

**UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF NEW YORK**

PLAINTIFFS 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' REPLY TO DEFENDANTS' ANSWER AND ASSERTED PROHIBITED  
TRANSACTION EXEMPTION**

Pursuant to the Court’s Opinion and Order dated March 9, 2026 (Dkt. 45) and Federal Rule of Civil Procedure 7(a)(7), Plaintiffs Seth Stern, Angela Bindner, and Marianne Schmitt (“Plaintiffs”) submit the following Reply to Defendants’ Answer and the prohibited transaction exemption asserted by Defendants in their Third Defense to the Class Action Complaint.

### **PRELIMINARY STATEMENT**

Plaintiffs object to Defendants’ Preliminary Statement in its entirety. Defendants’ Preliminary Statement falls outside the proper scope of an Answer to a Complaint, and consists largely of improper argument, inappropriate and inaccurate characterizations of the Court’s Opinion and Order (which speaks for itself), and unfounded attempts to minimize their own pleading burden in responding to Plaintiffs’ allegations and their burden of proof with respect to their asserted prohibited transaction exemption.

In particular, Plaintiffs object to Defendants’ attempt to engraft aspects of the Court’s ruling on the breach of fiduciary claims (which were dismissed) onto the prohibited transaction claims (which were not dismissed). Plaintiffs do not agree with – and specifically deny – Defendants’ assertion that “the prohibited transaction ruling is necessarily limited to that aspect of Caremark’s work on administering the Plan as designed, by ‘resolving prescription-drug claims’ and ‘processing prior authorizations’ and not in ... determining drug pricing.” Answer at 4. Nothing in the Court’s Opinion and Order regarding the prohibited transaction claims so states. And nothing in Plaintiffs’ Complaint alleged that Caremark’s “resolving prescription-drug claims” or “processing prior authorizations” were prohibited transactions. Rather, Plaintiffs alleged that Defendants engaged in prohibited transactions by “causing the Plan to enter into contracts with Caremark” and by “causing the Plan to repeatedly make excessive payments to Caremark.” Compl. ¶¶ 280, 288. This Court’s Opinion and Order identified the relevant conduct consistently with

Plaintiffs' allegations, not Defendants' inaccurate characterization. *See* Opinion and Order at 30 (“The complained-of conduct here is JPMorgan ‘enter[ing] into and/or renew[ing] a contract with Caremark’ and its payments to Caremark thereunder.”); *id.* (“Defendants thus acted as fiduciaries when they ‘entered into and/or renewed [the PBM agreement] with Caremark’ and made related payments.”); *id.* at 31 (“Plaintiffs plead ... that [] Defendants ‘entered into and/or renewed a contract with Caremark,’ Compl ¶ 104, and ‘repeatedly ma[d]e excessive payments to Caremark.’”). Those claims, based on the conduct described in the Complaint and by the Court, were not dismissed in any respect.

Plaintiffs also specifically object to Defendants' statement that they will “not respond” to allegations that they unilaterally determine to be outside the scope of the prohibited transaction claims that the Court allowed to proceed. Answer at 4. The Court did not dismiss any aspect of the prohibited transaction claims. To the extent that Defendants did not respond to Plaintiffs' allegations of excessive prescription drug prices paid to CVS Caremark (“Caremark”), or other allegations relating to the compensation received by Caremark or the services provided by Caremark, such allegations must be deemed admitted, *see* Fed. R. Civ. P. 8(b)(6), and the Court should determine that Defendants have not met their burden to support their asserted “reasonable” compensation exemption under 29 U.S.C. § 1108(b)(2).

Defendants' preliminary statement fundamentally misapprehends that: (1) the pending prohibited transaction claims are separate and distinct from the breach of fiduciary duty claims that were dismissed; and (2) for purposes of those prohibited transaction claims, ***Defendants*** (not Plaintiffs) bear the burden of proof on whether the compensation to Caremark was reasonable. Defendants have not met their burden at this stage. Indeed, they have not even engaged with Plaintiffs' overpricing allegations.

### REPLY TO THIRD AFFIRMATIVE DEFENSE

1. Plaintiffs, on behalf of themselves and all others similarly situated, and on behalf of the Plan, incorporate by reference all paragraphs of the Complaint (Dkt. 1) as if fully re-written herein.

2. Defendants admit that:

(a) “Caremark has been the Plan’s PBM,” Third Defense ¶ 1; *see also* Answer ¶¶ 281, 289 (“Defendants admit that they retained Caremark as the Plan’s PBM”);

(b) JPMorgan “entered into or renewed a contract with Caremark” during the putative class period, Answer ¶ 104;

(c) the Plan makes prescription drug benefits available through Caremark, *id.* ¶ 17; and

(d) Caremark is a “service provider” to the Plan, *id.*

Defendants also do not deny that “Caremark is a party in interest” as defined by ERISA, *see* Compl. ¶¶ 279, 287 (citing 29 U.S.C. § 1002(14)(B)); Answer ¶¶ 279, 287, and do not dispute that “the Complaint’s allegation that Defendants retained Caremark as a plan service provider was sufficient to state a viable prohibited transaction claim under the Supreme Court’s decision in *Cunningham v. Cornell Univ.*, 604 U.S. 693 (2005).” Answer at 3-4.

3. In their Third Defense, Defendants assert that this “action falls within the scope of one or more exemptions to ERISA § 406[.]” Answer at 61. However, the only exemption that Defendants specifically identify, much less attempt to support, is the exemption in ERISA § 408(b)(2). *Id.* Accordingly, Defendants’ Third Defense fails for lack of prosecution and lack of specificity with respect to any exemption other than the exemption in ERISA § 408(b)(2).

4. With respect to the exemption under ERISA § 408(b)(2), Defendants concede that:

(a) the services provided by a pharmacy benefit manager or other service provider to a plan (such

as the Plan here) must be “necessary for the establishment or operation of the plan”; and (b) it is also required that “no more than reasonable compensation is paid therefor.” Answer at 61. Plaintiffs deny that Defendants satisfy either of these elements, and deny Defendants’ allegation that the “exemption applies here.” *Id.*

5. The first element of the § 408(b)(2) exemption is lacking because Caremark’s services were *not* necessary for the establishment or operation of the Plan. Plaintiffs specifically plead that:

An internal document from December 2017 stated that prior efforts to reduce health care costs didn’t work “because they conceded the existence and role of intermediaries like PBMs ... which have a vested interest in maintaining the status quo.” The same document *proposed that JPMorgan manage pharmacy benefits in house instead of using a PBM.*

Compl. ¶ 149 (emphasis added). Defendants do not deny this allegation. *See* Answer ¶ 149.

6. Defendants do not assert in their Third Defense (or anywhere else in their Answer) that JPMorgan is incapable of administering its own prescription drug program or providing pharmacy benefit management services directly. Instead, Defendants generically assert that “Companies *generally* cannot efficiently provide PBM services themselves to their plan’s participants, and therefore *most* contract with PBMs to provide such services.” Third Defense ¶ 6 (emphasis added); *see also id.* at ¶ 5 (generically asserting that PBMs assist plan sponsors in processing claims and prior authorizations); *id.* at ¶ 7 (noting that “[m]any plan fiduciaries contract with” PBMs). Whether many or even most plan sponsors contract with PBMs does not address whether it was necessary for *this* plan sponsor – a sophisticated multinational company that has proposed managing pharmacy benefits in-house – to engage the services of a third-party PBM. As early as 2014, the ERISA Advisory Council specifically stated that “very large employers may conduct some of the core formulary-related PBM services in-house[.]”

7. Plaintiffs further allege that “JPMorgan is a member of the Purchaser Business Group on Health (“PBGH”),” Compl. ¶ 136, which “warns against using traditional PBMs” like Caremark, *id.* ¶ 138. Defendants do not deny these allegations, either. *See* Answer ¶¶ 136, 138.

8. Defendants assert that large, national companies who do contract with PBMs “must contract with PBMs of sufficient size and sophistication” and “cannot contract with PBMs that do not have national reach.” Third Defense ¶ 8. This does not establish, however, that it was necessary for Defendants to engage *Caremark* as the Plan’s PBM (even if it were necessary to engage a PBM in the first place, which Plaintiffs deny). Defendants concede that Caremark is just “one of” the PBMs that can provide adequate PBM services where outside PBM servicers are utilized. *Id.* at ¶ 9.

9. Defendants do not deny that “[t]here are several traditional PBMs in the marketplace that are capable of providing a high level of service and that will vigorously compete to win a PBM contract from a Fortune 50 company like JPMorgan.” Compl. ¶ 68; Answer ¶ 68. Defendants likewise do not deny that “[t]here are numerous pass-through PBMs in the marketplace that are capable of providing a high level of service and will vigorously compete to win a PBM contract from a Fortune 50 company like JPMorgan.” Compl. ¶ 73; Answer ¶ 73.

10. For these and other reasons, it was not “necessary” for JPM to engage and retain any third-party PBM, much less the services of a PBM like Caremark with serious flaws such as those described by Plaintiffs in their Complaint. Plaintiffs specifically deny Defendants’ averment that “[t]he services Caremark provided as the Plan’s PBM were necessary.” Third Defense ¶ 4. Such third-party services were not necessary to establish or operate the Plan.

11. Even if it were necessary to engage the services of a third-party PBM like Caremark (which Plaintiffs deny), the second element of the ERISA § 408(b)(2) exemption is not met.

Defendants have the burden to prove that the compensation to Caremark was “no more than reasonable” under ERISA § 408(b)(2). *See Cunningham*, 604 U.S. at 702. Defendants fail to meet that burden for multiple reasons.

12. Defendants repeatedly cite and rely upon “[t]he agreement pursuant to which Caremark provides services to the Plan, Third Defense ¶ 11; *see also id.* at ¶¶ 12, 15, 17, 18 (referring to “Caremark Agreement”); Answer ¶ 104 (“Defendants refer to the agreements with Caremark for their full terms”), but they do not provide a copy of the Caremark Agreement or any detail regarding the specific pricing terms and other terms of that agreement. Defendants 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.<sup>1</sup>

13. Defendants’ references to the purported “financial competitiveness” of the Caremark Agreement (Third Defense ¶ 15) and their purported due diligence regarding the Caremark Agreement are conclusory, unsupported, and insufficient to meet their burden with respect to the ERISA § 408(b)(2) exemption. Defendants do not even assert that the Caremark Agreement’s terms *were* financially competitive, but only that Defendants conducted a “check” to assess *whether* they were. Plaintiffs specifically deny that the terms of the Caremark Agreement are financially competitive.

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<sup>1</sup> Defendants provide no explanation for their failure to produce the contract or detail the contract terms. Nor is there any legitimate explanation or excuse for their failure to do so. To the extent that Defendants had any confidentiality concerns, they could have sought to file the contract under seal, as Plaintiffs did with respect to the names of the specific drugs that they purchased. *See* Dkt. 3 (unredacted Complaint filed under seal); *see also* Case No. 1:25-cv-00092 (S.D.N.Y.), Dkt. 1 (pre-filing request for leave to file under seal). Defendants’ lack of transparency in failing to produce the contract or identify the contract terms creates a reasonable inference that production of the contract and contract terms would undermine their asserted defense under ERISA § 408(b)(2) and their assertion that the compensation to Caremark was “reasonable.”

14. Defendants purport to describe an annual “market check” of the terms of the Caremark Agreement. *See* Third Defense ¶¶ 12, 15. However, 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.” Defendants’ allegation that these purported “market checks” resulted in “improved” pricing and contract terms, *id.*, suggests only that the pricing and contract terms had been lagging behind the market. Further, while Defendants allege that these purported market checks resulted in “improved” pricing and contract terms compared to Defendants’ prior pricing and contract terms, *id.*, they do not indicate how Caremark’s pricing and contract terms fared in relation to other PBMs or to pricing and terms offered to other employers of comparable size. Indeed, Defendants provide no comparison between the Plan’s pricing and the pricing for any other employer healthcare plan, or 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 that is entitled to no weight. Plaintiffs specifically deny this allegation. If anything, Defendants’ vague and opaque allegations regarding these purported market checks (which Defendants concede were not even conducted by Defendants, but rather “through HTA,” *id.* ¶ 12) create a further cloud over the Caremark Agreement. Defendants’ lack of transparency supports the inference that the Caremark Agreement is unreasonable and certainly does not rebut Plaintiffs’ well-pled allegations.

15. Defendants’ allegations regarding purported requests for proposals (“RFPs”) for PBM services are also insufficient to establish that Caremark’s compensation was “reasonable” for purposes of ERISA § 408(b)(2).

16. Defendants reference only two RFPs in their Third Defense, which were purportedly conducted in 2020 and 2021. *See* Third Defense ¶¶ 13-14. These RFPs do not and cannot establish the reasonableness of Caremark’s compensation in other years, particularly prior to the time that the RFPs were allegedly conducted.

17. Even as to the indicated years, Defendants’ allegations regarding these RFPs are vague, opaque, and conclusory, and lack critical substance that is material to the ERISA § 408(b)(2) exemption.

18. Defendants’ allegations regarding the 2021 RFP are deficient. Defendants concede that this RFP was conducted by HTA with respect to a “master agreement,” Third Defense ¶ 14, and was not conducted by Defendants with respect to PBM services for the Plan itself. Accordingly, this RFP does not and cannot establish the reasonableness of Caremark’s compensation for services to the Plan. This is especially so because Defendants allege that the Plan’s contract with Caremark includes “customizations to the HTA contract that are applicable just to the Plan’s arrangement with Caremark.” *Id.* ¶ 3. These alleged customizations would not be captured by HTA’s RFP for a master agreement.

19. Even if any conclusions could be drawn from HTA’s RFP for a “master agreement” for purposes of the Plan’s specific service provider arrangement with Caremark, Defendants do not include *any* allegations regarding pricing or other terms with respect to the 2021 RFP. Defendants simply assert that “HTA conducted a request for proposal for PBM services to determine if it should engage with a different PBM in connection with the master agreement,” and “[a]s a result of that request for proposal, HTA continued to engage Caremark.” Third Defense ¶ 14. 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 (or even whether pricing terms were solicited). It does not appear from Defendants' allegations that Defendants were afforded access to HTA's RFP process or have any knowledge about the range of proposals solicited or received. Moreover, even assuming that Caremark's proposal was deemed most favorable by HTA with respect to HTA's membership as a whole (which is not alleged and which Plaintiffs deny), that says nothing about whether that proposal was most favorable for the Plan specifically.

20. Moreover, Defendants do not deny that:

(a) HTA urged its members to "carve out specialty drugs" from HTA's master agreement, advising members that they could "reduce specialty spend ~47%" by doing so. Compl. ¶ 144; Answer ¶ 144;

(b) Despite this guidance, Defendants did not carve out specialty drugs from the HTA agreement, failing to take HTA's advice. Compl. ¶ 145; Answer ¶ 145;

(c) By carving out specialty drugs Defendants "could have saved the Plan and its participants/beneficiaries over \$60 million per year." Compl. ¶ 146; Answer ¶ 146.

Accordingly, even if HTA's "master agreement" had reasonable prices for non-specialty drugs (which Plaintiffs deny), payments for specialty drugs under the Plan were, by HTA's own telling and Defendants' failure to deny, millions of dollars higher than they would have been if Defendants had followed HTA's advice.

21. In the end, Defendants do not even contend that the 2021 RFP conducted by HTA supports the conclusion that Caremark's "compensation" was reasonable (as required under ERISA § 408(b)(2)) – only that the Plan's "arrangement" is reasonable. Third Defense ¶ 14. This further demonstrates the inadequacy of Defendants' allegations regarding the 2021 RFP for purposes of establishing their claimed exemption under ERISA § 408(b)(2).

22. The only RFP that Defendants discuss with respect to “the Plan’s PBM services” is an RFP that was purportedly conducted in 2020. *See* Third Defense ¶ 13. Defendants state that this RFP was conducted “with the assistance of a leading benefits consulting firm,” *id.*, but do not indicate which one. Relevant here, Defendants do not deny Plaintiffs’ allegations regarding the conflicts of interest that have been reported among employee benefits consultants, which frequently distort the RFP process. *See* Compl. ¶¶ 75-80; Answer ¶¶ 75-80. Defendants’ failure to identify their consultant leads to a reasonable inference that disclosure of the consultant’s identity would have revealed a conflict of interest. Further, Defendants provide no detail regarding how responses were “graded by the benefits consulting firm retained by Defendants,” Third Defense ¶ 13, and whether the consultant considered costs and other quantitative metrics or only made a determination as to which candidate was “most advantageous for the Plan *qualitatively*.” *Id.* (emphasis added). Without additional detail regarding the RFP consultant or the specifics of its RFP process, the alleged 2020 RFP does not and cannot support Defendants’ allegation that Caremark’s compensation was reasonable.

23. Similar to their alleged “market check[s],” Defendants do not attach a copy of the 2020 RFP or describe the RFP criteria; do not attach the RFP responses or provide a scorecard or any detail regarding the individual responses that were received; do not identify any specific PBMs who were provided the RFP or responded to the RFP (other than Caremark); do not indicate how pricing and other contract terms were evaluated; and do not indicate whether drug pricing was specifically considered (much less how) as part of the RFP process.

24. Although Defendants indicate that the final bid made by Caremark was the cheapest on a “total cost” basis, Third Defense ¶ 13, Defendants do not indicate what components were considered as part of the total cost calculus, do not indicate whether those costs included

prescription drug costs or were limited to “claims administration services and processing,” *id.*, and do not indicate whether Defendants considered any costs paid by Plan participants (as opposed to JPMorgan) as part of the RFP process.<sup>2</sup> Nor do Defendants provide the financial terms of Caremark’s bid or of any other bidders. Defendants’ allegations regarding total costs under a bundled arrangement are insufficient to meet their pleading burden and burden of proof.

25. Defendants’ explanation for ruling out “the PBM that described itself as not a traditional PBM” (Third Defense ¶ 13) is vague and conclusory, and provides no detail regarding the identity of the PBM, the pricing or service terms offered by that PBM, or whether its bid was even considered in the round of “final bid[s]” that were evaluated. In their Answer, Defendants do not deny that “the Plan would save a substantial amount of money by contracting with one or more pass-through PBMs instead of entering into and continuing its contract with Caremark, without meaningfully (or at all) sacrificing availability of drugs, scope of pharmacy network, quality of service, convenience, or any other factor related to plan features or services.” Compl. ¶ 174; Answer ¶ 174. Defendants also do not deny the Complaint’s allegations regarding lower pricing offered by three specific PBMs: SmithRx, Navitus, and Capital Rx. *See* Compl. ¶¶ 175-77; Answer ¶¶ 175-77.

26. As with the 2021 RFP (*see supra* at ¶ 21), Defendants do not contend that the 2020 RFP supports the conclusion that Caremark’s compensation was reasonable – only that the Plan’s “arrangement” is reasonable. Third Defense ¶ 14. This further demonstrates the inadequacy of

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<sup>2</sup> Defendants’ assertion that they “regularly evaluate the total cost of the Plan’s PBM services” (Third Defense ¶ 16) is similarly lacking in detail and does not meet their burden to show that the compensation to Caremark was reasonable for purposes of ERISA § 408(b)(2). Defendants state that they evaluate the “usage” of prescription drugs by the Plan’s participants, *see* Third Defense ¶ 16, but do not state that they evaluate the price of those prescription drugs or identify any concrete steps they take based on any supposed evaluation.

Defendants' allegations regarding the 2020 RFP for purposes of establishing their claimed exemption under ERISA § 408(b)(2).

27. Defendants do not contend that they have conducted (or that HTA has conducted) any RFP since 2021, suggesting that Defendants have failed to re-evaluate the market for four or more years. This further demonstrates that Defendants have not met their burden to plead and prove that the compensation to Caremark was reasonable throughout the relevant period.

28. 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 associated with prescription drugs obtained through the Plan.” Third Defense ¶ 18. This is irrelevant. Rebates are provided by drug manufacturers only with respect to brand-name drugs, not the generic drugs that are the subject of the Complaint. *See* Compl. ¶¶ 102, 128. Moreover, Defendants do not deny Plaintiffs' allegations regarding how PBMs like Caremark “attempt to denominate rebates by other names to obscure their nature, or hide these rebates by purchasing medications from a wholly owned group purchasing organization that sells drugs back to the PBM.” Compl. ¶ 65; Answer ¶ 65. In any event, Plaintiffs' Complaint is clear that “such rebates are not per se unlawful,” Compl. ¶ 66, and their prohibited transaction claims do not depend on Caremark retaining drug rebates. The question for purposes of reasonableness of compensation is not *how* Caremark is compensated, but *how much*. Defendants do not address this question anywhere in their Answer or their Third Defense, much less compare Caremark's compensation to a meaningful benchmark. Defendants' assertions regarding rebates and whether they are retained by Caremark do not establish that Caremark's compensation was “reasonable” for purposes of ERISA § 408(b)(2), much less undermine any of the Complaint's actual allegations.

29. Defendants assert 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. However, Defendants provide no factual support for these conclusory statements. They do not provide a copy of the Caremark Agreement or any meaningful detail regarding the pricing terms or other terms of that agreement. Moreover, Defendants’ conclusory statements are contradicted by other parts of their Answer. 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* Compl. ¶¶ 112-25; Answer ¶¶ 112-25. Regardless, as noted above, the relevant question is not *how* Caremark is compensated but *how much*. Because Defendants do not answer this question, they fail to establish the reasonableness of Caremark’s compensation.

30. In any event, Defendants do not deny that one of the ways traditional PBMs like Caremark “make their money” is by “owning their own pharmacies,” and that this is a separate revenue stream from spread compensation or rebates. Compl. ¶ 53; Answer ¶ 53; *see also* Compl. ¶ 67 (“Some traditional PBMs also earn revenue through ownership of pharmacies.”); Answer ¶ 67 (non-denial). Defendants also do not deny that Caremark is vertically integrated with the pharmacy CVS Specialty. Compl. ¶ 67; Answer ¶ 67. Further, Defendants do not deny that:

Through this arrangement, PBMs can misleadingly represent ... that they are not engaging in spread pricing (*i.e.*, they can promise that they are charging the plan the same amount they are paying the pharmacy), even though that is technically true only because the PBM “agreed” to pay its own pharmacy excessive amounts. In reality, the mechanism is the same as spread pricing—*i.e.*, the traditional PBM charges the plan far more than the drug actually costs, and then the PBM or its affiliated pharmacy pockets the difference.

*Id.* For this reason as well, Defendants’ assertion that “Caremark has not received spread-based compensation” (Third Defense ¶ 18) is insufficient to support their defense under ERISA § 408(b).

31. Defendants allege that they “have received all required information from Caremark,” and that they “regularly perform oversight of payments and compensation to Caremark, including through regular audits ... to confirm Caremark’s compliance with the Caremark Agreement.” Third Defense ¶ 17. However, these allegations also fail to rebut Plaintiffs’ claims or establish that the compensation to Caremark was reasonable. Plaintiffs do not assert claims relating to a failure to disclose (or receive) information or a breach of contract. Instead, Plaintiffs claim that the service provider relationship itself was prohibited under ERISA § 406, unless Defendants can establish the elements of their asserted prohibited transaction exemption under ERISA § 408(b)(2). Defendants do not and cannot establish that Caremark’s compensation was “reasonable” for purposes of this exemption by stating that they received unspecified information from Caremark or performed “oversight of payments,” without specifying how much those payments were and providing meaningful benchmarks establishing the reasonableness of those payments. Nor can Defendants establish that Caremark’s compensation was reasonable by stating that they audited compliance with the Caremark Agreement without providing information regarding the pricing terms and other terms of the Agreement.

32. As discussed above (*see* Preliminary Statement), Defendants do not respond in either their Answer or Third Defense to the substance of Plaintiffs’ allegations regarding excessive pricing for prescription drugs. Among other things, Defendants do not deny that:

- a. They “allow[ed] the Plan and its beneficiaries to pay unreasonable prices for prescription drugs.” Compl. ¶ 7; Answer ¶ 7.
- b. “The price discrepancies noted [in the Complaint] are illustrative of a pervasive and systematic problem of unreasonable prescription drug charges.” Compl. ¶ 8; Answer ¶ 8.

- c. Defendants' mismanagement has caused the Plan and its participants/beneficiaries to vastly overpay for prescription drugs, and has cost the Plan and its participants/beneficiaries (including Plaintiffs) millions of dollars over the Class Period." Compl. ¶ 103; Answer ¶ 103.
- d. Plaintiffs purchased the generic drugs set forth in the chart in paragraph 127 of the Complaint, the price for the drugs shown accurately reflects the total combined price paid by Plaintiffs and/or the Plan out of pocket (with the exception of Row 3, which Defendants solely deny), and those drug prices reflect "unreasonable markups" of up to 627.22%. *See* Compl. ¶ 127; Answer ¶ 127.
- e. The prices for generic drugs under the Plan have "not been offset by any corresponding discounts on other drugs." Compl. ¶ 128; Answer ¶ 128.
- f. Because of the extraordinarily high prices to which Defendants agreed, the Plan paid substantially more for prescription drugs than it would have otherwise paid, and likewise, participants and beneficiaries of the Plan paid more than they otherwise would have paid. Compl. ¶ 170; Answer ¶ 170.

33. Defendants cannot establish that Caremark's compensation as the Plan's PBM was reasonable without addressing prescription drug pricing. A recent proposed rulemaking confirms this. On January 30, 2026, the Employee Benefits Security Administration ("EBSA") published a set of proposed rules regarding PBM fee disclosures to Plan fiduciaries. *See* EBSA, *Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure*, 91 Fed. Reg. 4348 (Jan. 30, 2026). By their terms, these proposed rules are specific to "self-insured" (i.e., self-funded) group health plans like the JPMorgan Plan. *See id.* at 4358 (§ 1.2). Among other things, the rules require

disclosure of PBM compensation and net cost information for “each drug” a plan’s formulary, *id.* at 4364-65, 4368 (§§ 3.2-3.4, 3.9). One of the main purposes of these proposed rules is to allow plan fiduciaries to “assess ... the reasonableness of the compensation” provided to PBMs so they can determine whether “the standards for an exemption under ERISA section 408(b)(2)” are satisfied. *Id.* at 4379.

34. Defendants also do not deny that:
  - a. NADAC “offers a standardized benchmark for drug pricing, promoting fairness and transparency in the healthcare system.” Compl. ¶ 110; Answer ¶ 110.
  - b. “A prescription drug’s NADAC is a widely-accepted benchmark,” *id.*, which is “commonly used by other plans as a benchmark for the prices they pay for prescription drugs.” Compl. ¶ 111; Answer ¶ 111.
  - c. JPMorgan’s own trade group, PBGH, encourages its members to examine pricing benchmarks that include NADAC. Compl. ¶ 139; Answer ¶ 139.
  - d. Since at least 2011, the United States Office of Personnel Management has required that insurance carriers that provide health care coverage to federal employees “base Carrier costs on negotiated price with network pharmacies or *the actual acquisition cost* for PBM-owned or affiliated pharmacies.” Compl. ¶ 199 (emphasis added); Answer ¶ 199.
  - e. “NADAC is not only a commonly-used benchmark, but a conservative one[.]” Compl. ¶ 111; Answer ¶ 111.
  - f. Across all 366 generic drugs on the Plan’s published formularies for which NADAC information is publicly available, the Plan’s prescription drug prices at the time of the filing of the Complaint reflected, on average, a markup of

211.1% above NADAC. Compl. ¶ 112; Answer ¶ 112 (stating that “Defendants lack knowledge or information sufficient to form a belief as to the truth of the factual allegations regarding acquisition costs” for these 366 drugs).

- g. “No prudent fiduciary would agree or allow their PBM to receive an average 211.1% markup above pharmacy acquisition cost, especially where the PBM itself owns the pharmacy.” Compl. ¶ 112; Answer ¶ 112 (stating that defendants do not deny this allegation in the final sentence of paragraph 112 of the Complaint).
- h. Defendants could have negotiated NADAC-based pricing for the Plan, and if they had done so, “Defendants would have reduced ... spending on generic drugs by 30% or more.” Compl. ¶ 172; Answer ¶ 172.

Further, Defendants do not provide an alternative benchmark from which to assess the reasonableness of drug prices under the Plan. Without providing a meaningful benchmark (or any benchmark), Defendants cannot show whether prices were reasonable.

35. After this lawsuit was filed, Defendants secured substantially lower prices for prescription drugs under the Plan. By way of background, the Complaint analyzed all 366 generic drugs under the Plan’s formularies for which NADAC data was available, and alleged that at the time of the Complaint, “Defendants’ negotiated prices reflect[ed], on average, a markup of 211.1% above pharmacy acquisition cost.” Compl. ¶ 112. The Complaint further alleged that “Defendants agreed and/or allowed for prices that would result in one prescription of each of the 366 drugs costing the Plan and its beneficiaries ... \$119,617.92.” *Id.* At the time of the Complaint, the NADAC cost for one prescription of each of the 366 drugs was \$38,445.60. *Id.*

36. Currently, the prices for 352 of those drugs remain accessible through Defendants' pricing portal. At the time of the Complaint, the price under the Plan for one prescription of each of these 352 drugs was \$118,128.38, representing a markup of 220.3% above NADAC (which for these drugs was \$36,879.81). Defendants' current prices for those same 352 drugs total just \$43,968.59, representing a 63% decrease in prices since this lawsuit was filed. This decrease is not attributable to an equivalent decline in NADAC over the same time period, which has declined by just 15%. Put another way, at the time of the Complaint, Defendants' negotiated prices for these 352 drugs were 220.3% above NADAC, whereas they now are only 40.6% above NADAC. This substantial price decrease, both in absolute terms and in relation to NADAC, demonstrates that the prices charged beforehand were unreasonable, or at the very least, undercuts Defendants' assertion that Caremark's compensation was "reasonable." Moreover, the relative closeness of Defendants' current pricing to NADAC demonstrates that NADAC is, in fact, an appropriate benchmark for reasonable drug pricing as Plaintiffs have alleged. *See supra* at ¶ 34.

37. Defendants do not deny that "Charter Communications uses Caremark as its PBM, but Charter Communications has used its bargaining power to secure prices for generic drugs that are far lower than JPMorgan's prices." Compl. ¶ 207; Answer ¶ 207. Defendants also do not deny that "[a]cross the 356 generic drugs described in paragraph 112 [of the Complaint] that are also available under the Charter Communications plan, Defendants agreed to make the Plan and its participants/beneficiaries pay, on average, 2.4 times as much as Charter Communications' plan and participants/beneficiaries pay for the same drugs." *Id.* The Plan's sudden and precipitous reduction in drug prices since this lawsuit was filed (*see supra* at ¶¶ 35-36) has brought the Plan's current pricing much more in line with the pricing under the Charter Communications plan. At the time of the Complaint, the Charter Communications plan's prices were 28.3% above NADAC,

while JPM's were 211.1% above NADAC. Now, however, JPM's prices are closer to Charter's, at 40.6% above NADAC. These data demonstrate that the Charter Communications plan is another appropriate benchmark for reasonable drug pricing, and further demonstrate that Plan's previous pricing was unreasonable.

38. For these and other reasons, Plaintiffs specifically deny Defendants' averment that "Caremark received reasonable compensation in connection with its work as the Plan's PBM." Third Defense ¶ 10. Further, Plaintiffs deny all of Defendants other allegations in their Third Defense that are not expressly admitted herein, as Defendants have not provided the Caremark Agreement (or other relevant information) and no discovery has taken place at this stage.

Dated: April 27, 2026

Respectfully Submitted,

/s/ Michael Eisenkraft

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