UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

SETH STERN, ANGELA BINDNER, and MARIANNE SCHMITT, on their own behalf, on behalf of all others similarly situated, and on behalf of the JPMorgan Chase Health Care and Insurance Program for Active Employees and its component Medical Plan, Plaintiffs, v. JPMORGAN CHASE & CO., JPMORGAN CHASE BANK N.A., JPMORGAN CHASE U.S. BENEFITS EXECUTIVE, and JPMORGAN CHASE COMPENSATION & MANAGEMENT DEVELOPMENT COMMITTEE, Defendants.	Case No. 1:25-cv-02097 (JLR)

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION FOR JUDGMENT ON THE PLEADINGS

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INTRODUCTION

This Court previously denied Defendants' motion to dismiss Plaintiffs' prohibited transaction claims. *See* ECF 45 ("MTD Order"). Defendants now bring a motion for judgment on the pleadings on those same claims, but their new motion fares no better. Defendants' latest motion is based on two false premises: (1) the incorrect notion that Plaintiffs bear the burden of proof on Defendants' purported prohibited transaction exemption; and (2) the incorrect suggestion that Plaintiffs' prohibited transaction claims are not about the unreasonable compensation Caremark received for prescription drugs. Once these false premises are corrected, Defendants' motion fails.

Fundamentally, Defendants still fail to grasp the Supreme Court's decision in *Cunningham v. Cornell University*, 604 U.S. 693 (2025). *Cunningham* places "the burden of pleading ***and proving*** that a § 1108 exemption applies to an otherwise prohibited transaction" squarely on Defendants. *Id.* at 696 (emphasis added); *see also id*. at 702 ("[T]he § 1108 exemptions must be pleaded ***and proved by the defendant*** who seeks to benefit from them." (emphasis added)). Defendants have now filed an Answer (ECF 51) attempting to ***plead*** the exemption under 29 U.S.C. § 1108(b)(2), but they misstate their burden of ***proof*** as to the two key elements of the exemption: whether outsourcing prescription-drug services was "necessary" and whether Caremark received "reasonable compensation."

Defendants turn *Cunningham* on its head by arguing that Plaintiffs failed to ***dis***prove the exemption. *See, e.g.*, ECF 56 ("Motion") at 15 ("Plaintiffs … have not articulated 'specific, nonconclusory factual allegations' demonstrating that Caremark received 'more than reasonable' compensation."). This is the exact argument *Cunningham* rejected: "The exemptions set forth in [§1108] ***do not*** impose additional pleading requirements to make out a § 1106(a)(1) claim." *Cunningham*, 604 U.S. at 701 (emphasis added). The reply pleading discussed in *Cunningham* does not reallocate the burden of proof; it is a procedural tool that merely may provide fodder for

a defendant to satisfy its burden early in the case—where, for example, the plaintiff's reply "admit[s] one or more of the allegations in the answer, thereby obviating any need to present evidence on any such issue." Wright & Miller, 5C *Federal Practice & Procedure* § 1185 (4th ed. 2026). But the burden of establishing the defense always remains on the defendant, as *Cunningham* repeated over and over again.

Defendants have not met their burden of proof. On a Rule 12(c) motion, a defendant may rely only on the non-moving party's allegations and admissions. Yet Defendants never even claim their exemption is evident from the face of Plaintiffs' pleadings. That alone suffices to deny the motion.

Furthermore, even if the Court could credit *Defendants'* disputed pleadings on a Rule 12(c) motion—which it cannot—Defendants do not even adequately plead the exemption. As to the first element ("necessary"), Defendants fail to plead any facts suggesting that third-party PBM services were "necessary"; indeed, they admit that JPMorgan considered providing and could have provided PBM services in-house. As to the second element ("reasonable compensation"), Defendants do not disclose Caremark's compensation, provide no drug pricing comparisons of any kind, and do not deny Plaintiffs' allegations that the Plan and its participants overpaid for prescription drugs.

Defendants try to distract from their failure by arguing that Plaintiffs' prohibited transaction claims are somehow "limited to … Caremark's work on administering the Plan … by 'resolving prescription-drug claims' and 'processing prior authorizations' and not in … determining drug pricing." Answer at 4; *see also* ECF 56 at 8. "This argument fails as it does not accurately characterize the allegations in the Complaint." *Moreno v. Deutsche Bank Americas Holding Corp.*, 2016 WL 5957307, at *5 (S.D.N.Y. Oct. 13, 2016) (rejecting similar

mischaracterization, by same defense counsel). Plaintiffs' prohibited-transaction claims are focused on drug prices and the compensation paid to Caremark (as the Plan's PBM) for prescription drugs purchased through the Plan. In denying Defendants' motion to dismiss those claims, the Court identified the relevant conduct consistent with Plaintiffs' allegations, not Defendants' inaccurate characterization. *See* MTD Order at 6, 29, 30 (discussing allegations of excessive drug prices).[1] Indeed, Defendants themselves acknowledge that this case is about drug prices: they recently stipulated—after this Court's motion-to-dismiss order—that "[t]he Complaint (ECF No. 1) brings claims under [ERISA], regarding the pricing of prescription-drug benefits." ECF 58 ¶ 1; *see also* ECF 46 ¶ 1.

Defendants' other arguments also fail. Plaintiffs' claims are timely because the challenged payments were made within the relevant period, and also because Caremark's PBM contract was renewed and amended within the relevant period. Further, this Court has already ruled that Plaintiffs have standing to pursue their prohibited transaction claims, and there is no reason to revisit that decision now. Accordingly, Plaintiffs respectfully request that the Court deny Defendants' motion.

BACKGROUND

I. The Plan and Plaintiffs' Claims

Plaintiffs are current and former JPMorgan employees who received prescription-drug benefits through JPMorgan's employee health plan. ECF 1 ("Complaint") ¶¶ 13-15. Plaintiffs filed this putative class action alleging that Defendants breached their fiduciary duties under ERISA

[1] The Court's Order squares with caselaw confirming that determining "reasonable compensation" under § 1108(b)(2) requires "consider[ing] all compensation – direct and indirect – that the party in interest receive[d] 'in connection with' the services it provides to the plan under the contract." *Bugielski v. AT&T Servs., Inc.*, 76 F.4th 894, 911 (9th Cir. 2023) (citing 29 C.F.R. § 2550.408b-2(a)(3) (2012)).

§ 404, 29 U.S.C. § 1104, and engaged in prohibited transactions in violation of ERISA § 406(a), 29 U.S.C. §1106(a), by mismanaging the Plan's prescription drug benefit program. Specifically, Plaintiffs allege that Defendants contracted with pharmacy benefit manager CVS Caremark ("Caremark"), ¶¶ 17, 104, and permitted Caremark to charge the Plan and its participants grossly inflated prescription drug prices, resulting in millions of dollars in excessive drug costs. ¶¶ 7, 107-108, 267-269, 274-276.[2]

The Complaint identifies specific and striking examples of the overcharges at issue. Complaint ¶¶ 112-128. As this Court described: "By way of example, Plaintiffs allege that the Plan paid $749.30 for a 30-unit prescription of entecavir, despite the drug being widely available at retail pharmacies for under $40. … The Plan also allegedly paid $1,310.99 for a 30-unit prescription of cinacalcet, even though average pharmacy acquisition costs were approximately $25.50." MTD Order at 4 (citing Complaint ¶¶ 119-20). Plaintiffs allege that these systemic markups are a direct consequence of Defendants' imprudent decisions to retain Caremark as a pharmacy benefit service provider and allowing it to charge the Plan and participants unreasonably inflated prices.

II. The Court's Decision on Defendants' Motion to Dismiss

On March 9, 2026, the Court granted in part and denied in part Defendants' motion to dismiss. ECF 45. The Court dismissed Plaintiffs' claims regarding increased premiums as too speculative to confer Article III standing, *id*. at 13-14, but concluded that Plaintiffs' out-of-pocket overpayments for prescription drugs were sufficient to establish injury-in-fact, recognizing that

[2] Defendants assert that Plaintiffs' prohibited-transaction claims were "an afterthought" or "not Plaintiffs' Plan A for this litigation," Motion at 1, but that characterization is baseless and false. Plaintiffs' "Plan A" for this litigation has always been to obtain relief for the financial harm inflicted on Plaintiffs and the proposed class by utilizing the causes of action Congress provided in ERISA.

allegations of "personal financial loss … of this kind are generally sufficient to confer standing." *Id*. at 14.

On the merits, the Court dismissed Plaintiffs' breach of fiduciary duty claims on the basis that the challenged conduct fell within non-fiduciary functions. *Id*. at 23-29. But the Court ruled that Plaintiffs' prohibited transaction claims could proceed, holding that they concerned fiduciary conduct and that "Plaintiffs' allegations are sufficient to assert a plausible prohibited transaction claim at this juncture." *Id*. at 32. The Court ordered Defendants to file an Answer to the Complaint and Plaintiffs to file a Reply pursuant to Fed. R. Civ. P. 7(a)(7). *Id*. at 34.

III. Defendants' Answer and Plaintiffs' Reply

Defendants' Answer relies principally on the § 1108(b)(2) exemption as an affirmative defense, asserting that the services Caremark provided as the Plan's PBM were necessary and that Caremark received reasonable compensation for those services. Answer at 61-64 (labeled "Third Defense"). In support, Defendants claim that they or a third party conducted "market checks" of the "Caremark Agreement," Third Defense ¶¶ 12, 15, assert that RFP processes conducted in 2020 and 2021 support the reasonableness of the arrangement, *id.* ¶ 13, and contend that Defendants received required disclosures and performed adequate oversight of the Plan's total PBM costs and prescription drug utilization. *Id.* ¶¶ 16-17. Nowhere do they actually identify Caremark's compensation or compare it to any other plan or benchmark.

Defendants' Answer is procedurally deficient in numerous respects. As detailed below, Defendants refuse to admit or deny dozens of allegations in the Complaint, asserting that no response is required or denying allegations only "insofar as" they are inaccurate, which is circular. *See, e.g.*, Answer ¶¶ 111, 114, 149. Under the Federal Rules, these non-responses are deemed admissions: "An allegation—other than one relating to the amount of damages—is admitted if a responsive pleading is required and the allegation is not denied." Fed. R. Civ. P. 8(b)(6).

The Answer is also substantively deficient, as it does not adequately plead (let alone prove) the two elements required to invoke the § 1108(b)(2) exemption: necessity of the services and reasonable compensation:

- *No showing of necessity.* Defendants rely on generic allegations that PBMs are common, but offer no allegations showing that retaining an outside PBM was necessary for this specific Plan. In fact, it was unnecessary. An internal JPMorgan document proposed managing pharmacy benefits in-house, demonstrating that internal administration was not only viable but preferred. Complaint ¶ 149; *see also* ECF 54 ("Reply") ¶¶ 5-7.
- *Reasonable compensation pled without support.* Defendants assert that Caremark received reasonable compensation but provide no factual support for that assertion: they do not attach or quote from the "Caremark Agreement" or disclose its pricing terms or compensation details, and they provide no market-check results, RFP materials, scorecards, competing bids, or any meaningful benchmarks against which Caremark's compensation can be assessed. Reply ¶¶ 11-13, 28-31. Thus, they fail to answer the threshold questions of how much compensation Caremark received and whether the amount of that compensation was reasonable for the services rendered.
- *Defendants fail to address the excessive drug pricing allegations.* Defendants' Answer fails to meaningfully engage with—and for the most part, does not deny—Plaintiffs' core allegations regarding substantial generic-drug markups, comparisons to NADAC and other benchmarks, potential savings through alternative PBMs or specialty-drug carve-outs, and the post-lawsuit price reductions that further underscore the excessiveness of the charges the Plan was paying. *Id.* ¶¶ 20, 32-37.

STANDARD OF REVIEW

A Rule 12(c) motion for judgment on the pleadings is subject to the same standard as a motion to dismiss under Rule 12(b)(6). *Lively v. WAFRA Inv. Advisory Grp., Inc.*, 6 F.4th 293, 301 (2d Cir. 2021). The Court must accept all factual allegations in the non-movant's pleadings as true and draw all reasonable inferences in the non-movant's favor. *Id*. A Rule 12(c) motion tests the legal sufficiency of the pleadings, not the merits of the underlying dispute: "On a Rule 12(c) motion, the court's task is to assess the legal feasibility of the complaint; it is not to assess the weight of the evidence that might be offered on either side." *Id*. at 304 (citation modified). "Thus, where a question of fact is in dispute, it is improper for the district court to answer it on a motion for dismissal on the pleadings." *Id*. at 301 (internal quotations and citation omitted).

When deciding a Rule 12(c) motion, "courts may consider all documents that qualify as part of the non-movant's 'pleading'," including material incorporated by reference into the complaint, relied upon by the complaint, or subject to judicial notice. *Lively*, 6 F.4th at 306. Where, as here, the Court has ordered Plaintiffs to file a reply pursuant to Rule 7(a)(7), that reply becomes part of the pleadings for purposes of Rule 12(c). *See* Fed. R. Civ. P. 7(a)(7).

Affirmative defenses like "the § 1108 exemptions must be pleaded and proved by the defendant who seeks to benefit from them" in the first instance. *Cunningham*, 604 U.S. at 702. Further, to the extent Defendants' Answer did not "admit or deny the allegations asserted against" them, as required under Rule 8(b)(1)(B), those allegations are deemed "admitted." Fed. R. Civ. P. 8(b)(6).

ARGUMENT

I. Defendants' Motion Rests on Two Fundamental Errors

A. Defendants Bear the Burden of Proof on Their Claimed Exemption, but Wrongly Suggest the Burden Falls on Plaintiffs to Disprove It

Defendants' motion rests on a fundamental misallocation of the burden of proof. Defendants have moved for judgment on the pleadings based on the affirmative defense set forth in 29 U.S.C. § 1108(b)(2)(A). The burden of proof for this affirmative defense is ***on Defendants***. That was the whole point of *Cunningham*, which held that the § 1108 exemptions are "affirmative defenses" that "must be pleaded ***and proved*** by the defendant who seeks to benefit from them." *Cunningham*, 604 U.S. at 702 (emphasis added). And that, of course, is how affirmative defenses work generally: "an affirmative defense [is] entirely the responsibility of the party raising it." *Meacham v. Knolls Atomic Power Lab.*, 554 U.S. 84, 95 (2008). Defendants thus bear the burden of proving their affirmative defense, *i.e.*, that their third-party arrangement with Caremark was "necessary for the establishment or operation of the plan" and "no more than reasonable compensation is paid therefor." 29 U.S.C. § 1108(b)(2)(A).

Instead of trying to satisfy their burden of proof, Defendants invert it. Defendants characterize their motion as "challenging Plaintiffs' failure to plausibly allege that Defendants engaged in any *nonexempt* prohibited transactions." Motion at 11 (emphasis added). That framing—the word "nonexempt" in particular—is directly contrary to *Cunningham*, which squarely held that a plaintiff is not required to plead that a prohibited transaction is nonexempt. 604 U.S. at 695-96 ("The question presented is whether … a plaintiff must plead that § 1108(b)(2)(A) does not apply…. The answer is no."). Similarly, Defendants say that Plaintiffs' Complaint should be dismissed because it "do[es] not plausibly demonstrate that the retention of Caremark to provide benefits-administration services falls outside of a statutory exemption,"

Motion at 12, and that Plaintiffs "plead no facts overcoming" the exemption, *id.* at 13. Those assertions again run right into *Cunningham*: "[I]t is defendant fiduciaries who bear the burden of pleading and proving that a § 1108 exemption applies," not Plaintiffs' burden to show that it doesn't. *Cunningham*, 604 U.S. at 695.

Defendants suggest their inversion is supported by *Cunningham* itself, but that is wrong. While *Cunningham* authorized courts to order a reply pleading under Rule 7(a)(7), nothing about that procedure reallocates the burden of proof, which remains Defendants' alone. *See Cunningham*, 604 U.S. at 702 (explaining that a "§ 1106(a)(1)(C) claim will ultimately fail" only if the "defendant *establishes* that a §1108 exemption applies." (emphasis added)). It would have been more than passing strange for the Court to hold that "[t]he exemptions set forth in [§1108] do not impose additional pleading requirements" on plaintiffs, *id.* at 701, only to do a complete one-eighty and say that those exemptions *do* impose additional pleading requirements if a defendant takes the trivial step of asserting an affirmative defense in its answer. The Supreme Court did not undo its own decision with a passing reference to an additional pleading.

The function of a Rule 7(a)(7) reply is narrower than Defendants suggest: a reply is useful because the plaintiff may "admit one or more of the allegations in the answer, thereby obviating any need to present evidence on any such issue." 5 *Federal Practice & Procedure* § 1185. The defendant may then use any admitted facts to carry its burden on a Rule 12(c) motion or a motion for summary judgment. *Cunningham*, 604 U.S. at 702. But as explained in *Cole v. Carson,* 935 F.3d 444 (5th Cir. 2019)—the case *Cunningham* cited about the Rule 7(a)(7) reply process—the process will "not yield pretrial resolution" where, as here, the parties present "competing factual narratives." 935 F.3d at 446. The reply procedure is not a substitute for proof or a burden-flipping device; it is just a way for defendants to develop their proof—*i.e.* admissions—early in the case.

Put otherwise, the reply procedure does not change *Cunningham*'s holding that "it is defendant fiduciaries who bear the burden of pleading and proving that a §1108 exemption applies to an otherwise prohibited transaction." 604 U.S. at 696. The *Cunningham* court's reference to a plaintiff's obligation to "put[] forward specific, nonconclusory factual allegations," *id.* at 708, operates within the framework the Court had just announced—if the defendant pleads facts that would (if true) establish its exemption, courts can require the plaintiff to address those facts and, the defendant hopes, admit them. But the reply procedure does not excuse Defendants from independently establishing their defense. *See Meacham*, 554 U.S. at 95 (affirmative defense is "entirely the responsibility of the party raising it").

This is also clear from cases in the qualified immunity context—the one example of the Rule 7(a)(7) process the *Cunningham* court provided. The Fifth Circuit—whose cases Defendants rely on in their motion—explained it clearly: "The first part of the rule often gets overlooked: To even get into the qualified-immunity framework, the government official must satisfy his burden of establishing that the challenged conduct was within the scope of his discretionary authority." *Sweetin v. City of Tex. City, Texas*, 48 F.4th 387, 392 (5th Cir. 2022) (internal quotations and citation omitted). And to carry that burden, a defendant's "bald assertion that the acts were taken pursuant to the performance of duties and within the scope of duties will not suffice." *Harbert Int'l, Inc. v. James*, 157 F.3d 1271, 1282 (11th Cir. 1998); *see also Shechter v. Comptroller of N.Y.*, 79 F.3d 265, 270 (2d Cir. 1996) (reversing grant of 12(c) motion because defendants' "bald assertion" of immunity "provides no basis for a ruling in their favor").[3] Likewise here, the Court

[3] Courts do not always discuss this initial burden in the qualified immunity context because it is often undisputed that the defendant was acting within his or her discretionary authority—an element of a § 1983 claim is that the defendant was acting "under color of state law." *Rendell-Baker v. Kohn*, 457 U.S. 830, 838 (1982). For example, when an inmate alleges a constitutional

may not grant Defendants' Rule 12(c) motion unless and until Defendants prove the elements of their affirmative defense are satisfied, and do so under the appropriate Rule 12(c) standards.

Finally, Defendants' approach would violate the Rules Enabling Act, 28 U.S.C. § 2072. The Rules Enabling Act prohibits courts from applying the Federal Rules of Civil Procedure in a way that "abridge[s], enlarge[s] or modif[ies] any substantive right." *Id.* § 2072(b); *see Police & Fire Ret. Sys. v. IndyMac MBS, Inc.*, 721 F.3d 95, 109 (2d Cir. 2013) (rejecting interpretation of Rule 23 that might violate Rules Enabling Act). Courts accordingly construe the Rules to avoid that result. *See, e.g.*, *Semtek Int'l, Inc. v. Lockheed Martin Corp.*, 531 U.S. 497, 503–04 (2001) (adopting narrow construction of Rule 41(b) to avoid Rules Enabling Act problem). ERISA gives Plaintiffs a substantive right to relief from a transaction that violates the basic elements of Section 1106, *see Cunningham*, 604 U.S. at 701, and that right prevails unless Defendants carry their own substantive burden of pleading and proving an exemption, *id.* at 702; *see also Cities Serv. Oil Co. v. Dunlap*, 308 U.S. 208, 212 (1939) (allocation of burden of proof is substantive). Applying Rule 7(a)(7) in a way that would defeat Plaintiffs' substantive right—*i.e.*, by dismissing their claim on the merits—without requiring the defendant to "plead and prove" its affirmative defense, would improperly "abridge" the substantive right that Congress provided to Plaintiffs in 29 U.S.C. § 1106.

B. Defendants Misconstrue the Scope of the Prohibited Transaction Claims

Defendants' second fundamental error is their mischaracterization of Plaintiffs' prohibited transaction claims. Defendants incorrectly assert that the prohibited transaction claims are limited

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violation by a corrections officer, there is no dispute that the corrections officer has discretionary authority within the prison. *E.g.*, *Crawford-El v. Britton*, 523 U.S. 574, 588 (1998). But when a plaintiff disputes the discretionary-authority prong, as in *Harbert* and *Sweetin*, the initial burden is on the defendant, and it must be carried before the plaintiff owes anything in response. *Harbert*, 157 F.3d at 1281 ("If, and only if, the defendant does that will the burden shift to the plaintiff.").

to "the level of administrative services Caremark provides," *not* including "the Plan's prescription-drug pricing and structure." Motion at 17; *see also* Answer at 4. That is pure wishful thinking, and it has exactly zero support in Plaintiffs' Complaint or this Court's order fully denying Defendants' motion to dismiss the prohibited transaction claims.

In their prohibited transaction claims, Plaintiffs allege that Defendants engaged in prohibited transactions by "causing the Plan to repeatedly make excessive payments to Caremark" and that these prohibited transactions "needlessly increased the amounts that the Plan paid for prescription drugs, and as a result increased the amounts that Plaintiffs and members of the class were required to pay in premiums and out-of-pocket costs." Complaint ¶¶ 280, 284; *see id.* ¶¶ 221-223, 292. As those allegations reflect, Plaintiffs' prohibited-transaction claims were focused on drug prices.

This Court's MTD Order identified the relevant conduct consistently with Plaintiffs' allegations, not Defendants' inaccurate characterization. In describing Plaintiffs' prohibited transaction claims, the Court recognized that "Plaintiffs allege that the compensation Caremark received — ***including revenue from spread pricing*** and retained rebates — was unreasonable." MTD Order at 6 (emphasis added). Spread pricing is the exact mechanism through which Defendants needlessly increased the amounts the Plan and its participants paid for prescription drugs. *See, e.g.*, Complaint ¶¶ 4-7, 11, 61, 108-28, 140. And again later in its Order, the Court described the allegations the same way: "Plaintiffs allege that Defendants engaged in prohibited transactions by transferring assets to Caremark in exchange for services, ***with compensation that***

included spread pricing and retained rebates, which they allege was unreasonable and not exempt under ERISA." MTD Order at 29 (emphasis added).[4]

These prohibited transaction claims were not dismissed or narrowed in any respect. *See* MTD Order at 30 ("Plaintiffs' Prohibited Transaction Claims Challenge a Fiduciary Act"); *id.* at 31 ("Plaintiffs Assert Plausible Prohibited Transaction Claims"); *id.* at 34 ("Defendants' motion as to dismiss Counts Four and Five is denied."). Defendants contend that the Court's unqualified denial was "necessarily" limited to things other than drug prices because the Court dismissed Plaintiffs' *fiduciary-breach claims* as concerning settlor conduct. But that contention does not square with the record. The Court specifically held that "Defendants … acted as fiduciaries" with respect to the prohibited transaction claims, which the Court correctly recognized were about "compensation that included spread pricing," *i.e.*, drug pricing. MTD Order at 30. Defendants' contrary characterization just wishes away the Court's holding.

Finally, Defendants' position that deciding how much to pay for goods and services is not a fiduciary function within ERISA's scope cannot be squared with the plain language of the exemption on which Defendants rely. The entire focus of their motion, and of *Cunningham*, is the prohibited transaction exemption in § 1108(b)(2)(A). That exemption says that obtaining "goods, services, or facilities" from a party-in-interest does not violate ERISA if the fiduciary proves that

[4] Defendants assert that "Caremark has not received spread-based compensation in connection with the Plan," Third Defense ¶ 18, but that is a disputed fact issue based on competing allegations in the pleadings. Moreover, Defendants provide no factual support for their assertion. *See* Reply ¶ 29. They do not provide a copy of the Caremark Agreement or any meaningful detail regarding the pricing terms or other terms of that agreement. *Id.* Indeed, Defendants' conclusory statements are contradicted by other parts of their Answer. *Id.* Specifically, Defendants do not deny the Complaint's extensive allegations about the large differences between the Plan's drug prices and the prices at which the same drugs were available to other purchasers, which indicate significant spread pricing. *See* Complaint ¶¶ 112-125; Answer ¶¶ 112-125. Regardless, the relevant question is not *how* Caremark is compensated but *how much*. Reply ¶ 29.

doing so was necessary and "no more than reasonable compensation is paid." 29 U.S.C. § 1108(b)(2)(A). The converse, of course, is also necessarily true: buying "goods, services, or facilities" from a party-in-interest *does* violate ERISA unless the fiduciary can prove that "no more than reasonable compensation is paid." *Id.* §§ 1106(a)(1)(C), 1108(b)(2)(A). Defendants' position—that deciding how much to pay for goods and services is not a fiduciary function—would render the § 1108(b)(2)(A) exemption superfluous: no exemption would be necessary because that conduct would not be fiduciary regardless of whether the amounts paid were "reasonable." ERISA's plain text and the canon against surplusage, *see Pulsifer v. United States*, 601 U.S. 124, 143 (2024), require rejecting that cramped view of fiduciary conduct.

II. Defendants Have Not Established That the Section 1108(b)(2) Exemption Applies

Based on the prohibited transaction claims as actually pled, Defendants have failed to meet their burden of establishing an applicable exemption.

Section 406 of ERISA [29 U.S.C. § 1106] establishes a rule against fiduciary outsourcing: if a plan fiduciary transacts with a third party service provider, that transaction is presumptively unreasonable. *Cunningham*, 604 U.S. at 700. That presumption is not a technicality: it is consistent with the common law of trusts, under which "trustees were under a duty to the beneficiary not to delegate to others the doing of acts which the trustee can reasonably be required personally to perform." *Id.* at 702 n.4 (citing Restatement (Second) of Trusts § 171, p. 373 (1957)); *see also* Br. of United States at 27, *Cunningham v. Cornell Univ.*, No. 23-1007 (U.S. Dec. 2, 2024) ("Congress had good reasons, grounded in trust law's concern about fiduciary outsourcing, to presumptively prohibit third-party service-provider transactions."). As this Court already recognized, Plaintiffs pleaded a prohibited-transaction violation by alleging that Defendants caused the Plan to buy goods and services from Caremark, which is a party in interest by virtue of its status as a service provider to the Plan. MTD Order at 31-34; *see also* 29 U.S.C. § 1002(14)(B).

Defendants have moved for judgment on the pleadings based on the affirmative defense in 29 U.S.C. § 1108(b)(2)(A), which exempts presumptively unlawful outsourcing if the fiduciary proves that it was "necessary for the establishment or operation of the plan" and "no more than reasonable compensation is paid therefor." This exemption also follows from the common law of trusts, which recognized that the trustee could permissibly delegate only if it could show that "the agent's employment was necessary, that the trustee entered into a reasonable contract of employment with the agent, and that the agent rendered services to the trust." G. Bogert, *Law of Trusts and Trustees* § 555. This common-law "nondelegation rule placed the burden squarely on the trustee" to make the showing of necessity and reasonableness, *id.*, and ERISA does the same, *see Cunningham*, 604 U.S. at 704-05. Defendants have not met that burden here.

A. Under Rule 12(c), the Court May Credit Only Plaintiffs' Pleadings

As an initial matter, on a Rule 12(c) motion, the universe of materials from which Defendants may carry their burden is fixed and narrow. The Court must "remain within the non-movant's pleading[s]" and may accept only "the non-movant's pleading[s] as true." *Lively v. WAFRA Inv. Advisory Grp., Inc.*, 6 F.4th 293, 301, 305 (2d Cir. 2021). The allegations in the movant's pleading, in contrast, "are taken to be false" unless admitted by the non-moving party's Reply. Wright & Miller, 5C *Federal Practice & Procedure* § 1368 (citing *MacDonald v. Du Maurier*, 144 F.2d 696, 700 (2d Cir. 1944)). Defendants can therefore prevail only if Plaintiffs' allegations and any facts Plaintiffs have admitted establish each element of the § 1108(b)(2)(A) exemption. *Lively*, 6 F.4th at 301 ("[D]ismissal under Rule 12(c) is appropriate for self-defeating complaints—i.e., complaints whose allegations show that there is an airtight defense.") (internal quotation and citation omitted). Defendants cannot win judgment under Rule 12(c) based on disputed factual assertions. *Id.*; *MacDonald*, 144 F.2d at 700 (reversing judgment on pleadings because court improperly credited defendant's assertions).

B. Defendants Have Not Shown That Caremark's Services Were "Necessary"

Defendants have not met their burden to show that outsourcing prescription-drug-benefit services was "necessary for the establishment or operation of the plan[.]" 29 U.S.C. § 1108(b)(2)(A). When analyzing the § 1108(b)(2)(A) exemption, the question is not whether the types of services PBMs provide were necessary, but whether transacting with a third-party for those services was necessary.

The Supreme Court's decision in *Cunningham* makes this clear. In *Cunningham*, both the Second Circuit and the Supreme Court agreed that the relevant question is whether "'[the] ***transaction*** was unnecessary or involved unreasonable compensation.'" *Cunningham*, 604 U.S. at 699 (emphasis added) (quoting *Cunningham v. Cornell Univ.*, 86 F.4th 961, 975 (2d Cir. 2023)). The *Cunningham* Court stated this repeatedly, describing the exemption as applying to "***transactions that were necessary*** for the plan," *id.* at 700, and to "***reasonable arrangements*** that are necessary," *id.* at 706 (emphases added). *Cunningham* also observed that for complex modern plans, "a question would arise as to whether fiduciaries can perform all necessary tasks themselves without plans incurring greater costs." *Id.* at 702 n.4. That is a question about the necessity of *delegating*—precisely Plaintiffs' reading.

This also squares with the common law of trusts, from which ERISA derives. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989) (courts interpreting ERISA "are guided by principles of trust law"). At common law, trustees were "under a duty to the beneficiary ***not to delegate*** to others the doing of acts which ***the trustee can reasonably be required personally to perform***." Restatement (Second) of Trusts § 171 (1957) (emphasis added). A trustee could delegate "***only*** upon a showing that '***the agent's employment was necessary***, that the trustee entered into a reasonable contract of employment with the agent, and that the agent rendered services to the trust.'" *Cunningham*, 604 U.S. at 702 n.4 (emphasis added) (quoting *Law of Trusts and Trustees*

§ 555, at 54). The necessity inquiry, in other words, attached to the *employment of the agent*—not to the underlying task viewed in isolation. *See* Restatement (Second) of Trusts § 171 cmt. d (noting that trustee "can properly delegate" only "the performance of acts which it is unreasonable to require him personally to perform").

Here, Defendants do not even contend that JPMorgan is incapable of administering its own prescription-drug program or providing pharmacy benefit management services directly. *See Hughes v. Nw Univ.*, 595 U.S. 170, 173 (2022) (ERISA requires a "context-specific inquiry" considering the circumstances of the particular plan at issue). Indeed, their own internal documents characterized outsourcing to PBMs as a mistake and "proposed that JPMorgan manage pharmacy benefits in house instead of using a PBM." Complaint ¶ 149; *see* Answer ¶ 149. Defendants do not deny this allegation, which therefore must be deemed admitted. *See* Fed. R. Civ. P. 8(b)(6) ("An allegation … is admitted if a responsive pleading is required and the allegation is not denied.").[5] Moreover, Plaintiffs allege that (1) "very large employers" like JPMorgan can conduct PBM services in-house without hiring a service provider, Reply ¶¶ 5-7; and (2) Defendants proposed as early as 2017 that JPMorgan do exactly that, *id*. In this case, performing PBM services in-house was actually preferred over hiring a large PBM with an incentive and reputation for price-gouging.

Instead of claiming that outsourcing was necessary, Defendants urge the Court to adopt a textually strained interpretation of § 1108(b)(2) that ignores the fiduciary principles outlined in *Cunningham* and trust law. The statute provides an exemption for:

[5] Defendants assert that they were not required to respond to this allegation because it "exclusively concern[s] claims that the Court has dismissed, and therefore require[s] no response." Answer ¶ 149. However, the allegation is *very* relevant to whether transacting with a third-party PBM was "necessary," one of the elements of the § 1108(b)(2) exemption. The allegation is thus deemed admitted.

> Contracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.

29 U.S.C. §1108(b)(2)(A). Defendants claim that "'necessary' modifies the word 'services'," Motion at 13, such that outsourcing is permitted so long as the thing being outsourced is necessary to the plan. But that is not the best reading of the statute. The better reading is that "necessary" modifies "Contracting", which is the subject of the sentence. On that reading, the statute exempts "contracting" or "making reasonable arrangements" for the listed items only if that contracting is "necessary for the establishment or operation of the plan."

Defendants' contrary reading—which contradicts *Cunningham* and the common law—creates two textual problems. First, it would lead to results Congress could not have intended: if "necessary" modified the word "services", as Defendants claim, then "contracting … for office space" would be exempt even if the office space was unnecessary. That would make no sense. The better reading is that the *contracting* in question—for any of the enumerated items—must be necessary. Second, any reading that attaches "necessary" to the items procured—rather than to the fiduciary's decision to contract for them—renders the "necessary" portion of the exemption superfluous. Fiduciaries can never spend trust assets on unnecessary services, regardless of whether they outsource or perform the service in-house. *See Tibble v. Edison Int'l*, 843 F.3d 1187, 1198 (9th Cir. 2016) (en banc) ("Wasting beneficiaries' money is imprudent."). On Defendants' reading, then, § 1108(b)(2)'s necessity condition does no work: the only transactions that would be disqualified from the exemption—payments to a party-in-interest for unnecessary services—are transactions the duty of prudence already forbids. *See* 29 U.S.C. § 1104(a)(1)(B). Congress does not enact conditions that do no work. *Marx v. Gen. Revenue Corp.*, 568 U.S. 371, 386 (2013).

Only Plaintiffs' reading gives "necessary" independent effect: a fiduciary might procure a necessary service through unnecessary outsourcing, in which case the transaction is prohibited.

In sum, the question is whether it was necessary for Defendants to contract with a third party to administer the Plan's prescription-drug program. Because Defendants do not even *plead* that it was necessary, let alone *prove* that it was, they are not entitled to judgment under Rule 12(c).

C. Defendants Have Not Shown That Caremark's Compensation Was "Reasonable"

Defendants likewise have not demonstrated that Caremark's compensation was reasonable. To start, they do not claim that Plaintiffs' pleadings are "self-defeating" on this point, as is required for them to prevail on a Rule 12(c) motion. *Lively*, 6 F.4th at 301. And Plaintiffs' pleadings are not self-defeating. *See, e.g.*, Complaint ¶ 8 ("The price discrepancies noted herein are illustrative of a pervasive and systematic problem of unreasonable prescription drug charges."); Reply ¶ 14 (denying allegation that prices were reasonable). The Court's inquiry can end right there.

Even if the Court considered the disputed factual assertions in Defendants' Answer, *but see MacDonald*, 144 F.2d at 700 (reversing district court for doing exactly that), Defendants do not even adequately *plead* that they paid reasonable amounts. Defendants' Answer provides no comparisons between the Plan's pricing and the pricing for any other employer healthcare plan, and no comparison to any benchmark for prescription-drug pricing. Accordingly, Defendants' assertion that "pricing for the Plan's PBM services [is] reasonable and consistent with the market" (Third Defense ¶ 12) is an unadorned, conclusory allegation entitled to no weight.

Defendants allege various details about their *process*, but these allegations do not advance the ball for a prohibited transaction defense. *See* Reply ¶¶ 14-38. While a fiduciary breach claim "focuses on a fiduciary's conduct" and "asks whether a fiduciary employed the appropriate methods," *Pension Ben. Guar. Corp. ex. Rel. St. Vincent Cath. Med. Centers Ret. Plan v. Morgan*

Stanley Inv. Mgmt. Inc., 712 F.3d 705, 716 (2d Cir. 2013), a prohibited transaction claim is based on *results*—whether the prices were "reasonable." 29 U.S.C. § 1108(b)(2)(A). Thus, Defendants' allegations about process, market checks, and RFPs do not get them where they need to go absent allegations about the prices that resulted—and Defendants offer no non-conclusory allegations about their prices.

Nor could the Court infer reasonable prices from the process allegations. While *plaintiffs* pursuing a fiduciary-breach claim may raise an inference of poor process from high prices, *see Braden v. Wal-Mart Stores*, *Inc*., 588 F.3d 585, 598 (8th Cir. 2009), Defendants cite nothing for the inverse proposition—that a defendant seeking an exemption from a prohibited transaction claim can raise an inference of low prices from a (supposedly) prudent process. And that is no accident: the flexible pleading standard for plaintiffs is because "ERISA plaintiffs generally lack the inside information necessary to make out their claims in detail unless and until discovery commences." *Id.* Defendants, in contrast, have their own pricing information and their own contracts, and yet have chosen to hide them from the Court. They cannot hide the contract and contract terms, on the one hand, while meeting their burden of proving that those terms are reasonable, on the other hand.

In all events, even the process allegations are insufficient. With respect to the "market checks," Defendants do not describe or attach a copy of the market check criteria or results, do not indicate which PBMs were included, do not indicate how pricing or other contract terms were evaluated, and do not indicate whether drug pricing was considered at all (much less how) as part of this so-called "market check." And Defendants likely do not even *know* the answers to these questions: *they* did not do the market checks—the checks were performed by the organization Health Transformation Alliance ("HTA"), *see* Third Defense ¶ 12, the very organization whose

cost-saving advice Defendants admit they have repeatedly ignored, *see* Complaint ¶¶ 143-46; *see* Answer ¶¶ 143-46 (not denying, and thus admitting these allegations, *see* Fed. R. Civ. P. 8(b)(6)). Defendants' allegation that these "market checks" resulted in "improved" pricing and contract terms, Third Defense ¶¶ 12, 15, suggests only that the pricing and contract terms lagged behind the market for the period preceding each check.

Defendants' assertion that "an RFP is periodically run for PBM services," Third Defense ¶ 13, does not help them either. Defendants reference only two RFPs in their Third Defense, which were purportedly conducted in 2020 and 2021. *See* Third Defense ¶¶ 13-14. These RFPs cannot establish the reasonableness of Caremark's compensation before the RFPs were allegedly conducted, and Defendants do not contend they have conducted any RFP since 2021, suggesting that Defendants have failed to re-evaluate the market for four or more years. Even as to the indicated years, Defendants' allegations are vague, opaque, and conclusory, and lack critical substance that is material to the ERISA § 408(b)(2) exemption. No substance concerning the RFP criteria or responses thereto is provided, and no information whatsoever is provided as to the pricing terms offered by Caremark or other RFP respondents. It does not appear from Defendants' allegations that Defendants were even afforded access to HTA's RFP process or have any knowledge about the range of proposals solicited or received.

Finally, Defendants' assertions that "the amount Caremark has charged the Plan for prescription drugs has been the same as what Caremark reimbursed network pharmacies for … those purchases" and that "Caremark has not received spread-based compensation in connection with the Plan," Third Defense ¶ 18, are unadorned, conclusory allegations: Defendants do not provide a copy of the Caremark Agreement or any meaningful detail regarding the pricing or other terms of that agreement, wholly failing to make their factual assertion plausible. *See GEOMC Co.*

v. Calmare Therapeutics Inc., 918 F.3d 92, 99 (2d Cir. 2019) ("[Defendant] needed to support these defenses with some factual allegations to make them plausible.").

More important, the assertions directly contradict *admitted* allegations from the Complaint. Plaintiffs expressly alleged that "Defendants continue to allow Caremark to utilize spread pricing," Complaint ¶ 140, and Defendants did not deny (and thus admitted) this allegation, *see* Answer ¶ 140 ("Defendants neither admit nor deny the allegations of Paragraph 140."); *see also* Fed. R. Civ. P. 8(b)(1)(B) ("[A] party must … admit or deny the allegations asserted against it by an opposing party."); Fed. R. Civ. P. 8(b)(6) ("An allegation … is admitted if … the allegation is not denied."). Plaintiffs also included extensive allegations about the large differences between the Plan's drug prices and the prices at which the same drugs were available to other purchasers, which indicate significant spread pricing. *See* Complaint ¶¶ 112-125, Reply ¶ 32. Defendants do not deny these allegations either—they offer only a non-denial dressed in denial clothing, saying, *e.g.*, that they "deny the allegations of Paragraph 114 ***insofar as*** they misstate the price." Answer ¶ 114 (emphasis added). But because the allegations *do not* misstate the price, Defendants have not denied anything. *Cf., e.g.*, *Baumann v. Bayer,* 2002 WL 1263987, at *1 (N.D. Ill. June 5, 2002) ("[I]t is of course obvious that any purported response that begins with 'to the extent that' is wholly uninformative.").[6]

D. Even if the Pleading Burden Was on Plaintiffs, They Satisfied It.

Defendants' motion should be denied even if, contrary to *Cunningham*, Plaintiffs bear the burden of proof on the prohibited transaction exemption. *But see Cunningham*, 604 U.S. at 709

[6] Defendants assert that "the reasonableness of the fees the Plan pays to Caremark is [] demonstrated by the fact … the Caremark Agreement has not permitted Caremark to retain drug rebates." Third Defense ¶ 18. This is irrelevant. Rebates are provided only with respect to brand-name drugs, not the generic drugs that are the subject of the Complaint. *See* Complaint ¶¶ 102, 128.

("Plaintiffs are not required to plead and prove that the myriad §1108 exemptions pose no barrier to ultimate relief."). As explained in their opposition to Defendants' motion to dismiss, Plaintiffs plausibly alleged unreasonably high prescription-drug prices. *See* ECF 35 at 19-28.

The Court suggested these allegations were insufficient because they were based on comparisons to NADAC. MTD Order at 19 n.5. Plaintiffs disagree, but any concerns about NADAC have been dispelled by Defendants' Answer, which admits (or does not deny, which is the same thing) that NADAC is an appropriate benchmark. *See* Reply ¶ 34. For example, Plaintiffs allege that "NADAC is commonly used by other plans as a benchmark for the prices they pay for prescription drugs" and that other PBMs "use[] NADAC prices as a benchmark" and charge plans only "a small markup above NADAC prices." Complaint ¶ 111. Defendants do not deny these allegations. They claim the allegations "require no response," Answer ¶ 111, but the Federal Rules say otherwise: "a party must admit or deny the allegations asserted against it by an opposing party." Fed. R. Civ. P. 8(b)(1). "Answers that neither admit nor deny … or pleadings that allege that allegations … do not require an answer are insufficient to constitute a denial." 5 *Federal Practice & Procedure* § 1264. Similarly, Plaintiffs alleged that Defendants could have negotiated NADAC-based pricing for the Plan, and had they done so, "would have reduced … spending on generic drugs by 30% or more." Complaint ¶ 172. Once again, Defendants do not deny the allegation. *See* Answer ¶ 172. Defendants have thus admitted the fact that the Court initially questioned—*i.e.*, that NADAC is an appropriate benchmark for assessing a prescription-drug plan's pricing.

Despite their admissions, Defendants suggest that comparisons to acquisition cost can *never* plausibly allege an overcharge because markups are part of the "ordinary structure of retail pricing." Motion at 28. Not the sort of markups alleged here. As one example, Defendants agreed to pay $1,310.99 for a drug with an acquisition cost of $25.50. MTD Order at 4 (citing Complaint

¶ 120, regarding cinacalcet). That is not an "ordinary" retail markup. "Determining whether a complaint states a plausible claim for relief … requires the reviewing court to draw on its judicial experience and common sense," *Harris v. Mills*, 572 F.3d 66, 72 (2d Cir. 2009), and common sense forecloses Defendants' suggestion that these markups (211% on average and as high as ***38,352%***) are ordinary. *See* Complaint ¶¶ 112, 114.

And the Court need not rely solely on common sense: After this lawsuit was filed, Defendants secured substantially lower prices, lending plausibility to the allegations that the prior markups were unreasonable and unnecessary. Reply ¶¶ 35-36. The price of cinacalcet, mentioned above, dropped ***by 98%***—from $1,310.99 to $22.60. ECF 44 at 1. More broadly, the difference between pre-complaint and current prices is staggering: for the 352 drugs discussed in the Complaint that remain accessible through Defendants' pricing portal, Defendants' current prices are ***63% lower*** than they were before this lawsuit was filed. Reply ¶ 36. This decrease is not attributable to a broader decline in drug prices; over the same time period, drug acquisition cost has declined by just 15%. *Id.* Thus, even apart from the NADAC allegations, these substantial price decreases demonstrate (and certainly make plausible) that the prices to which Defendants previously agreed were unreasonable—they were paying at least 63% more than they needed to.

III. Plaintiffs' Claims Are Not Time Barred

Defendants' statute of repose arguments should also be rejected. ERISA's six-year statute of limitations "begins running [] on the date of the last action constituting a breach[.]" *Browe v. CTC Corp.*, 15 F.4th 175, 190 (2d Cir. 2021) (citing *Intel Corp. Inv. Pol'y Comm. v. Sulyma*, 589 U.S. 178, 180 (2020));[7] *see also* 29 U.S.C. § 1113 (stating that the limitations period runs six years after "the date of ***the last action*** which constituted ***a part of*** the breach or violation") (emphasis

[7] Defendants selectively omitted this language from their citation to *Browe*. *See* Motion at 17.

added). Consistent with this language, Plaintiffs alleged that Defendants committed prohibited transactions by "continuing to contract with Caremark and by causing the Plan to repeatedly make excessive payments to Caremark throughout the Class Period[.]" Complaint ¶¶ 280, 288. Similarly, the Court's MTD Order explicitly recognized that Plaintiffs' prohibited transaction claims involve "'JPMorgan 'enter[ing] into and/or renew[ing] a contract with Caremark' and its payments to Caremark thereunder." MTD Order at 30. Both the renewal of the contract and ongoing payments constitute prohibited transactions occurring within the six-year Class Period.

Notably, Defendants concede that they amended the contract with Caremark as a result of a request for proposal conducted in 2020. *See, e.g.*, Third Defense ¶ 13 (conceding that Defendants accepted the "final bid made by Caremark" as a result of a 2020 RFP). Amending or renewing the contract to incorporate Caremark's bid in response to the RFP is of course a separate transaction that ends the inquiry. Indeed, the statute explicitly covers any "extension or renewal of such a contract or arrangement." 29 U.S.C. § 1108(b)(2)(B)(i); *see also* 29 U.S.C. § 1113 (limitations period runs as of "the last action" constituting part of the breach). Plaintiffs are "aware of no decision holding that the decision to extend a services contract fails to qualify as a 'transaction' under ERISA. Accordingly, [Defendants'] argument fails." *Perez v. Chimes D.C., Inc.*, 2016 WL 4993293, at *6 n.10 (D. Md. Sept. 19, 2016) (distinguishing Defendants' preferred caselaw).

Moreover, "[t]he Complaint alleges that the relevant prohibited transactions were the [excessive payments to Caremark throughout the Class Period]… and not [only] the selection of" Caremark itself. *Moreno*, 2016 WL 5957307, at *5 (rejecting similar argument). Courts have consistently held that ongoing payments to a provider constitute prohibited transactions falling within the limitations period, even when the initial selection of a service provider or investment occurs outside of the limitations period. *See, e.g., Sweeney v. Nationwide Mut. Ins. Co.*, 2026 WL

352845, at *17 (S.D. Ohio Feb. 9, 2026) ("To the extent Plaintiffs assert that Defendants engage in prohibited transactions or self-dealing every time Nationwide Life applies charges to, or takes consideration or compensation from, earnings of the assets backing the Annuity Contract, those claims are not barred."); *Falberg v. Goldman Sachs Grp., Inc.*, 2020 WL 3893285, at *12 (S.D.N.Y. July 9, 2020) (denying motion to dismiss where ongoing payments to mutual fund company fell within limitations period even where the initial selection of the mutual fund occurred prior); *Moreno*, 2016 WL 5957307, at *5 (same); *Feinberg v. T. Rowe Price Grp., Inc.*, 2018 WL 3970470, at *11 (D. Md. Aug. 20, 2018) ("[T]he prohibited transactions at issue are the monthly fees being paid….not the initial selection of the investment for the Plan[.]"); *Trauernicht v. Genworth Fin., Inc.*, 2024 WL 4000258, at *5 (E.D. Va. Aug. 29, 2024) (distinguishing *David v. Alphin* from allegations of ongoing transactions); *Perez*, 2016 WL 4993293, at *6 n.10 (same); *Maier v. Sinnwell*, 2017 WL 9884545, at *4 n.3 (S.D. Iowa Aug. 22, 2017) (same); *Wildman v. Am. Century Servs., LLC*, 237 F. Supp. 3d 902, 911 (W.D. Mo. 2017) (denying MTD where "Plaintiffs complain Defendants engaged in prohibited transactions by causing the Plan to pay excessive fees" to service providers throughout the class period). Plaintiffs make the same allegations here.

Defendants ignore all of this. Despite this Court's MTD Order saying otherwise, Defendants frame Plaintiffs' claims as challenging "the Plan's engagement with Caremark to provide PBM services" and allege that Plaintiffs' claims are time-barred because the *original* engagement occurred before 2019. Motion at 18. "This argument fails as it does not accurately characterize the allegations in the Complaint." *Moreno*, 2016 WL 5957307, at *5.

Defendants' preferred caselaw challenges only the initial decision to retain a provider or investment. *See* Motion at 18-19 (citing cases); *see also White v. Chevron*, 2017 WL 2352137, at

*21 (N.D. Cal. May 31, 2017) ("[P]laintiffs are explicit about the transaction they purport to be prohibited – it is causing the Plan to engage Vanguard to be the Plan's recordkeeper.") (citation and internal quotations omitted), *aff'd*, 752 F. App'x 453 (9th Cir. 2018); *Cassell v. Vanderbilt*, 285 F.Supp.3d 1056, 1067 (M.D. Tenn. 2018) ("Plaintiffs allege that Defendants engaged in a 'prohibited transaction' by locking the Plan into the CREF Stock Account and the record-keeping services of TIAA."); *David v. Alphin*, 704 F.3d 327, 340 (4th Cir. 2013) (challenging initial selection of investments, not ongoing fees); *D.L. Markham DS, MSD, Inc. 401(k) Plan v. Variable Annuity Life Ins. Co.*, 88 F.4th 602, 606-607 (5th Cir. 2023) (suit challenging a single, contractual termination fee without analyzing statute of limitations). None of these cases address the allegations made here, where the "last action which constituted a part of the breach or violation" occurred within the Class Period. 29 U.S.C. § 1113.

IV. The Court Already Held that Plaintiffs Have Standing to Pursue Their Prohibited Transaction Claims

Finally, Defendants' attempt to re-litigate the standing question should be rejected. As they twice acknowledge, *see* Motion at 20 n.13, 25 n.15, the Court already ruled that Plaintiffs have Article III standing to pursue their prohibited-transaction claims. MTD Order at 19 ("Plaintiffs have alleged facts that satisfy Article III standing."). Nothing has changed since then.

Defendants rest their already-rejected standing argument on their incorrect contention that this Court dismissed all aspects of this case involving prescription-drug pricing. *See* Motion at 21-25. As shown above, that characterization is false. *See supra* Part I.B. Moreover, Defendants' attempt to separate Caremark's compensation into one bucket for "benefits-administration functions" and another bucket for "retail-drug costs" is a false dichotomy—determining "reasonable compensation" under § 1108(b)(2) requires "consider[ing] all compensation – direct and indirect – that the party in interest receive[d] 'in connection with' the services it provides to

the plan under the contract." *Bugielski*, 76 F.4th at 911 (citing 77 Fed. Reg. 5632, 5650 (Feb. 3, 2012)).

Defendants invoke *Navarro v. Wells Fargo & Co.*, 2025 WL 897717 (D. Minn. Mar. 24, 2025), and reasoning akin to that in *Lewandowski v. Johnson & Johnson*, 2025 WL 3296009 (D.N.J. Nov. 26, 2025), to argue traceability. Motion at 23-25. This Court already addressed and rejected those arguments. MTD Order at 16-19. Defendants' "injury-in-fact" arguments, *see* Motion at 25-28, are either repeats of already-rejected arguments, *see* MTD Order at 14-18, or are merits arguments in the guise of standing arguments, *see id.* at 18 ("[T]his is a question for the merits and not a ground for dismissal based on lack of standing."). Those merits arguments are addressed above, *see supra* Part II.D.

CONCLUSION

For the foregoing reasons, Defendants' motion should be denied.

Dated: July 10, 2026

Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

I, Michael Eisenkraft, hereby certify that the foregoing Memorandum of Law in Opposition to Defendants' Motion for Judgment on the Pleadings contains 8,745 words, as reported by Microsoft Word, not including those portions of the document that do not count against the word limit.

Dated: July 10, 2026

/s/ Michael Eisenkraft
Michael Eisenkraft