UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

SETH STERN, et al. Plaintiffs, v. JPMORGAN CHASE & CO., et al. Defendants.	Case No. 1:25-cv-02097 **ORAL ARGUMENT REQUESTED**

REPLY BRIEF IN SUPPORT OF DEFENDANTS'
MOTION TO DISMISS THE CLASS ACTION COMPLAINT

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INTRODUCTION

Plaintiffs want this Court to unquestioningly accept a never-before-accepted theory rather than assess their actual allegations. They contend that so long as they claim an "overcharge," this Court must exercise jurisdiction and proceed into discovery without further inquiry. But federal courts are required to do the opposite—on standing, they must probe whether purported economic injuries are "plausibly and clearly alleged," *Thole v. U.S. Bank N.A.*, 590 U.S. 538, 544 (2020), and on the merits they must assess whether ERISA claims asserting excessive service-provider fees are improperly based on naked cost comparisons, *Singh v. Deloitte LLP*, 123 F.4th 88, 95-98 (2d Cir. 2024). Plaintiffs ignore these principles, mischaracterize authorities JPMC cites, and fail to address the most on-point, well-reasoned decision dismissing virtually identical claims, *Navarro v. Wells Fargo & Co.*, 2025 WL 897717 (D. Minn. Mar. 24, 2025).[1] The Complaint should be dismissed.

ARGUMENT

I. Plaintiffs lack Article III standing.

Plaintiffs contend that simply *asserting* they were overcharged is sufficient to establish standing. Opp. 5. But injury, *including economic injury*, must be "plausibly and clearly" alleged,[2] and courts cannot gapfill from conclusory pleadings, *e.g.*, *Calcano v. Swarovski N. Am. Ltd.*, 36 F.4th 68, 75 (2d Cir. 2022). "Factual allegations of standing must be plausible and nonconclusory to survive a motion to dismiss." *Collins v. Ne. Grocery, Inc.*, -- F.4th --, 2025 WL 2382948, at *3 (2d Cir. Aug. 18, 2025).

[1] This brief uses the abbreviations in JPMC's Motion ("Mot."). Plaintiffs' opposition is abbreviated "Opp."
[2] *Thole*, 590 U.S. at 544; *Moreira v. Societe Generale, S.A.*, 125 F.4th 371, 384-385 (2d Cir. 2025).

Accordingly, Second Circuit precedent makes clear that "even if overpayment may constitute a sufficient injury in fact in the general case," plaintiffs must "adequately allege that overpayment occurred." *Plutzer v. Bankers Tr. Co.*, 2022 WL 17086483, at *2 (2d Cir. Nov. 21, 2022) ("overpayment" allegations conclusory and speculative); *e.g.*, *Carlone v. Lamont*, 2021 WL 5049455, at *2 (2d Cir. Nov. 1, 2021) (similar); *Wilson v. Mastercard Inc.*, 2022 WL 3159305, at *4 (S.D.N.Y. Aug. 8, 2022) (similar). As explained below, Plaintiffs do not and cannot plausibly allege standing here.

A. Plaintiffs' "higher premium" theory is speculative.

Plaintiffs do not cite any ERISA health-plan case accepting their "higher premium" theory, and they fail to engage with well-reasoned decisions rejecting virtually identical allegations. *See Navarro*, 2025 WL 897717, at *9-*10; *Lewandowski v. Johnson & Johnson*, 2025 WL 288230, at *5 (D.N.J. Jan. 24, 2025). They attempt to distinguish their case from the wall of contrary authority by claiming that JPMC "set participant contributions as a fixed percentage" (30%) of Medical Plan costs, and therefore $100 million in prescription-drug-cost savings *necessarily* would have meant $30 million in participant-contribution savings. Opp. 8; *see* Opp. 7-12.

But just as in *Knudsen v. MetLife Group, Inc.*, 117 F.4th 570, 574 (3d Cir. 2024), and *Navarro*, 2025 WL 897717, at *9, Plaintiffs offer no facts to support the "fixed percentage" they say JPMC chose.[3] Not for lack of opportunity: participants have access to plan documents and

[3] Plaintiffs ignore *Navarro* and contend that *Knudsen* is distinguishable because the plaintiffs did not allege any connection between rebates and participant premiums. Opp. 10-11. But that was the plaintiffs' *entire theory* of standing, *Knudsen*, 117 F.4th at 573; it simply was not supported by "nonspeculative allegations" that the plaintiffs paid "more in premiums, or other out-of-pocket costs" due to the alleged breach. *Id.* at 580-582.

SPDs. 29 U.S.C. §1024(b). If anything in the Plan set participant contributions as a fixed percentage, Plaintiffs would have cited it.

Instead, they ask the Court to *infer* a "fixed percentage" because DOL filings reflect *around* 30% in employee contributions. Opp. 8-9; Compl. ¶229. That argument is flawed. First, Plaintiffs' Complaint alleges variation, including participant contributions of 32.26% in 2017 and 35.49% in 2020. Second, JPMC's filings collectively report on all constituent plans in JPMC's "Health Care and Insurance Program for Active Employees"[4]—medical, vision, dental, COBRA, life insurance, etc., Ex. B, SPD, at MTD-14-17—which do not have uniform employer subsidies, *e.g.*, *id.* at MTD-040 (noting unsubsidized COBRA benefits). Accordingly, these filings indicate nothing about participant contributions to *the Medical Plan* in any particular year, much less suggest an unwavering "fixed percentage" *every year*.

This case is therefore indistinguishable from *Knudsen* and *Navarro* and distinct from Plaintiffs' cited cases, which involved *nonspeculative* financial-injury allegations. Opp. 9.[5] And while Plaintiffs try to factually distinguish the remaining cases JPMC cited (Mot. 10; Opp. 10), they ignore the *legal principle established* by those cases that applies equally here: standing is lacking where a plaintiff relies on speculative "cost savings" allegations, whether framed as "inflated premiums" or the failure to receive "additional benefits." *Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450, 453 (3d Cir. 2003); *Gonzalez de Fuente v. Preferred Home Care of N.Y. LLC*, 858 F. App'x 432, 434 (2d Cir. 2021); *Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598, 608 (6th Cir. 2007). That is true whether the issue is analyzed under injury-in-fact, as in the cases above, or redressability, as in *Glanton v. AdvancePCS Inc.*, 465 F.3d 1123,

[4] *E.g.*, Ex. D, 2020 Form 5500, at MTD-157.
[5] *AARP v. EEOC*, 226 F. Supp. 3d 7 (D.D.C. 2016), for example, challenged a regulation permitting employee-premium increases, and a plaintiff had experienced *that price increase*.

1125 (9th Cir. 2006). The individual standing prongs are "flip sides of the same coin"—"different descriptions of the same judicial effort to ensure" concrete adverseness. *Sprint Commc'ns Co. v. APCC Servs., Inc.*, 554 U.S. 269, 288 (2008).[6]

B. Plaintiffs' "lower out-of-pocket costs" theory is speculative.

Plaintiffs contend they have adequately alleged overcharge by pointing to "completed financial transactions in documented amounts." Opp. 6. But Plaintiffs do not claim injury from being *charged* for drugs—they claim injury from being *over*charged. *Id.* Accordingly, their own theory requires plausible allegations that "the amounts they paid *were higher than they would have been*" absent a breach. *Id.* They fail to offer any, as previously explained. Mot. 11-13. Most fundamentally, referencing NADAC pricing does not plausibly establish that Plaintiffs were overcharged since NADAC is a measure of *pharmacies'* costs, not *customer* pricing.

Plaintiffs ask the Court to accept their "overcharge" characterization as true, irrespective of whether factual allegations support it. Opp. 7. But Plaintiffs cannot establish standing by incanting "overcharge." *Supra* pp. 1-2; *e.g.*, *Wilson*, 2022 WL 3159305, at *4 (rejecting conclusory "overcharge" allegations). And given the complicated nature of prescription-drug pricing, Plaintiffs' assumption they were overcharged for four generic drugs because of JPMC's PBM arrangement is speculative. *See Navarro*, 2025 WL 877717, at *9-*10; *Earl v. Boeing Co.*, 53 F.4th 897, 903 (5th Cir. 2022) ("overcharge" theory relied on unsupportable inferences about complex airline-pricing market).

[6] Cases analyzing the issue under redressability often cite cases addressing injury-in-fact, *e.g. Glanton*, 465 F.3d at 1125 (citing *Horvath* and *Cent. States Se. & Sw. Areas Health & Welfare Fund v. Merck-Medco Managed Care, L.L.C.*, 433 F.3d 181, 202 (2d Cir. 2005)), and vice versa, *e.g.*, *Navarro*, 2025 WL 897717, at *10 (citing *Knudsen*). Accordingly, Plaintiffs are wrong that JPMC "does not dispute" redressability. Opp. 5.

C. That Plaintiffs do not sue under 29 U.S.C. §1132(a)(1) is irrelevant to constitutional standing.

Plaintiffs contend it is "irrelevant" they received all their contractually promised benefits because they did not assert denial-of-benefit claims under §1132(a)(1)(B). Opp. 13. That is wrong—*Thole* involved fiduciary-breach claims asserted under the same provisions Plaintiffs invoke, yet the Supreme Court emphasized that the "defined," and "fixed," nature of the plaintiffs' plan was "[o]f decisive importance" for standing. 590 U.S. at 540. As *Thole* explained, these benefits are "in the nature of a contract," and a participant's only interest is receiving the benefits promised. *Id.* at 542-543. The failure to receive *more* is not "an invasion of a legally protected interest" and thus not injury-in-fact. *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016).

Nor did *Knudsen* reject this argument. Opp. 14. *Knudsen* rejected the idea that *Thole* precludes *all* fiduciary-breach lawsuits by health-plan participants—because if a plan sponsor "charge[s] Plan participants thousands of dollars more in premiums *than is allowed under Plan documents*," *that* would be a basis for standing. 117 F.4th at 580 (emphasis added). Here, Plaintiffs lack standing precisely because they do not allege they paid more "than is allowed under Plan documents." *Id.*

II. Plaintiffs' claims fail on the merits.

A. Plaintiffs' claims fail for lack of relevant fiduciary status.

Plaintiffs do not dispute that much of the conduct they target—the dissolution of Haven Healthcare in favor of the internally missioned Morgan Health team, corporate transactions and client relationships, etc.—involved *corporate* decisions, not fiduciary judgments. Mot. 16-17; Opp. 16-18. Instead, they argue that hiring and monitoring a plan "service provider"—Caremark—and its compensation is a fiduciary function. Opp. 16-17.

But Plaintiffs confuse Caremark's service-provider role in *administering* JPMC's prescription-drug benefits by resolving prescription-drug claims, processing prior authorizations, etc., *e.g.*, Ex. B, MTD-044-045, -075, -093, -107, and its role helping JPMC set the benefits promised by the Plan. Plaintiffs are not challenging Caremark's administration of JPMC's prescription-drug plan or its compensation for doing so;[7] they are challenging the Plan's formulary and prescription-drug pricing, which *are* the Plan's benefits. The law is clear: those are *plan-design* (*i.e.*, settlor) decisions, not fiduciary ones—whether JPMC made those decisions alone or with Caremark's help. *See Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967, 1001-1002 (N.D. Cal. 2018); *Mulder v. PCS Health Sys., Inc.*, 432 F. Supp. 2d 450, 458 (D.N.J. 2006); *Moeckel v. Caremark, Inc.*, 622 F. Supp. 2d 663, 693 (M.D. Tenn. 2007); Mot. 15-16.

Plaintiffs mischaracterize these cases rather than grapple with them. They claim *Doe One* "challenged only the defendant's 'agreement to provide a benefit plan.'" Opp. 18 (quoting *Doe One*). But read on: the rest of the quoted sentence says the plaintiffs challenged the sponsor's "agreement to provide a benefit plan *that has terms Plaintiffs feel are unfavorable*." *Id.* (emphasis added). As here, they challenged the sponsor's PBM arrangement with Caremark and its financial terms (including prescription-drug costs), which the court held were non-fiduciary plan-design decisions. *Id.* at 1000-1002.

[7] Plaintiffs' opposition abandons their contention that JPMC used a "spread"-based compensation model, rather than a "pass-through" model. As JPMC explained (Mot. 6, 20), Plaintiffs offered no well-pled allegations that Caremark was paid through "spread" and instead seemed to *assume* such an arrangement from the mere fact that JPMC contracts with Caremark. *Contra* Evan Sweeney, *CVS Caremark Shifts PBM Model to 100% Pass-Through Pricing and Focus on Net Cost*, Fierce Healthcare (Dec. 5, 2018), https://www.fiercehealthcare.com/payer/cvs-caremark-launches-guaranteed-pbm-model-100-pass-through-pricing. Plaintiffs' opposition makes no mention of spread-based compensation or says anything about Caremark's compensation; it instead focuses entirely on drug-pricing differentials. Opp. 19-20.

Nor did the plaintiffs in *Argay v. National Grid USA Service Co*., 503 F. App'x 40 (2d Cir. 2012), simply challenge the decision "to amend" a life insurance plan, as Plaintiffs suggest. Opp. 18. They challenged allegedly "excessive premiums" (*i.e.*, "overcharge[s]"), just like Plaintiffs here.[8] And while *Moeckel* and *Mulder* indeed involved claims against service providers (Opp. 18), the claims failed because the court "f[ound] no justification to impose upon [the PBM] fiduciary duties *where none could be extended to* [the plan sponsor]." *Mulder*, 432 F. Supp. 2d at 458-459; *Moeckel*, 622 F. Supp. 2d at 693.

Plaintiffs cite *Mahoney v. J.J. Weiser & Co.*, 564 F. Supp. 2d 248, 251 (S.D.N.Y. 2008), which had nothing to do with prescription-drug arrangements.[9] And not a single court has ever relied on *Mahoney* for the proposition that prescription-drug formularies or their associated costs are fiduciary decisions. Plaintiffs also cite inapposite authorities about *retirement* plans (Opp. 16-17): these authorities have no bearing on the settlor/fiduciary distinction for *health* plans, which involve extensive *settlor* conduct in designing benefits and pricing.

B. Plaintiffs have not plausibly alleged a breach of the duty of prudence.

Plaintiffs' prudence argument boils down to the following: *some* drugs covered by JPMC's plan *on average*[10] cost more than the average price at which *some* pharmacies *buy* these

[8] *E.g.*, Reply Br., *Argay*, 2012 WL 1799141, at *1, *5, *14-*17 (W.D.N.Y. May 10, 2012).
[9] The other cases Plaintiffs stringcite after *Mahoney* (at 17) have nothing to do with this issue. *Bowers v. Russell*, 2025 WL 1474307 (D. Mass. Mar. 26, 2025), and *Rodriguez v. Intuit, Inc.*, 744 F. Supp. 3d 935 (N.D. Cal. 2024), involved retirement plans. *Abraha v. Colonial Parking, Inc.*, 243 F. Supp. 3d 179 (D.D.C. 2017), and *Perez v. Chimes Dist. Of Columbia, Inc.*, 2016 WL 5815443 (D. Md. Oct. 5, 2016), were about selecting and monitoring a third-party plan administrator (itself a fiduciary)—unquestionably fiduciary conduct.
[10] Plaintiffs assert that a 211% "mark-up" existed "[a]cross 366 generic drugs" Opp. 1, 4, 19. Plaintiffs' *actual* allegation is that there was an "average" "mark-up" for this subset (Compl. ¶¶6, 112, 207)—which necessarily means that some drugs fall below the reported average pharmacy acquisition costs and others above it.

drugs and more than *one* other plan (among millions nationwide) pays. Opp. 19-20. The Court cannot infer from this that Plan fiduciaries "gave Caremark free rein" without oversight (Opp. 3).

First, Plaintiffs do not cite a single ERISA provision, regulation, or case recognizing a fiduciary obligation to individually negotiate and monitor the cost of each covered drug, such that pointing to purportedly "excessive" costs of certain drugs states a fiduciary-breach claim. Opp. 20-21. Instead, they point to defined-contribution retirement-plan cases where fiduciaries must choose and monitor investment options individually because participants choose what to invest in from a fiduciary-curated list. *See Hughes v. Northwestern Univ.*, 595 U.S. 170, 176-177 (2022). That analogy is inapt: health-plan participants do not decide between penicillin and chemotherapy based on their subjective preferences, and requiring fiduciaries to negotiate thousands[11] of drug prices individually would grind health-plan functioning to a halt. Notably, while DOL advises *retirement-plan* fiduciaries to select and monitor "individual investment alternatives that are made available under the plan,"[12] its guidance for health-plan fiduciaries says *nothing* about individually selecting and monitoring prescription drugs.[13]

Second, Plaintiffs disregard the key pleading principles applicable to retirement-plan excessive-fee cases. They ignore the Second Circuit's most recent precedent, *Singh*, 123 F.4th 88 (cited at Mot. 4, 19, 22, 25), and barely mention its earlier landmark decision, *PBGC v. Morgan Stanley Inv. Mgmt. Inc.*, 712 F.3d 705 (2d Cir. 2013). These cases make clear that

[11] Plaintiffs cannot seriously dispute the broad scope of the Plan's prescription-drug coverage. Opp. 20. The website cited by Plaintiffs' declarant (Dkt. 37) includes 46 pages non-exhaustively listing covered drugs. *See* https://info.caremark.com/oe/jpmc.
[12] DOL, *Meeting Your Fiduciary Responsibilities* 3 (2021), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/meeting-your-fiduciary-responsibilities-booklet-2021.pdf.
[13] DOL, *Understanding Your Fiduciary Responsibilities Under a Group Health Plan* (2023), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/group-health-plan-fiduciary-responsibilities.pdf.

plaintiffs cannot simply point to "cheaper" options that supposedly "were available," *PBGC*, 712 F.3d at 718. Instead, when pleading by comparisons to other plans' arrangements, plaintiffs *must* account for the entire package of "services rendered" and show that the "type and quality of services" were the same. *Singh*, 123 F.4th at 96-98. In short, "Plaintiffs cannot rely … on bare allegations that other plans paid lower fees." *Collins v. Ne. Grocery, Inc.*, 2025 WL 2383710, at *3 (2d Cir. Aug. 18, 2025); *accord Mowry v. Mitsubishi Chem. Am., Inc.*, 2025 WL 2402281, at *12 (S.D.N.Y. Aug. 19, 2025) (Rochon, J.).

Plaintiffs' claims defy these principles. They do not substantively defend their invocation of 13 other plans unaccompanied by the services contracted for *or even prices paid*. Mot. 24. As to the one comparator (Charter) with *limited* pricing information, Plaintiffs say "JPMorgan has no response." Opp. 22. But JPMC explained why Charter was an insufficient comparator under *Singh*. Mot. 24-25. It is Plaintiffs who have "no response." Nor do they explain how selective retail-drug prices or average pharmacy *acquisition* costs are apt comparisons for the package of benefits obtained from Caremark. Mot. 23. Instead, they say this Court cannot question the aptness of their comparators. Opp. 22. The Second Circuit holds otherwise. *Singh*, 123 F.4th at 95-98. And while Plaintiffs nakedly assert that their cost-comparison allegations are "similar" to other cases, Opp. 20, they ignore that those cases *all* precede *Singh*'s adoption of the "meaningful benchmark" standard, 123 F.4th at 95-98, and do not attempt to explain the purported similarity.

Third, Plaintiffs defend their pricing data with a declaration about Entecavir. Opp. 21 (citing ECF 37). If anything, this declaration highlights why courts cannot infer inadequate

process from bare cost comparisons. It shows the relevant pricing information was collected *12 months ago*—in a different plan year, when Entecavir's wholesale cost was much higher.[14]

Finally, Plaintiffs contend that while they do not have to directly allege process failures, they do so here. Opp. 24-25. But Plaintiffs' process "allegations" are conclusory and vague "information and belief" assertions, or *assumptions* that the process must have been subpar, without supporting facts. *E.g.*, Compl. ¶¶105, 106, 108.[15] There simply are no factual "process allegations" to support Plaintiffs' claims.

C. Plaintiffs' reliance on non-fiduciary corporate decisionmaking does not plausibly allege a breach of the duty of loyalty.

Plaintiffs say they are not challenging corporate conduct but rather the "failure to implement" fiduciary cost-saving measures. Opp. 26. But Plaintiffs offer no *factual allegations* about measures fiduciaries did or did not take. *Supra* pp. 9-10; Mot. 3, 18 & n.20. Instead, they ask the Court to *infer* a lack of cost-saving measures based on purported "conflicts of interests" arising from *non-fiduciary* corporate conduct, *e.g.*, JPMC's "banking relationships" with the healthcare industry. Mot. 25-26. To state a loyalty claim, however, Plaintiffs cannot merely rely on potential conflicts from "a common business relationship." *Patterson v. Morgan Stanley*, 2019 WL 4934834, at *14 (S.D.N.Y. Oct. 7, 2019); *Anderson v. Intel Corp. Inv. Pol'y Comm.*, 137 F.4th 1015, 1027 (9th Cir. 2025) (rejecting claim that "fiduciaries' investment in certain hedge funds and private equity funds 'had the potential to benefit'" the sponsor's venture-capital arm).

[14] Nat'l Drug Codes List, Entecavir, https://ndclist.com/ndc/31722-833/package/31722-833-30/price (showing a 50% decrease since the beginning of the 2024 Plan year).
[15] Plaintiffs contend that JPMC's "fail[ure] to implement cost-saving recommendations from two organizations" is a well-pled process allegation. Opp. 25 (citing ¶¶136-146). This allegation, like the others, simply disagrees with outcomes, rather than allege facts about process.

That makes sense: corporations are *allowed* to act out of self-interest when making corporate decisions (their duties to shareholders require it), and so assuming improper fiduciary misconduct from appropriate non-fiduciary activity is unreasonable. *See Pegram v. Herdrich*, 530 U.S. 211, 225 (2000) (describing ERISA's "two hats" framework). "Put simply, the mere existence of a business relationship between two large financial institutions is not enough to lift Plaintiffs' otherwise deficient disloyalty claims above the bar set by *Twombly*." *Patterson*, 2019 WL 4934834, at *14. The same is true here, particularly absent allegations that any relevant Plan fiduciaries were involved in the corporate decisions Plaintiffs highlight. Mot. 25.

Plaintiffs' argument also misstates the public record it relies on. Plaintiffs contend that JPMC "abandoned" cost-saving efforts through Haven Healthcare upon pushback from corporate clients, citing a 2018 interview. Opp. 26 (quoting Compl. ¶147).[16] But Haven Healthcare operated *until 2021*—hardly a hasty retreat.[17] As for JPMC's investment-banking work, Plaintiffs offer a grab bag of unrelated numbers spread across two decades to gin up a potential conflict they suggest could have influenced JPMC's fiduciaries. But this ignores that those numbers are dwarfed by JPMC's own healthcare expenditures and, again, includes no factual allegations that Plan fiduciaries were involved in or influenced by investment-banking work.[18]

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[16] Evan Sweeney, *Jamie Dimon: Amazon, Berkshire Partnership 'Pissed Off' Healthcare Companies*, Fierce Healthcare (June 1, 2018), https://www.fiercehealthcare.com/payer/jamie-dimon-amazon-jpmorgan-berkshire-hathaway-health-insurers.

[17] Hugh Son, *Haven, the Amazon-Berkshire-JPMorgan Venture to Disrupt Health Care, Is Disbanding After 3 Years* (Jan. 4, 2021), https://www.cnbc.com/2021/01/04/haven-the-amazon-berkshire-jpmorgan-venture-to-disrupt-healthcare-is-disbanding-after-3-years.html.

[18] JPMC did not rely on "unexplained" investment-banking-fee figures. Opp. 27. JPMC relied on the figures *in Plaintiffs' Complaint*. Mot. 25 (citing Compl. ¶¶158-166). The only *mea culpa* was attempting arithmetic—$123 million (¶161) plus $58 million (¶162) equals $181 million, not $178 million. *See* Arden Rowell & Jessica Bregant, *Numeracy and Legal Decision Making*, 46 Ariz. St. L.J. 191, 193 (2014) (studying the "pervasive" maxim that "attorneys are bad at math").

D. Plaintiffs' prohibited-transaction claims parrot the elements of ERISA's prohibited-transaction provisions.

Plaintiffs are wrong that JPMC's prohibited-transaction arguments are "foreclosed" by *Cunningham v. Cornell Univ.*, 145 S. Ct. 1020 (2025). Opp. 2, 14. *Cunningham* held that plaintiffs need not plead around ERISA's prohibited-transaction *exemptions*, which JPMC's motion did not invoke. *Cunningham* notably did *not* hold that plaintiffs could simply parrot ERISA's prohibited-transaction provisions, as Plaintiffs' claims do. Compl. ¶¶278-293. They now try to gapfill with prohibited-transaction theories based on various paragraphs of the Complaint. Those theories are not set forth in the claims, so if Plaintiffs' claims are not dismissed for lack of standing[19] or fiduciary status, Plaintiffs should be required to specify their prohibited-transaction theories so JPMC can meaningfully address them.

CONCLUSION

The Complaint should be dismissed.

Dated: August 22, 2025

Respectfully submitted,

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[19] "District courts must …, consistent with Article III standing, dismiss suits that allege a prohibited transaction occurred but fail to identify an injury." *Cunningham*, 145 S. Ct. at 1032.

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CERTIFICATE OF COMPLIANCE

I, Jaime A. Santos, hereby certify that the foregoing Reply Brief in Support of Defendants' Motion to Dismiss the Class Action Complaint contains 3,500 words, as reported by Microsoft Word, not including those portions of the document that do not count against the word limit.

/s/ Jaime A. Santos
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