) Vernon h. Schiefer
Title: Vice President Middle & Small Group	Title: Corporate Accountant
Date: 3/3/16	Date: 2/5/16

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

Exhibit L

Blue Cross Blue Shield of Michigan

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]		10/14/2019	1,496.32	448.90	1,047.42
		0000		MEDICAL					10/16/2019	1,490.06	447.02	1,043.04
		0002		MEDICAL					10/21/2019	2,500.00	750.00	1,750.00
		0002		MEDICAL		[redacted]		09/21/2019	12/06/2019	1,358.87	407.66	951.21
		0002		MEDICAL			[redacted]		10/28/2019	14,256.02	4,276.81	9,979.21
		0007		MEDICAL		[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 M

Blue Cross Blue Shield of Michigan

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	[redacted]	[redacted]		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 T

Blue Cross Blue Shield of Michigan

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	[redacted]		[redacted]		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 P

Blue Cross Blue Shield of Michigan

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	[redacted]	[redacted]		02/10/2020	07/03/2020	106.53	31.96	74.57
		0007		MEDICAL	[redacted]	[redacted]		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	[redacted]		[redacted]		05/01/2020	1,573.09	471.93	1,101.16
		0007		MEDICAL		[redacted]		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 N

Blue Cross Blue Shield of Michigan

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 U

Blue Cross Blue Shield of Michigan

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	[redacted]		[redacted]		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	[redacted]	[redacted]		02/18/2021	02/25/2022	142.00	42.60	99.40
		0000		MEDICAL	[redacted]	[redacted]		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 W

Blue Cross Blue Shield of Michigan

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	[redacted]		[redacted]		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	[redacted]	[redacted]		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

Exhibit S

Blue Cross Blue Shield of Michigan

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	[redacted]	[redacted]		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	[redacted]	[redacted]		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 I

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

GROUP SIGNATURE PAGE

Effective for 2/1/2022 – 12/31/2022

Between Blue Cross Blue Shield of Michigan and

OPUS PACKAGING GROUP INC - CID 236567

Group and Blue Cross Blue Shield of Michigan agree to sign the specified documents checked-off below ("Documents") via this Group Signature Page. 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 referenced. 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:

☒ **Administrative Services Contract** →

- ☐ ASC Contract Amendment
- ☒ Business Associate Agreement

☒ **Schedule A**

- ☒ Exhibit 1 to Schedule A
- ☐ Exhibit 2 to Schedule A

☒ **Schedule B**

- ☒ Exhibit 1 to Schedule B

☒ **Stop-Loss Policy**

- ☒ Stop-Loss Exhibit →
- ☐ Amendment to Stop-Loss Insurance

Requires Group Selection: ***Customer Attestation***

Group Health Plan Type –	
Is Groups' Plan governed by ERISA?	☒ Yes ☐ No
BCBSM will rely on this response to determine requirements applicable to Group and the performance of the Administrative Services Contract.	

Specific Stop-Loss Run-Out Coverage	
Group is electing "Run-Out" Coverage for their Specific Stop-Loss:	☒ Yes ☐ No

Upon signature by the parties, this page will be electronically attached to applicable Documents and stored for reference and record. Copies of this fully executed ASC Contractual package will be shared with all parties upon completion.

AGREED AND ACCEPTED.

BLUE CROSS BLUE SHIELD OF MICHIGAN:	**GROUP CUSTOMER:**
By: (Signature) DocuSigned by: Jeff Connolly 5C17E52EE0EB42B...	**By:** (Signature) DocuSigned by: Louis F. Sicilia 15F28CC0BB8E414...
Name: (Print) Jeff Connolly	**Name:** (Print) Louis F. Sicilia
Title: SVP & President, WMUP	**Title:** CFO
Date: 12/29/2021	**Date:** 12/29/2021

Blue Cross Blue Shield of Michigan
SCHEDULE A – Renewal Term (Effective 02/01/2022 thru 12/31/2022)
Administrative Services Contract (ASC)

1. Group Name OPUS PACKAGING GROUP INC
2. Customer ID 236567
3. ASC Funding Arrangement Weekly Invoice

4. Line(s) of Business and Services

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

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

A. Fixed Administrative Fees	Amount Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Admin Fee	Effective Start Date	Effective End Date
i. 2022 Base Admin Fee	$62.31	392	$24,425.52	02/01/2022	12/31/2022

B. Variable Administrative Fees – *Not Applicable*

6. Data Feeds – *Not Applicable*

7. Advance Deposit – *Not Applicable*

8. Advance Deposit Monthly Cap / Level Payment Amount – *Not Applicable*

9. BCBSM Account

Wire Number	Bank	American Bank Association
	Comerica	

10. Late Payment / Interest Charges

Late Payment Charge	2.00%
Health Care Provider Interest Charge	12.00%

11. Buy-Ups

A. Programs	Pricing Method	Unit Price	Unit Volume	Amount	Effective Start Date	Effective End Date
Online Visits	PCPM	$0.20	392	$78.40	02/01/2022	12/31/2022

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. Hospital Bill Review	30%	Cost avoidance of improper hospital billing by line-by-line reviews of each inpatient claim's itemized bill to identify defects and improprieties before the bill is paid.
B. Advanced Payment Analytics	30%	Recoveries of overpayments using proprietary data mining analytics as a second pass review along with continual monitoring enabling up-to-date policy compliance.
C. Subrogation	30%	Recoveries of money already paid through Blue Cross benefits that is the responsibility of non-health insurance carrier.
D. Hospital Credit Balance	30%	Recoveries of claims through enhanced reviews of hospital patient accounting systems and identified credit balances from overpayments.
E. Advanced Editing	30%	Cost avoidance through applied advanced algorithms and extensive analytic reviews of professional and outpatient facility Claims for adherence to medical, clinical and national coding guidelines.
F. 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.
G. Home Infusion Therapy Medical Drugs	30%	The difference between BCBSM's 2021 home infusion therapy (''HIT'') network pricing and the improved negotiated pricing administered through a third party HIT vendor.
H. 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.
I. Rebate Service Fee for Pharmacy Prescription Drugs	10%	Pharmacy benefit manufacturer rebates on Claims incurred in the renewal term.

13. Pharmacy Pricing Arrangement

A. Traditional Prescription Drug Pricing and Administrative Compensation

Group acknowledges and agrees the amount BCBSM pays its contracted pharmacy benefit manager ("PBM") for a prescription drug may be more or less than the amount Group pays BCBSM for such prescription drug, and BCBSM may retain the difference as administrative compensation as specified below, when the amount is less.

BCBSM shall retain the following administrative compensation ("Traditional Rx Drug Pricing Admin Fee"):

a. Up to two (2) percentage points of the aggregated Average Wholesale Price ("AWP") discount BCBSM receives from its PBM for drugs classified by BCBSM as retail or 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.

c. $0.10 of the dispensing fee for 30-day supplies of retail prescription drugs.

The actual Traditional Rx Drug Pricing Admin Fee paid by Group to BCBSM shall depend on Group's aggregated AWP discount referenced above, which is based 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 Traditional Rx Drug Pricing Admin Fee retained by BCBSM 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.

B. Pharmacy Monitoring Fee (PMF) Pricing – *Not Applicable*

14. Additional Pharmacy Services and/or Programs

A. 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.

B. High-Cost Drug Discount Optimization Program

The High-Cost Drug Discount Optimization Program uses coupons available from pharmaceutical manufacturers to reduce the cost of certain prescription drugs for Enrollees and the Group.

Group will pay BCBSM twenty five percent (25.00%) ("Program Fee") of the difference between the amount Group would have paid for the prescription drug and the amount Group actually paid after the coupon is applied to reduce the cost of the drug. The Program Fee will be billed to Group as a line item on its invoice.

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 may occur in conjunction with BCBSM's customer savings refund process as set forth in the administrative services contract.

Notwithstanding the above, in the first three years of the program (2020-2022), BCBSM will not invoice Group for any additional reimbursement earned by a PE. Moreover, reimbursement returned to BCBSM may 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 Schedule B to ASC and Exhibit 1 to Schedule A 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 J

DocuSign Envelope ID: 145CCBA1-1788-4EB0-B297-70B15D4855A6

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

GROUP SIGNATURE PAGE

Effective 1/1/2023 **thru** 12/31/2023

Between Blue Cross Blue Shield of Michigan and

OPUS PACKAGING GROUP INC - CID # 236567

Group and Blue Cross Blue Shield of Michigan agree to sign the specified documents checked-off below ("Documents") using an electronic signature ("E-Signature"). Each party's E-Signature is the legal equivalent of a manual / handwritten signature on the specified Documents. By providing their E-Signatures below, the parties are legally bound by the terms and conditions in the Documents referenced. Group agrees that no certification authority or other third-party verification is necessary to validate Group's E-Signature, and that the lack of such certification or third-party verification will not in any way affect the enforceability of Group's E-Signature or the Documents.

Documents Included:

- [X] **Schedule A**
  - [X] Exhibit 1 to Schedule A
  - [ ] Exhibit 2 to Schedule A
- [X] **Schedule B**
  - [X] Exhibit 1 to Schedule B
- [X] **Stop-Loss Coverage Policy**
  - [X] Exhibit to the Stop-Loss Coverage Policy
  - [ ] Amendment to Stop-Loss Coverage

If Group has Purchased Specific Stop-Loss:

Group is electing "Run-Out" Coverage: [X] Yes [ ] No

Upon E-Signature by the parties, this page will be electronically attached to applicable Documents and stored for reference and record. E-Signed copies of this fully executed ASC Contractual package will be shared with all parties upon completion.

AGREED AND ACCEPTED.

BLUE CROSS BLUE SHIELD OF MICHIGAN:		**GROUP CUSTOMER:**	
By: (Signature)	DocuSigned by: 0B8AA54DD3AF4C2...	**By:** (Signature)	DocuSigned by: Louis F. Sicilia 15F28CC0BB8F414...
Name: (Print)	Jeffrey Connolly	**Name:** (Print)	Louis F. Sicilia
Title:	SVP/President, WMUP	**Title:**	CFO
Date:	1/11/2023	**Date:**	1/11/2023

DocuSign Envelope ID: 145CCBA1-1788-4EB0-B297-70B15D4855A6

Blue Cross Blue Shield of Michigan
SCHEDULE A – Renewal Term (Effective 01/01/2023 thru 12/31/2023)
Administrative Services Contract (ASC)

1. **Group Name** OPUS PACKAGING GROUP INC
2. **Customer ID** 236567
3. **ASC Funding Arrangement** Weekly Invoice

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

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

5. **Administrative Fees**

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

A. Fixed Administrative Fees	Amount Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Admin Fee	Effective Start Date	Effective End Date
i. 2023 Base Admin Fee	$62.62	415	$25,987.30	01/01/2023	12/31/2023

B. Variable Administrative Fees – *Not Applicable*

6. **Data Feeds – *Not Applicable***

7. **Advance Deposit – *Not Applicable***

8. **Advance Deposit Monthly Cap / Level Payment Amount – *Not Applicable***

9. **BCBSM Account**

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

10. **Late Payment / Interest Charges**

Late Payment Charge	2.00%
Health Care Provider Interest Charge	12.00%

11. **Buy-Ups**

A. Programs	Pricing Method	Unit Price	Unit Volume	Amount	Effective Start Date	Effective End Date
Online Visits	PCPM	$0.20	415	$83.00	01/01/2023	12/31/2023

DocuSign Envelope ID: 145CCBA1-1788-4EB0-B297-70B15D4855A6

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. Hospital Bill Review	30%	Cost avoidance of improper hospital billing by line-by-line reviews of each inpatient claim's itemized bill to identify defects and improprieties before the bill is paid.
B. Advanced Payment Analytics	30%	Recoveries of overpayments using proprietary data mining analytics as a second pass review along with continual monitoring enabling up-to-date policy compliance.
C. Subrogation	30%	Recoveries of money already paid through Blue Cross benefits that is the responsibility of non-health insurance carrier.
D. Hospital Credit Balance	30%	Recoveries of claims through enhanced reviews of hospital patient accounting systems and identified credit balances from overpayments.
E. Advanced Editing	30%	Cost avoidance through applied advanced algorithms and extensive analytic reviews of professional and outpatient facility Claims for adherence to medical, clinical and national coding guidelines.
F. 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.
G. Home Infusion Therapy Medical Drugs	30%	The difference between BCBSM's 2021 home infusion therapy (''HIT'') network pricing and the improved negotiated pricing administered through a third party HIT vendor.
H. 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.
I. Rebate Service Fee for Pharmacy Prescription Drugs	10%	Pharmacy benefit manufacturer rebates on Claims incurred in the renewal term.

DocuSign Envelope ID: 145CCBA1-1788-4EB0-B297-70B15D4855A6

13. Pharmacy Pricing Arrangement

A. Traditional Prescription Drug Pricing and Administrative Compensation

Group acknowledges and agrees the amount BCBSM pays its contracted pharmacy benefit manager ("PBM") for a prescription drug may be more or less than the amount Group pays BCBSM for such prescription drug, and BCBSM may retain the difference as administrative compensation as specified below, when the amount is less.

BCBSM shall retain the following administrative compensation ("Traditional Rx Drug Pricing Admin Fee"):

a. Up to two (2) percentage points of the aggregated Average Wholesale Price ("AWP") discount BCBSM receives from its PBM for drugs classified by BCBSM as retail or 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.

c. $0.10 of the dispensing fee for 30-day supplies of retail prescription drugs.

The actual Traditional Rx Drug Pricing Admin Fee paid by Group to BCBSM shall depend on Group's aggregated AWP discount referenced above, which is based 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 Traditional Rx Drug Pricing Admin Fee retained by BCBSM 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.

B. Pharmacy Monitoring Fee (PMF) Pricing – *Not Applicable*

14. Additional Pharmacy Services and/or Programs

A. 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.

B. High-Cost Drug Discount Optimization Program

The High-Cost Drug Discount Optimization Program uses coupons available from pharmaceutical manufacturers to reduce the cost of certain prescription drugs for Enrollees and the Group.

Group will pay BCBSM a ("Program Fee"), as detailed below based on benefit design:

a. For benefit designs without an integrated or Rx deductible, the Program Fee will be 25% of the difference between the amount Group would have paid for the prescription drug and the amount Group actually paid after the coupon is applied to reduce the cost of the drug.

b. For benefit designs with an integrated or Rx deductible, the Program Fee will be $90.00 per Claim for which a coupon is applied.

The Program Fee will be billed to Group as a combined line item on its invoice.

DocuSign Envelope ID: 145CCBA1-1788-4EB0-B297-70B15D4855A6

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 care coordination 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.

See Schedule B to ASC and Exhibit 1 to Schedule A 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.

DocuSign Envelope ID: 145CCBA1-1788-4EB0-B297-70B15D4855A6

Exhibit 1 to the Schedule A:
Value-Based Provider Reimbursement

As in prior years, the Claims billed to Group include amounts that BCBSM reimburses health care providers including reimbursement tied to value. BCBSM has adopted a provider payment model that includes both fee-based and value-based reimbursement. BCBSM does not unbundle Claims and does not retain any portion of Claims as compensation. Provider reimbursement is governed by separate agreements with providers, BCBSM standard operating procedures, and BCBSM Quality Programs, which are subject to change at BCBSM's discretion. BCBSM shall provide Group with at least sixty (60) days' advance written notice of any additions, modifications, or changes to BCBSM Quality Programs describing the change and the effective date thereof.

BCBSM negotiates provider reimbursement rates on its own behalf and makes those rates available to customers through its products and networks. The reimbursement rates can, and often do, vary from provider to provider. Providers may qualify for higher reimbursement rates for satisfying requirements of certain BCBSM Quality Programs, including, but not limited to:

A. Pay-for-Performance.
Hospitals earn reimbursement for improving quality, cost efficiency and population health. This program recognizes both mid-to-large sized and small rural short-term acute care hospitals for quality improvements such as lower re-admission rates, participating in a statewide health information exchange, and performance in a varied portfolio of collaborative quality initiatives to address many of the most common and costly areas of surgical and medical care in Michigan.

B. Value-Based Contracting.
Hospitals earn reimbursement for improving quality, cost efficiency and population health. Hospitals work with physicians to provide cost-efficient care for a shared patient population, and earn rewards based on improved outcomes across that population.

C. Collaborative Quality Initiatives ("CQIs").
CQIs address many of the most common and costly areas of surgical and medical care in Michigan. In each CQI, hospitals and physicians across the state collect, share and analyze data on patient risk factors, processes of care and outcomes of care, then design and implement changes to improve patient care.

D. Physician Group Incentive Program.
The Physician Group Incentive Program connects approximately 40 physician organizations (representing about 20,000 physicians) statewide to collect data, share best practices and collaborate on initiatives that improve the health care system in Michigan. Participating physician organizations are evaluated and rewarded on transformation of health care delivery, quality metric performance, and performance enablement – all efforts designed to improve the overall value of care delivered while reducing total cost of care.

E. Patient-Centered Medical Home ("PCMH").
In our PCMH model of care, patients get the right care at the right time in the right setting. Since 2009, Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home designation program has fueled statewide movement of primary care into a team-based, proactive model of efficient, cost-effective care centered around the patient.

F. Provider-Delivered Care Management.
PCMH-designated practices increasingly provide personalized care management services for patients with chronic conditions or multiple, ongoing health needs. Patient care teams are assembled according to each patient's needs, and may include nurses, nutritionists, counselors, psychologists, respiratory therapists, asthma educators, certified diabetes educators, social workers, pharmacists and community health workers. Services are coordinated with the care patients are already receiving from their doctor.

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G. Blueprint for Affordability.

The Blueprint for Affordability program combines quality outcomes with a shared financial risk contract that enables providers to manage the health of their patient population and their total cost of care. BCBSM contracting arrangements may also include risk sharing with certain provider entities ("PE"), e.g., physician organizations, physician hospital organizations, health systems, or any combination thereof, that have contracted with BCBSM for upside and downside financial risk.

Providers may receive reward and incentive payments from BCBSM Quality Programs funded through an allocation from provider reimbursement. Such allocations may be to a pooled fund from which value-based payments to providers are made. If a provider's performance results in a payment of additional reimbursement, the reward payment is made from the pooled funding. For Blueprint for Affordability, if the PE's performance results in a return of reimbursement, the amount at risk is returned to the pooled fund to offset a portion other provider gains. BCBSM will not retain any amounts resulting from BCBSM Quality Programs.

As explained in the Blue Card Program disclosure (Schedule B to ASC), an out-of-state Blue Cross Blue Shield Plan ("Host Blue") may also negotiate fee-based and/or value-based reimbursement for their providers. A Host Blue may include all provider reimbursement obligations in Claims or may, at its election, collect some or all of its value-based provider (VBP) reimbursement obligations through a PaMPM benefit expense, as in, for example, the Total Care Program. All Host Blue PaMPM benefit expenses for VBP reimbursement will be consolidated on your monthly invoice and appear as "Out-of-State VBP Provider Reimbursement." The supporting detail for the consolidated amount will be available on e-Bookshelf as reported by each Host Blue Plan. Host Blues determine which members are attributed to eligible providers and calculate the PaMPM VBP reimbursement obligation based only on these attributed members. Host Blue have exclusive control over the calculation of PaMPM VBP reimbursement.

Additional information is available at *www.valuepartnerships.com* and *www.bcbs.com/totalcare*. Questions regarding provider reimbursement and BCBSM Quality Programs or Host Blue VBP reimbursement should be directed to your BCBSM account representative.

Intellectual property may be developed through BCBSM Quality Programs for subsequent license and use by BCBSM or a third party. Group specifically understands, acknowledges, and agrees that it has no rights to any intellectual property, or derivatives thereof, including, but not limited to, copyrights, patents, or licenses, developed thru BCBSM Quality Programs.

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Schedule B
BlueCard Disclosures
Inter-Plan Arrangements

Out-of-Area Services

Overview

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Enrollees access healthcare services outside the geographic area BCBSM serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSM for payment in accordance with the rules of the Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCBSM serves, Enrollees obtain care from Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Enrollees may obtain care from Providers in the Host Blue geographical area that do not have a contractual agreement ("Nonparticipating Providers") with the Host Blue. BCBSM remains responsible for fulfilling its contractual obligations to you. BCBSM's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that Dental Care Benefits, except when paid as medical claims / benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSM to provide the specific service or services, are not processed through Inter-Plan Arrangements.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Enrollees access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. **Liability Calculation Method Per Claim – In General**

    a. Enrollee Liability Calculation

The calculation of the Enrollee liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the Participating Provider's billed covered charges or the negotiated price made available to BCBSM by the Host Blue.

Under certain circumstances, if BCBSM pays the Healthcare Provider amounts that are the responsibility of the Enrollee, BCBSM may collect such amounts from the Enrollee.

Where Group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, Enrollees will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Nonparticipating Provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a Provider's billed charge, the Enrollee will incur no liability, other than any applicable Enrollee cost sharing.

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b. Group Liability Calculation

The calculation of Group liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSM by the Host Blue under contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Group may be liable for the excess amount even when the Enrollee's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSM may include a factor for such settlement or reconciliations as part of the fees BCBSM charges to Group.

2. Claims Pricing

The Host Blue determines a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to BCBSM by the Host Blue may be represented by one of the following:

(i) an actual price. An actual price is a negotiated payment in effect at the time a Claim is processed without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(iii) an average price. An average price is a percentage of billed charges for covered services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or an average price in its respective Provider agreements. The use of estimated or average pricing may result in a difference (positive or negative) between the price Group pays on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Enrollee and Group is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Group will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Group. If Group terminates, Group will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume / number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. The Host Blue may retain interest earned on funds held in variance accounts.

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3. BlueCard Program Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which BCBSM is obligated under the BlueCard Program to pay to the Host Blue, to the Blue Cross and Blue Shield Association (BCBSA), and/or to vendors of BlueCard Program related services. The specific Blue Card Program fees and compensation that are charged to Group and which Group is responsible related to the foregoing are set forth in Exhibit 1 to this Schedule B. BlueCard Program Fees and compensation may be revised annually from time to time as described in **section H** below.

B. Negotiated Arrangements

With respect to one or more Host Blue, instead of using the BlueCard Program, BCBSM may process your Enrollee claims for covered healthcare services through Negotiated Arrangements.

In addition, if BCBSM and Group have agreed that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in BCBSM's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Enrollees access such network(s). In negotiating such arrangement(s), BCBSM is not acting on behalf of or as an agent for Group, the Group's health care plan or Group Enrollees.

1. Enrollee Liability Calculation

Enrollee liability calculation for covered healthcare services will be based on the lower of either billed covered charges for covered services or negotiated price that the Host Blue makes available to BCBSM that allows Group's Enrollees access to negotiated participation agreement networks of specified Participating Providers outside of BCBSM's service area.

Under certain circumstances, if BCBSM pays the Healthcare Provider amounts that are the responsibility of the Enrollee, BCBSM may collect such amounts from the Enrollee.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSM may include a factor for such settlement or reconciliations as part of the fees BCBSM charges to Group.

Where Group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, Enrollees will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Nonparticipating Provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a Provider's billed charge, the Enrollee will incur no liability, other than any applicable Enrollee cost sharing.

2. Group Liability Calculation

The calculation of Group liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSM by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Group may be liable for the excess amount even when the Enrollee's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

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3. Claims Pricing

Same as in the BlueCard Program above.

4. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangement may be revised annually as described in **section H** below. In addition, the participation agreement with the Host Blue may provide that BCBSM must pay an administrative and/or a network access fee to the Host Blue, and Group further agrees to reimburse BCBSM for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Group under the Negotiated Arrangements are set forth in Exhibit 1 to this Schedule B.

C. Special Cases: Value-Based Programs

Value-Based Programs Overview

Group Enrollees may access covered healthcare services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways, including but not limited to retrospective settlements, Provider Incentives, share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to BCBSM, which BCBSM will pass directly on to Group as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Group via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the Claim, they may be billed as a Per Attributed Member Per Month (PaMPM) amount for Value-Based Programs incentives/Shared Savings settlements to Group outside of the Claim system. BCBSM will pass these Host Blue charges directly through to Group as a separately identified amount on the Group's invoices.

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The amounts used to calculate either the supplemental factors for estimated pricing or PaMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing **section A.3** above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, the Host Blue will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PaMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PaMPM price methods, described above, are calculated. If Group terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of the administrative services contract.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated / drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume / number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. The Host Blue may retain interest earned on funds held in variance accounts.

Note: Enrollees will not bear any portion of the cost of Value-Based Programs except when the Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

The Host Blue may also bill BCBSM for Care Coordinator Fees for Covered Services which BCBSM will pass on to Group as follows:

1. PaMPM billings; or
2. Individual Claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of this agreement / contract, BCBSM and Group will not impose Enrollee cost sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If BCBSM has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to Enrollees, BCBSM will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

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D. Return of Overpayments

Recoveries of overpayments from a Host Blue or its Participating Providers and Nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied so that corrections will be made, in general, on either a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from the Host Blue to BCBSM they will be credited to the Group account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments or recovery amounts. The fees of such a third party may be charged to Group as a percentage of the recovery.

Unless the Host Blue agrees to a longer period of time for retroactive cancellations of membership, the Host Blue will provide BCBSM the full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, BCBSM will request such refunds for a period of up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this agreement / contract.

E. Inter-Plan Programs: Federal / State Taxes / Surcharges / Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSM will provide prior written notice of any such surcharge, tax or other fee to Group, which will be Group liability.

F. Nonparticipating Healthcare Providers Outside BCBSM's Service Area

1. Enrollee Liability Calculation

a. In General

When covered healthcare services are provided outside of BCBSM's service area by Nonparticipating Providers, the amount an Enrollee pays for such services will generally be based on either the Host Blue's Nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Enrollee may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

b. Exceptions

In some exception cases, BCBSM may pay Claims from Nonparticipating Providers outside of BCBSM's service area based on the Provider's billed charge, such as in situations where an Enrollee did not have reasonable access to a Participating Provider, as determined by BCBSM in BCBSM's sole and absolute discretion or by applicable state law. In other exception cases, BCBSM may pay such Claims based on the payment BCBSM would make if BCBSM were paying a Nonparticipating Provider inside of its service area where the Host Blue's corresponding payment would be more than BCBSM's in-service area Nonparticipating Provider payment. BCBSM may choose to negotiate a payment with such a Provider on an exception basis.

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Unless otherwise stated, in any of these exception situations, the Enrollee may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph.

2. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Group and that Group will be responsible for in connection with the foregoing are set forth in Exhibit 1 to this Schedule B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in **section H** below.

G. Blue Cross Blue Shield Global Core (Formerly known as BlueCard Worldwide® Program)

1. General Information

If Enrollees are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists Enrollees with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Enrollees receive care from Providers outside the BlueCard service area, the Enrollees will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if Enrollees contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Enrollees to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit Enrollee Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Enrollee paid in full at the time of service, the Enrollee must submit a Claim to obtain reimbursement for covered healthcare services. Enrollees must contact BCBSM to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Enrollees to pay in full at the time of service. Enrollees must submit a Claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Enrollees pay for covered healthcare services outside the BlueCard service area, they must submit a Claim to obtain reimbursement. For institutional and professional claims, Enrollees should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSM, the Blue Cross Blue Shield Global Core Service Center, or online at *www.bcbsglobal.com*. If Enrollees need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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2. Blue Cross Blue Shield Global Core Program-Related Fees

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Group under the Blue Cross Blue Shield Global Core Program and that Group is responsible for relating to the foregoing are set forth in Exhibit 1 to this Schedule B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in **section H** below.

H. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, BCBSM shall provide Group with at least sixty (60) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Group right to terminate the ASC without penalty by giving written notice of termination before the effective date of the change. If Group fails to respond to the notice and does not terminate the ASC during the notice period, Group will be deemed to have approved the proposed changes, and BCBSM will then allow such modifications to become part of the ASC.

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Exhibit 1

BlueCard Program Access Fees may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in BCBSM's administrative fee, unless otherwise agreed to by Group. The BlueCard Access Fee is charged by the Host Blue to BCBSM for making its applicable Provider network available to Group's Enrollees. The BlueCard Access Fee will not apply to Nonparticipating Provider Claims. The BlueCard Access Fee is charged on a per-Claim basis and is charged as a percentage of the discount / differential BCBSM receives from the applicable Host Blue and is capped at $2,000.00 per Claim. The percentages for 2023 are:

1. 3.62% for fewer than 1,000 PPO or traditional enrolled Blue contracts;
2. 2.02% for 1,000–9,999 Blue PPO or traditional enrolled Blue contracts;
3. 1.87% for 10,000–49,999 Blue PPO or traditional enrolled Blue contracts;

For Groups with 50,000 or more Blue PPO or Traditional enrolled contracts, Blue Card Access Fees are waived and not charged to the Group. If Group's enrollment falls below 50,000 PPO enrolled contracts, BCBSM passes the BlueCard Access Fee, when charged, directly on to the Group.

Instances may occur in which the Claim payment is zero or BCBSM pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, BCBSM will pay the Host Blue's Access Fee and passes it directly on to the Group as stated above even though the Group paid little or had no Claim liability.

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Blue Cross Blue Shield of Michigan

STOP-LOSS INSURANCE POLICY

between

BLUE CROSS BLUE SHIELD OF MICHIGAN
a Nonprofit Mutual Insurer

Herein called "the Company"

and

OPUS PACKAGING GROUP INC

Herein called "the Policyholder"

The Exhibit attached hereto and made a part of this Policy shall establish the Policyholder's Group Name, Customer ID, and the Policy Period.

In consideration of the Exhibit attached hereto and in consideration of the payment made by the Policyholder of all premiums when due as hereinafter provided, the Company agrees to make the payments herein specified, subject to the provisions and conditions of this Policy.

All definitions of the administrative services contract between the Policyholder and the Company (herein called the "Contract") shall apply equally to this Policy unless otherwise specified in this Policy or the Exhibit.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYHOLDER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE POLICYHOLDER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This Policy is exempt from the filing requirements of Section 2236 of the Insurance Code of 1956, 1956 PA 218, MCL 500.2236.

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SECTION I
DEFINITIONS

Additional definitions applicable to this Policy are contained in the Contract.

1. **"Additional Administrative Compensation" or "AAC"** has the meaning as defined in the applicable Contract.

2. **"Aggregate Attachment Point"** means the dollar amount above which Aggregate Stop-Loss Coverage will apply. The Aggregate Attachment Point is the product of (a) the average number of Coverage Units per month for the Policy Period, (b) the expected Claims per Coverage Unit for the Policy Period and (c) the attachment point percentage listed in Item A of the Exhibit to this Policy provided, however, that the Aggregate Attachment Point shall never be less than the Minimum Aggregate Attachment Point specified in Item A.4. of the Exhibit.

3. **"Aggregate Stop-Loss Coverage"** means the Amounts Billed during the Policy Period (less Specific Stop-Loss Claims, if any) that exceed the Aggregate Attachment Point. For any aggregate credits to be provided, a twelve-month Policy Period is required.

4. **"Aggregating Specific Deductible"** means a deductible, in addition to the Specific Attachment Point, that must be satisfied during the Policy Period before Amounts Billed are credited under this Policy.

5. **"Amounts Billed"** means paid Claims, including any adjusted and re-adjudicated Claims, in addition to the combined amount of BlueCard Fees and AAC, if any. AAC and/or BlueCard Fees shall only be included as "Amounts Billed" where such AAC or fees are paid in association with the types of Claims Covered and in settlement of Claims for any benefits under the Plan, and are:

   (a) In the case of new stop-loss coverage or an existing self-funded customer adding stop-loss coverage: (i) incurred and paid during the Policy Period or (ii) incurred prior to and paid during the Policy Period for which Policyholder is not reimbursed or paid by the prior stop-loss carrier, as specified on the Exhibit.

   (b) In the case of a renewal of existing stop-loss coverage, incurred on or after the Original Effective Date of Policy and paid during the Policy Period, as specified on the Exhibit. Notwithstanding the prior sentence, Amounts Billed includes Claims incurred on or after the effective date of the most recent Contract and paid during the Policy Period.

   (c) Paid during the Run-Out Period, where applicable, in accordance with the provisions of this Policy.

   Claims, AAC, and BlueCard Fees are considered "incurred" on the date the associated service or supply is furnished; Claims, AAC, and BlueCard Fees are considered "paid" on the date they are processed.

6. **"Amounts Billed"** shall not include:

   (a) AAC or BlueCard Fees associated with claims incurred prior to the Original Effective Date of Policy, except as specified on the Exhibit;

   (b) AAC or BlueCard Fees associated with claims incurred after the termination date of this Policy;

   (c) Extra-contractual damages of any nature, compensatory damages, punitive damages, or any similar damages however assessed (including as a result of settlement), or any payments made as an exception to the Plan;

7. **"BCBS Plan"** means a company that has been licensed by the Blue Cross and Blue Shield Association ("BCBSA").

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8. **"BlueCard Fees"** means the fees assessed under the national program established by BCBSA under which BCBS Plan Enrollee claims are processed by BCBS Plans when an Enrollee receives health care services outside of the area served by their BCBS Plan.

9. **"Claim"** means "Claim" as that term is defined in the Contract for the lines of business specified in Items A.2 and/or B.2 in the Exhibit.

10. **"Claims Covered"** means the coverage specified in Items A.1. and/or B.1. of the Exhibit.

11. **"Coverage Unit"** means an Employee plus such person's eligible enrolled dependents. Those dependents are not counted separately but are included within the Employee's "Coverage Unit."

12. **"Enrollee"** means "Enrollee," as that term is defined in the Contract unless the Contract provides coverage for inmates of a penal institution, in which case "Enrollee" means "Inmate," as defined in such Contract.

13. **"Effective Date of Policy"** means the Policy Period start date referenced in the Exhibit.

14. **"Employee"** means "Employee," as that term is defined in the Contract unless the Contract provides coverage for inmates of a penal institution or participants in a Trust Fund, in which case "Employee" means "Inmate" or "Participants," as defined in the relevant Contract.

15. **"Exhibit"** means the attached Exhibit to the Stop-Loss Coverage Policy or any subsequent replacement Exhibit supplied by the Company. The specifications or items of the Exhibit shall be applicable for the Policy Period indicated on the Exhibit, except that any item of the Exhibit may be changed in accordance with the provisions described in this Policy.

16. **"Final Policy Period"** means the period of time beginning on the first day of the Policy Period specified on the Exhibit and ending on the date the Policy is terminated.

17. **"Minimum Aggregate Attachment Point"** is the minimum Claims amount shown in Item A.4 of the Exhibit that must be paid by the Policyholder before Aggregate Stop-Loss Coverage is credited. The Minimum Aggregate Attachment Point is 90 percent of a) the Aggregate Attachment Point as shown in Item A.3. of the Exhibit on a per Coverage Unit basis times b) the number of Coverage Units as shown in Item A.6. of the Exhibit.

18. **"Month"** means each succeeding calendar month period beginning on the first day of the Policy Period.

19. **"Original Effective Date of Policy"** means the date the Policyholder became a Blue Cross Blue Shield of Michigan stop-loss insurance policyholder. If stop-loss coverage was terminated for any reason, the Original Effective Date of Policy means the start date of the most recent uninterrupted policy periods.

20. **"Plan"** shall mean the self-funded group health plan of the Policyholder.

21. **"Policy"** as used herein means this Stop-Loss Insurance Policy.

22. **"Policy Period"** means the period of coverage beginning and ending on the dates shown on the Exhibit.

23. **"Proof of Loss"** means evidence of the Plan's payment or liabilities of Amounts Billed by or on behalf of an Enrollee during the Policy Period.

24. **"Run-In Period"** means the period immediately prior to the initial Policy Period, if any, as specified in Item B.1. of the Exhibit.

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25. **"Run-Out Amounts Billed"** means those Amounts Billed that are incurred on or after the Original Effective Date of Policy but prior to termination and that are paid during the Run-Out Period.

26. **"Run-Out Period"** means the 24-month period immediately following the termination of this Policy.

27. **"Specific Attachment Point"** means the dollar amount above which Specific Stop-Loss Coverage will apply as shown in Item B.3 of the Exhibit.

28. **"Specific Stop-Loss Coverage"** means the Amounts Billed during the current Policy Period in excess of the Specific Attachment Point and the Aggregating Specific Deductible in Item B.4. of the Exhibit, if applicable, per Policy Period.

29. **"Stop-Loss Claims"** means the Amounts Billed for which the Company assumes responsibility and risk.

    (a) If the Amounts Billed that have accumulated during the Policy Period for any Coverage Unit exceed the amount indicated in Item B.3. and the Aggregating Specific Deductible indicated in Item B.4., if applicable, of the Exhibit to this Policy, such excess, up to the maximum amounts indicated, if any, shall be referred to in this Policy as Specific Stop-Loss Claims. A monthly review will occur to determine if such excess exists.

    (b) Specific Stop-Loss Coverage does not extend beyond the termination date of this Policy unless coverage for Run-Out Stop-Loss Insurance is elected at least twelve months prior to termination of the Contract.

    (c) If, during the Run-Out Period, Run-Out Amounts Billed exceed the Specific Attachment Point and the Aggregating Specific Deductible indicated in Item B.4., if applicable, of the Exhibit, such excess, if any, shall be referred to in this Policy as Run-Out Stop-Loss Claims and the coverage provided hereunder for such claims as Run-Out Stop-Loss Insurance.

    (d) If, during the current Policy Period, aggregate Amounts Billed less Specific Stop-Loss Claims, if any, exceed 1) the Aggregate Attachment Point and 2) Minimum Aggregate Attachment Point indicated in Item A.4. of the Exhibit to the Policy, such excess, if any, shall be referred to in this Policy as Aggregate Stop-Loss Claims.

    (e) Stop-Loss Claims may also include claims paid by the Policyholder's prior claim administrator as specified on the Exhibit.

30. **"Stop-Loss Premium"** means the Monthly or annual premium, calculated by multiplying the number of Coverage Units for a particular Month by the premium rate indicated in Items A.5. and/or B.5. of the Exhibit, that is required by the Company for the risk assumed under the Policy as indicated in Item A.1. and/or B.1. of the Exhibit. The Policyholder shall pay to the Company the Stop-Loss Premium by the date set forth on the Stop-Loss Premium invoice. If the Policyholder's payment is more than one business day late, the Policyholder shall pay a late fee in the amount as described in this Policy.

    The Stop-Loss Premium shall be subject to change by the Company (and the Aggregate Stop-Loss Attachment Point revised retroactive to the first month of the Contract Year) upon the occurrence of any of the following:

    (a) Any changes or benefit variances in the Policyholder's Plan, its administration, or the level of benefit valuation which would increase the Company's risk;

    (b) Changes imposed by governmental entities, including taxes and fees, increase expenses incurred by the Company provided that such increases shall be limited to an amount sufficient to recover such increase in expenses; or

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(c) Company determines that there has been a change in Coverages or the number of Coverage Units has changed by an amount equal to 10% or more of total enrollment from the number shown in Items A.6. and/or B.6. of the Exhibit.

Any Stop-Loss Premium changes will be effective beginning on the first day of the first full month following thirty (30) day notification by Company to Policyholder.

SECTION II
POLICY PROVISIONS

1. **STOP-LOSS CREDIT.** The Company hereby agrees to credit the Policyholder as specified in the section of this Policy entitled SETTLEMENTS against the Amounts Billed during the Policy Period which are in excess of the Aggregate Attachment Point or Specific Attachment Point. If the Policyholder selects an Aggregating Specific Deductible as part of its Policy, in addition to the Specific Attachment Point, a deductible of amount specified in Item B.4. in Amounts Billed must be met before any credit is made by the Company. This additional deductible amount may be met on behalf of one or more Enrollees and must be an accumulation of Amounts Billed in excess of those applied to the Specific Attachment Point within the Policy Period. The Company shall not be liable for, nor shall the credit be extended to, any claim or liability for extra-contractual, compensatory, or punitive damages, including interest, statutory penalties and attorney fees or any payments made as an exception to the Plan. Unless otherwise specified in the Exhibit, the Company shall not be liable for the cost of administration of a Plan, including any costs related to investigation, payment or other services provided by a third-party administrator or any other party.

2. **ENTIRETY.** This Policy, the Exhibit, and any attachments shall constitute the entire Policy between the parties for the purposes of this Policy and shall supersede any and all prior or contemporaneous Policies or understandings, either oral or in writing, between the parties with respect to the subject matter herein. This Policy shall not create any right or legal obligation between the Company and any Enrollee under the Plan.

3. **MODIFICATION.** Except for the Exhibit to this Policy, which may be changed at any time in accordance with the provisions of this Policy by notifying the Policyholder in writing of such change, no modification, amendment, change, or waiver of any provision of this Policy shall be valid unless agreed to by an officer of Company and an authorized representative of the Policyholder.

SECTION III
PREMIUM PROVISIONS

1. **PREMIUM PAYMENT.** The premium amounts to be paid to the Company as consideration for the insurance provided hereunder shall be specified on the Exhibit and the method of payment shall be set forth in the Contract.

2. **REMITTANCE.** The Company shall bill the Policyholder for the Stop-Loss Premium amount due and the Policyholder shall remit payment as set forth in the Contract. A remittance will be considered received when actually delivered into the possession or control of the Company.

3. **LATE FEE.** A late fee shall be assessed for the late remittance of any amount(s) due and payable to the Company by the Policyholder. This charge shall be an amount equal to the lesser of:

   (a) 2.0% of any outstanding amount due; or

   (b) The maximum rate permitted by state law.

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4. **NOTICE, SUBROGATION, AND PROOF OF LOSS.** The Company shall reimburse the Policyholder as specified in the section of this Policy entitled SETTLEMENTS. Payment to the Policyholder in settlement of claims hereunder shall not be construed as a waiver of, or prohibition against, the Company's right to adjudicate or make further adjustments to such settlements. The subrogation provisions of the Contract are hereby incorporated by reference except to the extent they conflict with a specific provision of this Policy.

   No action at law or in equity shall be brought to recover on this Policy more than three (3) years from the date of Termination of the Policy regardless of any "Run-Out" Coverage.

   If any time limitation of this section of the Policy is less than that permitted by the state of Michigan at the time this Policy is issued, such limitation is hereby extended to agree with the minimum permitted by such law.

   The books and records of the Policyholder which pertain to the Plan, including any Proof of Loss required by the Plan, shall be open to the Company and its representatives at all times during the usual business hours for inspection.

5. **RUN-OUT STOP-LOSS PREMIUM.** If Run-Out Stop-Loss Insurance is selected by the Policyholder (only available for Specific Stop-Loss Coverage and only if selected at least twelve months prior to termination of the Policy), the Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for the final month before termination by the Specific Stop-Loss Premium amount indicated in Item B.5. and shall be payable for the first three months after termination of the Policy. However, if the number of Coverage Units in the final month is less than the number in the month exactly one year earlier, BCBSM shall calculate the Monthly Premium using the higher count from one year earlier.

SECTION IV
SETTLEMENTS

1. **SPECIFIC STOP-LOSS SETTLEMENT.** The invoices or payment schedules provided under the Contract shall include the premium due under this Policy as well as any credits to the Policyholder for Specific Stop-Loss Claims existing at that time. To the extent that a true-up is needed to reflect corrections or adjustments based on the actual number of Employees covered at any one-time during Policy Period or for other reasons, including but not limited to recovery of claims, the Company will provide, within 120 days after the end of each Policy Period during which this Policy is in effect, an annual settlement. Any deficit or surplus resulting from this settlement will be reflected in a subsequent bill. If the Policyholder owes payment to the Company, the Company reserves the right to deduct amount(s) owed from any payment due the Policyholder as a result of the settlement.

   If this Policy is terminated prior to the expiration of the Policy Period, claim settlements for Specific Stop-Loss Claims will be made, as specified herein, for only those full Months of the Policy Period immediately preceding Policy termination. Specific Stop-Loss Coverage shall not extend beyond the termination date of this Policy.

2. **AGGREGATE STOP-LOSS SETTLEMENT.** For any Aggregate Stop-Loss Claims, the claim settlement shall be provided to the Policyholder by the Company within 120 days after the end of each Policy Period during which this Policy is in effect. If the Policyholder owes payment to the Company, the Company reserves the right to deduct amount(s) owed from any payment due the Policyholder as a result of the settlement.

3. **RUN-OUT PERIOD SETTLEMENT.** If Run-Out Stop-Loss Insurance is selected by the Policyholder (only available for Specific Stop-Loss Insurance and only if selected at least twelve months prior to termination of the Policy), credits shall be provided to the Policyholder for Run-Out Stop-Loss Claims under this Policy as part of the Run-Out process under the Policy. Within 120 days following the Run-Out Period, the Company shall prepare a settlement statement that will include a final reconciliation of all Run-Out Stop-Loss Claims.

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SECTION V
GENERAL PROVISIONS

1. **TERMINATION.** This Policy will terminate upon the earliest of the following dates:

   (a) The end of the Policy Period.

   (b) The date specified in writing by the Policyholder provided that Company is notified at least 30 days in advance of the termination date.

   (c) The date mutually agreed to in writing by both parties.

   (d) The date specified in writing by Company following Policyholder's failure to timely pay amounts due provided that Policyholder is notified at least 5 days in advance of the termination and during which Policyholder's delinquency is not cured.

   (e) The date the Plan terminates.

   (f) The date the Contract terminates.

   In the event of termination of this Policy for any reason prior to the expiration of a Policy Period, no Aggregate Stop-Loss Coverage will exist for the Final Policy Period or Run-Out Period. The Policyholder will be required to fund all claims during the Final Policy Period and Run-Out Period. The Company shall have no obligation to determine a Claim settlement for the period during which coverage was not in effect nor shall the Company refund any portion of the premium(s) to the Policyholder.

2. **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 Policy. Neither party has executed this Policy in reliance on any representations, warranties, nor statements made by the other party hereto other than those expressly set forth herein.

3. **ASSIGNMENT.** No part of this Policy, or any rights, duties, or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Company's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel from other parties shall not constitute an assignment under this Policy.

4. **GOVERNING LAW.** This Policy shall be governed by, and shall be construed in accordance with, the laws of the State of Michigan without regard to any state choice-of-law statutes, and any applicable federal law.

5. **INSOLVENCY.** The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Enrollees under a Plan.

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6. **LIABILITY.** The Company will have neither the right nor the obligation under this Policy (though such right or obligation may exist under the separate Contract) to directly pay any Enrollee or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit an Enrollee to have a direct right of action against the Company. The Company will not be considered a party to the Plan or to any supplement or amendment to it by reason of this Policy.

7. **NO WAIVER.** The failure of either the Policyholder or the Company to insist upon strict performance of any of the terms of this Policy shall not be construed as a waiver of its respective rights or remedies with respect to any subsequent breach or default in any of the terms of this Policy.

8. **NOTICES.** Unless otherwise provided in this Policy, any notice required shall be given in writing and sent to the other party either by hand-delivery, electronic message to a designated representative of the other party, or postage-pre-paid U.S. first-class mail at the following address or such other address as a party may designate from time to time:

   If to Policyholder: to the Policyholder's address as shown in the Contract

   If to the Company: Blue Cross Blue Shield of Michigan
   600 Lafayette East, Mail Code B612
   Detroit, Michigan 48226-2998

9. **OFFSET.** Policyholder must promptly refund any erroneous reimbursement or credit issued by Company upon notice to Policyholder of such error. To the extent Policyholder fails to make such refund, Company may deduct the amount erroneously credited from any future reimbursement or credit owed to Policyholder.

10. **SERVICE MARK LICENSEE STATUS.** The Company is an independent licensee of BCBSA and is licensed to use the "Blue Cross" and "Blue Shield" names and service marks in Michigan. The Company is not an agent of BCBSA and, by entering into this Policy, Policyholder agrees that it did so based solely on its relationship with the Company or its agents. Policyholder agrees that BCBSA is not a party to this Policy, has no obligations under this Policy, and that no BCBSA obligations are created or implied under this Policy.

11. **SEVERABILITY.** In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Policy, but this Policy shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

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Blue Cross Blue Shield Blue Care Network of Michigan

EXHIBIT TO THE STOP-LOSS COVERAGE POLICY

Policyholder:	**OPUS PACKAGING GROUP INC**				
Customer ID:	236567	Policy Period:	01/01/2023	through	12/31/2023

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

Attachment Point percentage of the expected Claims for the Policy Period	125%
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 and Prescription Drug Claims covered by Stop-Loss Policy
3. Attachment Point (per Coverage Unit)	$9,647.00
4. Minimum Aggregate Attachment Point	$3,603,154.50
5. Monthly Premium (per Coverage Unit)	$4.49
6. Number of Coverage Units	415

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 and Prescription Drug Claims covered by Stop-Loss Policy
3. Specific Attachment Point (per Coverage Unit)	$175,000.00
4. Aggregating Specific Deductible	[N/A]
5. Monthly Premium (per Coverage Unit)	$121.45
6. Number of Coverage Units	415
7. Run-Out Coverage	*Group may elect "Run-Out" Coverage by checking the "Yes" box on the Group Signature Page. Unless checked "Yes", Group will not have Stop-Loss Run-Out coverage.* *"Run-Out" Coverage applies to claims incurred on or after the Original Effective Date of Policy and paid during the Run-Out Period*

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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 coverage details in Items B.2, B.3, and B.4 remain the same 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:	01/01/2024
through	12/31/2024

Exhibit H

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

GROUP SIGNATURE PAGE

Effective for 2/1/2022 – 12/31/2022

Between Blue Cross Blue Shield of Michigan and

OPUS PACKAGING GROUP INC - CID 236567

Group and Blue Cross Blue Shield of Michigan agree to sign the specified documents checked-off below ("Documents") via this Group Signature Page. 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 referenced. 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:

- ☒ **Administrative Services Contract** →
  - ☐ ASC Contract Amendment
  - ☒ Business Associate Agreement
- ☒ **Schedule A**
  - ☒ Exhibit 1 to Schedule A
  - ☐ Exhibit 2 to Schedule A
- ☒ **Schedule B**
  - ☒ Exhibit 1 to Schedule B
- ☒ **Stop-Loss Policy**
  - ☒ Stop-Loss Exhibit →
  - ☐ Amendment to Stop-Loss Insurance

Requires Group Selection: ***Customer Attestation***

Group Health Plan Type –	
Is Groups' Plan governed by ERISA?	☒ Yes ☐ No
BCBSM will rely on this response to determine requirements applicable to Group and the performance of the Administrative Services Contract.	

Specific Stop-Loss Run-Out Coverage	
Group is electing "Run-Out" Coverage for their Specific Stop-Loss:	☒ Yes ☐ No

Upon signature by the parties, this page will be electronically attached to applicable Documents and stored for reference and record. Copies of this fully executed ASC Contractual package will be shared with all parties upon completion.

AGREED AND ACCEPTED.

BLUE CROSS BLUE SHIELD OF MICHIGAN:	**GROUP CUSTOMER:**
By: (Signature) DocuSigned by: Jeff Connolly 5C17E52EE0EB42B...	**By:** (Signature) DocuSigned by: Louis F. Sicilia 15F28CC0BB8E414...
Name: (Print) Jeff Connolly	**Name:** (Print) Louis F. Sicilia
Title: SVP & President, WMUP	**Title:** CFO
Date: 12/29/2021	**Date:** 12/29/2021

Blue Cross Blue Shield of Michigan

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

ADMINISTRATIVE SERVICES CONTRACT
WEEKLY INVOICE PROGRAM

Group Name: **Opus Packaging Group Inc**

Address: **6995 Southbelt Drive, Caledonia, MI 49316**

Customer ID: **236567** **Effective Date:** **2/1/2022**

This Contract commences on the above effective date ("Effective Date") and is made between Blue Cross Blue Shield of Michigan, a Michigan non-profit mutual insurance corporation ("BCBSM") and the group customer named above ("Group"), as the plan sponsor and administrator of its group health care plan ("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. **"BCBS Plan"** means a company that has been licensed by BCBSA other than BCBSM.

B. **"BCBSA"** means the Blue Cross and Blue Shield Association.

C. **"BlueCard Program"** means the national program established by BCBSA under which Claims are processed by BCBS Plans when Enrollees receive health care services outside of Michigan. 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 sixty (60) days prior written notice to Group.

D. **"Claim"** means, for the lines of business set forth in Schedule A, a payment request from a health care provider or an Enrollee for a health care service, product, or prescription drug provided to an Enrollee, with an incurred date during the term of this Contract. Claims billed to Group are negotiated rates paid to health care providers pursuant to BCBSM or a BCBS Plan's provider agreements, which may include both service-based and value-based reimbursement. Service-based reimbursement means a BCBSM or BCBS Plan fee for a health care service. Value-based reimbursement means a fee for Quality Programs, as more fully described in Exhibit 1 to Schedule A.

BCBSM and BCBS Plans negotiate provider reimbursement rates on their own behalf, and not Group, and may set rates for health care services to cover any obligations to health care providers. Through this Contract, Group receives the benefit of provider rates, but it has no entitlement to a particular rate or to unbundle the service-based or value-based components of Claims. Except as set forth in Schedule A, BCBSM does not retain any portion of Claims as compensation and all amounts collected from Group in Claims are used to satisfy provider obligations.

E. **"Contract"** means this administrative services contract and any schedules, parts, exhibits and addenda attached hereto and incorporated herein by reference as amended from time to time.

F. **"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 to the termination date.

G. **"Coverages"** means the health care benefits set forth in the benefit design document or Part C of the Group Enrollment and Coverage Agreement and BCBSM's medical policies, which are incorporated into this Contract.

H. **"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.

I. **"Enrollee"** means an individual that Group enrolled as an Employee, spouse or dependent in the Plan pursuant to *Article II.B*.

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

K. **"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.

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

M. **"Quality Programs"** refer to BCBSM or BCBS Plan 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.

N. **"Rebates"** means retrospective payments collected from drug manufacturers and paid to BCBSM that are attributable to Enrollee drug utilization.

O. **"Renewal Date"** means the date one (1) 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.

P. **"Transition Assistance Period" or "TAP"** means the period that begins on the Termination Date and concludes twenty-four (24) months thereafter, during which BCBSM shall provide those services, and Group shall perform those obligations, set forth in *Article IV.B*.

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ARTICLE II
GENERAL RESPONSIBILITIES

A. **Claims Administrator Status.** Group delegates to BCBSM the responsibility and discretionary authority as claims administrator to make Plan interpretations and final 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 §503. 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 PPACA.

C. **Claims Processing.** During the term of this Contract, Claims will be directly submitted to BCBSM and will be processed according to the Coverages and BCBSM's standard operating procedures for Claims. Notwithstanding the foregoing, Claims from out-of-state providers may, depending on the type of payment request, be directly submitted to the applicable out-of-state BCBS Plan and are processed and paid under the BlueCard Program as set forth in Schedule B. Claims from out-of-state providers are reported and billed to Group as they are received by BCBSM from a BCBS Plan and may include a BlueCard Access Fee for processing the Claim.

D. **Disputed Claims.** Group shall notify BCBSM in writing of any Claim that Group disputes within sixty (60) days of Group's access to a paid Claims listing. BCBSM shall investigate such Claim 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. **Recoveries.**

1. Subrogation. BCBSM shall be subrogated to all of Group's, the Plan's, or an Enrollee's rights with respect to any Claim. BCBSM will use reasonable efforts to evaluate information provided by the Enrollee and other sources to identify Claims in which the Plan may have a subrogation or reimbursement interest. However, BCBSM is not obligated to pursue any subrogation or reimbursement claim, including commencing, becoming a party to, or intervening in any litigation. BCBSM will remit to Group the funds recovered from third parties less (a) any attorney fees resulting from recovery litigation undertaken by BCBSM, (b) any negotiated lien reduction, and (c) the percentage set forth on Schedule A. Group will reasonably assist in any BCBSM recovery efforts, including providing BCBSM with requested Plan documents.

2. Class Actions and Similar Litigation. Group and the Plan authorize BCBSM to act on their behalf in any health care class action or other similar litigation of which BCBSM has knowledge, e.g., a drug manufacturer or product liability lawsuit ("Class Action"). Group and the Plan further authorize BCBSM to submit Claims, agree to any Class Action settlement, and collect and remit to Group any funds recovered less any reasonable expenses incurred by BCBSM. If Group notifies BCBSM that it desires to independently pursue a Class Action, BCBSM will provide Group with applicable Claims and other necessary information.

F. Benefit Litigation Defense. 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 request that BCBSM select counsel and defend litigation. BCBSM retains the right to deny this request and require Group to defend the Litigation.

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

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

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

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

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

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

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

7. When BCBSM defends the Litigation, the cost and expenses of such defense shall be paid by BCBSM. However, Group shall pay for any judgment, award, settlement or payment of amounts due with respect to the underlying Litigation.

8. Subject to *paragraph 6* above, when the Group defends the Litigation, Group shall pay the cost and expenses of such defense, reasonable attorney fees and any judgment, award, settlement or payment of amounts due with respect to the underlying Litigation.

G. Group Audits.

1. 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 twenty-four (24) months.

2. Prior to any audit, Group and BCBSM must mutually agree upon any independent third-party auditor that Group wishes to perform the audit. BCBSM shall not unreasonably withhold its consent. Additionally, prior to audit, Group and any third-party auditor shall sign BCBSM's audit agreement.

3. 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 up to ninety (90) days to begin gathering requested documentation and to schedule the on-site phase of the audit.

4. Sample sizes shall not exceed two hundred (200) Claims and shall be selected to meet standard statistical requirements (i.e., 95% Confidence Level; precision of +/- 3%). If BCBSM agrees to any additional Claims above the 200, Group shall reimburse BCBSM for Claims documentation in excess of 200 Claims at fifty dollars ($50.00) per Claim.

5. 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.

6. BCBSM shall have no obligation to make any payments or reimbursements 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 based on 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.

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 Plan benefits and any changes thereto.
5. Group is responsible for eligibility and 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. Provider Proprietary Information. Health care provider names, addresses, tax identification numbers, and financial amounts paid to such providers.

2. 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. **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 fifteen (15) business days of BCBSM's receipt of Group's notice.

L. **Prescription Drug 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 the Coverages, participating pharmacy contracts, and fees set forth on Schedule A. Payments to participating pharmacies may include prescription drug costs, dispensing fees, and incentive fees for dispensing a generic drug or compounding a prescription drug.

BCBSM may contract with rebate administrators ("Rebate Administrators") to submit drug claims for Rebates. Group, directly or indirectly, will not submit any claims for Rebates. Rebate Administrators may retain a portion of the gross Rebates as a claims processing and rebate administration fee ("Rebate Administrator Fee"). BCBSM may retain a portion of the Rebates as administrative compensation ("BCBSM Rebate Service Fee"). The Rebate Administrator Fee and BCBSM Rebate Service Fee are set forth in Schedule A. Any change to the Rebate Administrator Fee during a Contract Year shall be effective and automatically incorporated in Schedule A following thirty (30) days notice by BCBSM to Group. BCBSM will distribute Rebates net of any fees set forth in the Schedule A to Group. 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 BCBSM customers with prescription drug benefits.

ARTICLE III
FINANCIAL RESPONSIBILITIES

A. **Group Responsibilities.** Group shall be responsible and liable for:

1. Claims;
2. Fees set forth in Schedules A, B, and C, including administrative fees, additional administrative compensation, and any other fees identified therein;
3. Health Care Provider Interest;
4. Taxes and surcharges imposed by state and federal governments on Claims or number of Enrollees;
5. Statutory court costs and attorney fees awarded by a court of competent jurisdiction to an Enrollee as a result of Litigation; and
6. All other risks, financial obligations, and liabilities which BCBSM may assume or which might otherwise attach with respect to the administration of Coverages.

B. **Group's Weekly Wire and Other Payments.** Group shall make weekly payments of all amounts due to BCBSM within one (1) business day of the invoice issue date. In addition, Group shall pay to BCBSM any separately invoiced amounts within fifteen (15) days of invoice or settlement issue date. If Group's payment for any amount payable under this Contract is more than one (1) business day late, Group shall pay a late fee equal to two percent (2%) of any outstanding amount due or the maximum percentage permitted by law, whichever is less. BCBSM may cease processing Claims retroactive to the last date for which full payment was made.

C. **Interest and Float.** Group shall make payments of amounts due and owing 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.** At least thirty (30) days prior to each Renewal Date, BCBSM shall send Group a Schedule A for the new Contract Year with all pricing terms for a single or multiple Contract Year(s). Any renewal Schedule A shall be deemed fully executed and effective as of the Renewal Date if Group fails to sign it and makes any payment according to its terms.

E. **Settlements.**

1. Annual Settlements. Group shall receive its Annual Settlement approximately one hundred twenty (120) days after the end of each Contract Year, which may include a reconciliation of any administrative fees based on BCBSM's enrollment records for the Contract Year at the time the reconciliation is performed.

   If the Group has an arrangement whereby it pays additional administrative compensation ("AAC"), the total AAC reported to Group with the annual settlement equals the total amount of AAC collected from Group during the year 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 Claims during the twelve (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) Class Action recoveries, and (3) 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 may be offset against future CSR payments or 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 Employees from the number stated in Schedule A during any month of the Contract Year or a change in Coverages, BCBSM may revise any affected pricing terms in the Schedule A to reflect such changes in Enrollment and/or Coverages. Any revisions will be effective beginning on the first day of the first full month following thirty (30) day notification by BCBSM to the Group.

ARTICLE IV
TERMINATION AND TERMINATION ASSISTANCE

A. **Termination & Notice.**

1. With or Without Cause. Either party may, with or without cause, terminate this Contract by providing the other party with at least ninety (90) days prior written notice of the termination date ("Termination Date").

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 terminate this Contract by providing Group with at least five (5) days prior written notice of the Termination Date.

3. Termination within the First Contract Year. If Group gives notice of termination before the end of the first Contract Year or if BCBSM terminates under *subsection 2* above before the end of the first Contract Year, Group shall pay BCBSM twelve (12) months of the administrative fees as set forth in Schedule A multiplied by the average monthly Employee count (less the administrative fees paid prior to the Termination Date) to compensate BCBSM for its implementation costs.

B. **Post-Termination Assistance.** BCBSM will assist Group during the TAP and each party's obligations will continue to be governed by the terms of this Contract, except as set forth below.

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 on or after the Termination Date.

2. Obligation to Pay. Notwithstanding any other provisions contained herein, Group is obligated to timely pay all amounts incurred under the Contract during the TAP.

3. Claims Processing. All Claims incurred, but not paid, prior to the Termination Date shall be processed by BCBSM or other BCBS Plans pursuant to the terms and conditions in this Contract. BCBSM may cease processing Claims if Group fails to timely pay BCBSM for amounts due and owing, is insolvent, or files for bankruptcy. Group represents and warrants that it will be solely liable for any Claims BCBSM does not pay as a result of Group's failure to make timely payment. Group will indemnify, defend, and hold BCBSM harmless for any Litigation or other adversary proceeding brought by an Enrollee whose claim was not paid as a result of Group's failure to timely pay BCBSM. This paragraph is independent of BCBSM's rights under *Article IV.A.2* above.

4. Administrative Fee and Claim Payments. For the first three (3) months of the TAP, Group shall pay the fixed administrative fees and shall continue to make Claim payments in the same manner as prior to the Termination Date. For the next twenty-one (21) months of the TAP, BCBSM will invoice Group for Claims each month. AAC, if any, will continue to be paid for the duration of the TAP.

5. Settlement – Last Contract Year. Within one-hundred eighty (180) days following the Termination Date, BCBSM shall prepare a settlement statement for the last Contract Year.

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

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

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

ARTICLE V
GENERAL PROVISIONS

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

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 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 eligibility and enrollment, benefit design, disclose Plan information to Enrollees, respond to requests for Plan documents, and to read and understand the terms of this Contract. The indemnity and hold harmless provisions of this Contract shall survive the termination of the Contract.

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

D. **Notices.** Any notice required under this Contract shall be given in writing and sent to the other party by hand-delivery, overnight carrier, email to the other party's representative, or US first class mail at the following address or such other address as a party may designate from time to time.

If to Group:	If to BCBSM:
Address set forth above	Blue Cross Blue Shield of Michigan 600 Lafayette East, Mail Code B612 Detroit, Michigan 48226-2998

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

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

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

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

I. **HIPAA.** The parties have entered into a business associate agreement that governs the access, use, and disclosure of protected health information. 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.

J. **Force Majeure.** Neither BCBSM nor Group shall be deemed to have breached this Contract or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Contract if prevented from doing so by acts of God or the public enemy, fires, floods, storms, earthquakes, riots, strikes, boycotts, lock-outs, epidemics, pandemics, wars and war-operations, restraints of government, power or communication line failure, judgment, ruling, order of any federal or state court or agency of competent jurisdiction, change in federal or state law or regulation subsequent to the execution of this Contract, or other circumstances beyond the party's reasonable control for so long as such "force majeure" event reasonably prevents performance.

K. **Enrollee Out-of-Pocket Maximum Compliance.** Group is solely responsible to ensure an Enrollee's maximum out-of-pocket amount complies with PPACA. If a third party provides any essential health benefit(s) to Enrollees, Group shall disclose to BCBSM the name of such third party or parties, the benefits provided, the participants receiving such benefits, applicable claim information, and the cost sharing arrangements for such benefits.

L. **Record Retention.** Group 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.

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. Group shall also provide a copy of any findings or reports issued by or to any federal or state regulatory agency related to the Plan.

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

M. **Summary of Benefits and Coverage.** Group is solely responsible for the creation and distribution of the summary of benefits and coverage form.

N. **Plan Year.** Group's plan year is the one-year period beginning on the Effective Date and each Renewal Date thereafter unless Group notifies BCBSM at least six months in advance of a change thereto.

O. **Knowing Assent.** Group acknowledges that it has had a full opportunity to consult with such legal and financial advisors as it has deemed necessary or advisable in connection with its decision to knowingly enter into this Contract. Group acknowledges that it has an 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.