

**UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT**

SERGIO NAVARRO, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans; THERESA GAMAGE, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans; DAYLE BULLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans; JANE KINSELLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans; ERICA MCKINLEY, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans, *Plaintiffs – Appellants*

v.

WELLS FARGO & COMPANY, *Defendant - Appellee*

On Appeal from the United States District Court
for the District of Minnesota, Honorable Laura M. Provinzino
24-cv-3043 LMP/DLM

PLAINTIFFS-APPELLANTS' OPENING BRIEF

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SUMMARY OF THE CASE

Appellants are former Wells Fargo employees who received prescription drug benefits as participants in the Wells Fargo & Company Health Plan (“Plan”). Appellee Wells Fargo outsourced administration of the Plan’s pharmacy benefits to Express Scripts, Inc. (“ESI”), which served as the Plan’s Pharmacy Benefit Manager. Appellants allege that Wells Fargo breached its fiduciary duties and engaged in prohibited transactions in violation of ERISA by failing to monitor ESI and allowing ESI to charge the Plan and its participants exorbitant prices for prescription drugs and administrative services. Wells Fargo’s fiduciary mismanagement harmed Appellants at two levels: it caused them to incur excessive drug charges at the point of sale, and it also led to increased Plan expenses that were passed on to Appellants in the form of increased premiums.

The District Court dismissed the Amended Complaint for lack of standing, ruling that Appellants had not plausibly alleged that the inflated drug costs and administrative fees caused them harm. But the District Court applied an overly restrictive standing analysis and erred in holding that Appellants failed to allege a redressable monetary injury. Appellants request 20 minutes of oral argument because this appeal presents important questions concerning Article III standing principles at the pleading stage, with far-reaching consequences for cost of coverage in employer health plans.

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INTRODUCTION

This is a straightforward case arising from the failure of an ERISA plan sponsor to appropriately select and monitor a plan service provider and ensure that the expenses charged to the plan and its participants are reasonable. Appellants are former employees of Wells Fargo who were enrolled in Wells Fargo’s employee healthcare plan. They allege that Wells Fargo breached its fiduciary duties and engaged in prohibited transactions in violation of ERISA by failing to monitor the Plan’s pharmacy benefits manager (“PBM”) and allowing it to charge exorbitant prices for prescription drugs and unreasonable administrative fees. The Amended Complaint alleges, for example, that Wells Fargo allowed the Plan and its participants to pay *more than double* the pharmacy acquisition cost for generic drugs on the Plan’s formulary—and for the subset of generic drugs known as “specialty” drugs, a markup of 383%. Wells Fargo does not dispute these alleged markups, and the District Court itself described them as “staggering.”

Remarkably, however, the District Court dismissed Appellants’ claims without even reaching the merits, ruling that Appellants lacked standing to sue even though they alleged the paradigmatic Article III injury: financial harm. Appellants were harmed in two independent ways—they directly paid the full amount of the allegedly excessive drug prices at the point of sale prior to meeting their deductible (and a percentage thereafter through co-insurance), and they indirectly footed the

bill for amounts covered by the Plan because the Plan's spending is financed in significant part by employee premium contributions that are tied to the Plan's overall spending. These two alleged financial harms—inflated out-of-pocket costs and inflated premiums—independently and straightforwardly satisfy Article III.

The District Court held otherwise on two principal theories, and erred on both. As to the direct out-of-pocket drug payments, it reasoned that Appellants suffered no injury because they received their prescriptions, no matter how much they paid for them. As to premiums, it deemed the connection between the Plan's costs and participants' premiums "speculative"—disregarding Appellants' detailed allegations, historical Plan data, scientific studies, and an unrebutted expert report, all of which the court was required to credit at the pleading stage. Neither holding can be reconciled with Article III or ERISA. It is beyond dispute that when prescription drugs cost more, participants pay more—both at the pharmacy counter and through higher premiums. Indeed, Wells Fargo admitted in its prior briefing that "lower pharmacy prices benefit participants." R. Doc. 30, at 23.

The District Court's approach conflicts with several of this Court's precedents, and its consequences reach well beyond this case. If a participant who is overcharged for covered benefits suffers no cognizable injury so long as the benefits are delivered, then no participant in an employer-sponsored health plan could ever challenge fiduciary mismanagement short of an outright denial of benefits—wiping

out a swath of ERISA’s protections that this Court has repeatedly enforced. And if the link between a plan’s costs and a participant’s contributions is too “speculative” on this extensive record, no plaintiff could ever plead such harm, even as the Plan’s overspending shortens their paycheck every month. Nothing in Article III or this Court’s cases compels either result. Appellants respectfully request that the Court reverse the District Court’s judgment and allow them to pursue their claims on the merits.

JURISDICTIONAL STATEMENT

The District Court had subject matter jurisdiction under 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e)(1), but dismissed the case for lack of standing under Rule 12(b)(1). This Court has jurisdiction pursuant to 28 U.S.C. § 1291 because the District Court entered final judgment for Wells Fargo on all claims on March 3, 2026, and Plaintiffs timely filed a notice of appeal on April 1, 2026.

STATEMENT OF ISSUES

1. Whether Appellants plausibly alleged Article III standing based on their allegations that Wells Fargo’s ERISA violations caused them to pay more out of pocket for their prescription drugs than they otherwise would have paid.

Most apposite authority:

Braden v. Wal-Mart Stores, Inc., 588 F.3d 585 (8th Cir. 2009); *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570 (3d Cir. 2024); 29 U.S.C. § 1132(a)(3).

2. Whether Appellants plausibly alleged Article III standing based on their allegations that Wells Fargo's ERISA violations caused them to pay more in healthcare premiums while they were employed by Wells Fargo than they otherwise would have paid.

Most apposite authority:

Braden v. Wal-Mart Stores, Inc., 588 F.3d 585 (8th Cir. 2009); *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570 (3d Cir. 2024); *Wilson v. Centene Mgmt. Co., L.L.C.*, 168 F.4th 217 (5th Cir. 2026); 29 U.S.C. §§ 1109(a), 1132(a)(2).

3. Whether Appellant Erica McKinley plausibly alleged Article III standing based on her allegations that Wells Fargo's ERISA violations caused to her pay more in healthcare premiums while she was enrolled in continuation coverage under COBRA than she otherwise would have paid.

Most apposite authority:

Geissal v. Moore Med. Corp., 524 U.S. 74, 79-80 (1998); *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585 (8th Cir. 2009); *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570 (3d Cir. 2024); 29 U.S.C. §§ 1109(a), 1132(a)(2).

STATEMENT OF THE CASE

I. Statutory Background

Congress enacted ERISA in response to concerns that employers were mismanaging employee benefit plans. *See Cunningham v. Cornell Univ.*, 604 U.S. 693, 696 (2025). To address those concerns, ERISA imposes strict “standards of conduct, responsibility, and obligation for fiduciaries of employee benefits” that are “derived from the common law of trusts.” *Id.* ERISA’s duty of loyalty requires plan fiduciaries to act “solely in the interest of the [plan’s] participants and beneficiaries ... for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying *reasonable expenses* of administering the plan.” 29 U.S.C. § 1104(a)(1)(A) (emphasis added). The duty of prudence requires plan fiduciaries to exercise the “care, skill, prudence, and diligence” that would be expected in managing a plan of similar scope. *Id.* § 1104(a)(1)(B). These twin fiduciary duties are “the highest known to the law.” *Braden*, 588 F.3d 585, 598 (8th Cir. 2009).

ERISA authorizes participants to bring suits for violations of these duties, *see* 29 U.S.C. §§ 1132(a)(2)-(3), and provides two distinct enforcement mechanisms relevant here. Section 1132(a)(2) authorizes a participant to sue in a representative capacity on behalf of the plan, with a breaching fiduciary liable to “make good to the plan” any losses. 29 U.S.C. §§ 1132(a)(2), 1109(a). Section 1132(a)(3), by

contrast, authorizes participants to obtain “appropriate equitable relief” for injuries to themselves, *see* 29 U.S.C. § 1132(a)(3), including the monetary remedy of surcharge. *See CIGNA Corp. v. Amara*, 563 U.S. 421, 441-42 (2011); *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 722 (8th Cir. 2014).

One recognized form of breach is where fiduciaries fail to ensure that the fees and expenses charged to the plan and its participants are reasonable. *See, e.g.*, Dep’t of Labor, Meeting Your Fiduciary Responsibilities at 6 (Sept. 2021) (“[T]he plan’s fees and expenses should be monitored to determine whether they continue to be reasonable.”);¹ Restatement (Third) of Trusts § 88 cmt. a (2007) (“Implicit in a trustee’s fiduciary duties is a duty to be cost conscious”). Courts have repeatedly allowed such excess fee claims to proceed. *See, e.g., Hughes v. Nw. Univ.*, 595 U.S. 170, 172 (2022); *Tibble v. Edison Int’l*, 575 U.S. 523, 525 (2015); *Davis v. Washington Univ.*, 960 F.3d 478, 483 (8th Cir. 2020); *Tussey v. ABB, Inc.*, 746 F.3d 327, 336 (8th Cir. 2014); *Braden*, 588 F.3d at 595.

II. Background on the Wells Fargo Plan

Wells Fargo offers its employees healthcare benefits, including prescription-drug benefits, through the Plan. App. 302; R. Doc. 64, at ¶ 21. Wells Fargo is the Plan sponsor and a Plan fiduciary. App. 304; R. Doc. 64, at ¶ 24. Accordingly, it is

¹ Available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/meeting-your-fiduciary-responsibilities-booklet-2021.pdf> (last visited May 19, 2026).

subject to ERISA’s fiduciary duties and must administer the Plan in the interest of Plan participants and beneficiaries, ensure that the Plan’s arrangements with service providers are reasonable, and monitor Plan expenses to ensure they are reasonable. 29 U.S.C. § 1104(a)(1); App. 291, 297, 304; R. Doc. 64, at ¶¶ 2, 11, 24.

The Plan is “self-funded.” App. 302, 306; R. Doc. 64, at ¶¶ 22, 29-30. Unlike a “fully insured” health plan, where a third-party insurance company assumes all insurance risk and pays claims out of its own assets, the Plan pays all covered expenses itself, with no ability to shift costs to a third party. App. 306-07, 391; R. Doc. 64, at ¶¶ 29-32, 231.

Prescription-drug pricing affects Plan participants in two distinct ways. First, participants bear some prescription-drug costs directly at the point of sale: they pay the full cost of covered prescriptions until they satisfy their deductible, and even after they meet their deductible, they pay a portion of each prescription’s price through copays or coinsurance. App. 307, 312, 335; R. Doc. 64, at ¶¶ 33, 46, 106. None of those “out of pocket” costs are reimbursed by the Plan.

Second, participants indirectly bear the Plan’s prescription drug spending through their monthly premium contributions. When the Plan provides coverage (*e.g.*, by paying the full price of a drug less the participant’s coinsurance payment), it pays those costs from a trust account—and that trust account is funded not only by contributions from Wells Fargo, but also by employee premiums deducted from their

paychecks. App. 302, 306-07, 391, 396; R. Doc. 64, at ¶¶ 22, 29-33, 230-32, 244. Wells Fargo uses employee premiums to fund approximately 25% of the trust account's outlays. App. 392-95; R. Doc. 64, at ¶¶ 233-43. Accordingly, the Plan's increasing prescription-drug spending and PBM administrative charges caused employees' 25% share to increase—from \$3,175 per participant in 2018 to \$4,048 per participant in 2023. App. 392-93, R. Doc. 64, at ¶ 235; App. 431; R. Doc. 64-1, at 14.

III. Background on PBMs

Employers like Wells Fargo sometimes outsource the administration of their prescription-drug plans to PBMs. App. 315; R. Doc. 64, at ¶ 53. PBMs serve as a middleman between the benefits plan and network pharmacies. *Id.* ¶ 54. In that role, they engage in two sets of price negotiations: first, they negotiate with benefits plan fiduciaries like Wells Fargo to determine the prices the plan and its participants will pay for each drug. App. 316; R. Doc. 64, at ¶ 57. Second, they negotiate with network pharmacies to determine the prices the pharmacy will accept for each drug. App. 318-19; R. Doc. 64, at ¶¶ 63-64.

This arrangement creates a risk that, absent careful oversight and a prudent process, the PBM will charge the plan more than it owes the pharmacy, and pocket the difference. App. 320; R. Doc. 64, at ¶¶ 66-67. For example, a PBM might negotiate with a pharmacy to pay only \$17 for a drug but then try to charge the plan

\$20 (or more) for that same drug, keeping the difference, or “spread,” for itself. *See* App. 318; R. Doc. 64, at ¶¶ 63-64. This “spread pricing” structure gives the PBM a financial incentive to maximize the amount charged to the plan while minimizing the amount paid to the pharmacy. App. 320; R. Doc. 64, at ¶¶ 66-67; *see also* App. 371-79; R. Doc., at ¶¶ 177-198 (extensive industry guidance warning about spread pricing).

Prudent fiduciaries must do more than simply retain a PBM and accept its pricing. They must monitor the pricing terms, methodologies, and contractual arrangements that determine how much the plan pays the PBM for each drug and separately ensure that the Plan pays only reasonable fees for administrative services. App. 291, 297, 309-10, 314, 320, 322, 325; R. Doc. 64, at ¶¶ 2, 11, 38-39, 52, 67-68, 70, 78; *see also Sweda v. Univ. of Pa.*, 923 F.3d 320, 328 (3d Cir. 2019) (“[F]iduciaries should be vigilant in ‘negotiation of the specific formula and methodology’” for payments.).

In addition, a prudent fiduciary should use an open, competitive bidding process for PBM services sufficient to secure favorable pricing for the plan and its participants, App. 323, 325; R. Doc. 64, at ¶¶ 72, 77; ensure that any consultants or brokers involved in PBM selection are free from conflicts of interest, App. 327-28; R. Doc. 64, at ¶¶ 84-86; consider whether certain drug categories should be carved

out or managed separately, App. 332, R. Doc. 64, at ¶ 96; and consider lower-cost sourcing alternatives where available, App. 334, R. Doc. 64, at ¶ 99.

IV. Appellants' Allegations

Appellants allege that Wells Fargo failed to prudently monitor its PBM (Express Scripts or “ESI”), including the amounts that ESI charged for prescription drugs and administrative services. App. 291, 295-97, 325, 338, 360-01, 365-67; R. Doc. 64, at ¶¶ 3, 7-12, 77, 111, 113, 155-57, 164-70. Appellants also allege that Wells Fargo caused the Plan to engage in transactions prohibited by ERISA, in connection with its service provider arrangement with ESI. App. 412-15; R. Doc. 64, at ¶¶ 295-309. Defendant’s ERISA violations resulted in excessive costs to both the Plan and its participants.

To measure the excessive drug charges, the Amended Complaint compares the drug prices Wells Fargo agreed to make the Plan and its participants pay with the National Average Drug Acquisition Cost (“NADAC”), a commonly used benchmark compiled by the federal government’s Centers for Medicare and Medicaid Services. App. 316; R. Doc. 64, at ¶ 59. The Amended Complaint details massive markups from NADAC across Wells Fargo’s “National Preferred Formulary.”² For all generic drugs on the Preferred Formulary for which NADAC

² The “National Preferred Formulary” is the Wells Fargo-specific Express Scripts drug list identifying “the most commonly prescribed drugs” covered under the Plan. App. 341; R. Doc. 64, at ¶ 118.

data were available, the average markup was **115%**, meaning the Plan and its participants paid *more than double* the NADAC benchmark. App. 341-42; R. Doc. 64, at ¶¶ 120-122. For generic drugs categorized as “specialty” drugs, the average markup was even higher—a staggering **383%**. App. 343; R. Doc. 64, at ¶ 125. Wells Fargo does not dispute this.

The Amended Complaint alleges that major pharmacies sell these same drugs for prices near, and sometimes even below, NADAC, even though the Plan and its participants were charged far more. For example, a 90-unit prescription of the drug fingolimod (a multiple sclerosis drug) has a NADAC of \$876.60 and is available to retail customers (*i.e.*, with no insurance coverage) from Wegmans for \$648.00, ShopRite for \$677.68, Rite Aid for \$891.63, or Walmart for \$895.63. App. 291-93, 348-49; R. Doc. 64, at ¶¶ 3-4, 132-33. But Wells Fargo allowed ESI to charge the Plan and its participants an astonishing **\$9,994.37** for the same drug. App. 349; R. Doc. 64, at ¶133; *see also* App. 344-47, 350-53; R. Doc. 64, at ¶¶ 126-131, 134-138 (detailing similar examples). In other words, the Wells Fargo Plan—with its massive purchasing power and sophistication—was charged over ten times more than an individual walking off the street with no ability to negotiate.

For drugs on the National Preferred Formulary for which NADAC data are unavailable, the Amended Complaint relies on publicly-available retail prices as comparators. App. 355-56; R. Doc. 64, at ¶¶ 139-44. To illustrate, anyone could have

walked in the door and purchased, without using insurance, a 90-day supply of betaine powder for \$742.04 at Wegmans, \$1,315 at Walgreens, \$1,193 at Rite Aid, and \$1,784 at CVS. *Id.* ¶ 142. But if they presented their Wells Fargo insurance, the Plan and its participants were charged **\$4,438.24**. *Id.*; *see also* App. 355-56; R. Doc. 64, at ¶¶ 139-141, 143 (detailing similar examples).

The Amended Complaint includes other comparisons as well. For example, Appellants compare the prices that Wells Fargo negotiated with ESI to the public price list of a different PBM, SmithRx. App. 368-69; R. Doc. 64, at ¶¶ 172-73. This comparison reveals that ESI charged the Plan and its participants more than two thousand percent more, on average, for certain generic drugs than SmithRx charges its clients for the same drugs. *Id.* Further, the Plan's prescription drug charges are two to four times higher than another large plan (sponsored by Pepsico) that also uses ESI as its PBM. App. 380; R. Doc. 64, at ¶ 204.

Notably, *after* this suit was filed, Wells Fargo renegotiated its pricing with ESI, lowering prices for 158 of the 260 drugs on its Preferred Formulary for which NADAC data were available and reducing average prices by 11%. App. 366; R. Doc. 64, at ¶166. This reinforces Appellants' core allegation: that the Plan and its participants were being charged more for prescription drugs than necessary, and that savings were available if Wells Fargo had only paid greater attention to drug costs before being sued.

Separate from these drug charges, the Amended Complaint alleges that Wells Fargo allowed the Plan to pay excessive administrative fees to ESI. Between 2019 and 2023, those administrative fees skyrocketed from \$9,235,645 to \$31,239,311 per year, App. 361; R. Doc. 64, at ¶ 156, while the number of Plan participants decreased from 218,107 to 176,012. App. 361, 392; R. Doc. 64, at ¶¶ 157, 235. In 2022 and 2023, administrative fees amounted to \$135.81 and \$177.48 per participant. *Id.* ¶ 157. In those same years, comparable plans that used ESI for the same PBM services paid far less—between \$18.97 and \$102.68 per participant. *Id.* ¶ 157.

Appellants were personally injured by these excessive charges. App. 298-01, 385, 390; R. Doc. 64, at ¶¶ 14-18, 217, 229. Each of them paid inflated amounts out of their own pocket for prescription drugs, App. 385-90; R. Doc. 64, at ¶¶ 217-228, and they also paid inflated employee premiums to fund the Plan's expenses, App. 390-91; R. Doc. 64, at ¶¶ 229-230, which increased over time alongside the Plan's increases in costs, App. 392, 404; R. Doc. 64, at ¶¶ 235, 268. In addition, Appellant McKinley continued her Plan coverage through COBRA after ceasing employment with Wells Fargo, and paid the full premium amount (both the employee and employer share) under COBRA. App. 400; R. Doc. 64, at ¶ 257. By operation of law, her COBRA premiums were tied to Plan costs. *Id.* at ¶ 258.

V. Procedural History

Appellants allege that Wells Fargo breached its fiduciary duties under 29 U.S.C. § 1104(a) and caused the Plan to engage in prohibited transactions under 29 U.S.C. § 1106(a). For both claims, Appellants seek relief on behalf of the Plan under 29 U.S.C. § 1132(a)(2) (Counts One and Three) and individual participants under 29 U.S.C. § 1132(a)(3) (Counts Two and Four).

The District Court granted Wells Fargo's motion to dismiss the original complaint on Article III standing grounds. App. 255; R. Doc. 57; Add. 31. Appellants then filed an Amended Complaint,³ App. 290; R. Doc. 64, and the District Court again granted Wells Fargo's motion to dismiss on Article III standing grounds. App. 557; R. Doc. 99; Add. 1.

In reaching this result, the District Court first analyzed the claims on behalf of the Plan under 29 U.S.C. § 1132(a)(2). Appellants alleged that the Plan's overpayments for prescription drugs harmed them personally because it caused their monthly premiums to increase. Specifically, the Amended Complaint: (1) discussed the self-funded nature of the plan, App. 302, 306-07, 336, 391; R. Doc. 64, at ¶¶ 22, 30-32, 108, 231; (2) alleged that Wells Fargo intentionally and in every year made Plan participants cover 25% of Plan spending through their monthly premiums,

³ The Amended Complaint included all four original plaintiffs plus a fifth plaintiff, Erica McKinley, who was still in the Plan and had elected continuing coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

regardless of any changes in overall Plan spending, meaning participants always bore a proportional share of the Plan's overspending on prescription drugs, App. 392-95; R. Doc. 64, at ¶¶ 233-43; (3) analyzed historical data demonstrating participants' 25% share, *id.*; (4) cited numerous studies recognizing the link between higher Plan costs (including prescription drug costs) and higher premium contributions, App. 396-98; R. Doc. 64, at ¶¶ 245-52; and (5) included an expert report from an experienced professional (Bonnie Albritton), who specifically evaluated the Wells Fargo Plan and concluded that "employees' contributions were directly impacted by ... prescription drug costs," App. 401-04; R. Doc. 64, at ¶¶ 261-70; App. 418; R. Doc. 64-1. In addition, the Amended Complaint noted that McKinley paid the full premium contribution under COBRA (both the employer and employee share), App. 301, 400; R. Doc. 64, at ¶¶ 18, 257, rendering the allocation of premiums between the company and its employees irrelevant as to her.

The District Court nevertheless found it "speculative" that the Plan's excessive spending on prescription drugs and administrative fees "'had any effect at all' on Plaintiffs' [premium] contribution rates" App. 576; R. Doc. 99, at 20; Add. 20 (citation omitted). In this regard, the District Court deemed it "[o]f critical importance ... that the Plan vests Wells Fargo with 'sole discretion' to set participant contribution rates." App. 575; R. Doc. 99, at 19; Add. 19. The District Court also noted that "Plaintiffs' contributions are used to cover *overall* Plan expenses, not

specifically or exclusively their prescription drug benefits.” App. 577; R. Doc. 99, at 21; Add. 21. As for redressability, the District Court reasoned that it could not grant Appellants’ request for *retrospective* relief because Wells Fargo could make changes to the Plan *prospectively* after the case ends. App. 581; R. Doc. 99, at 25; Add. 25. The District Court did not explain why hypothetical future adjustments would make retrospective relief ineffective, especially given that Appellants no longer work for Wells Fargo.

The District Court then turned to the individual claims under 29 U.S.C. § 1132(a)(3) regarding the drug overpayments that Appellants made directly out of their pockets at the point of sale. As to those claims, the District Court acknowledged that “the price comparisons alleged in Plaintiffs’ complaint are staggering,” App. 585; R. Doc. 99, at 29; Add. 29, but opined that overpaying for prescription drugs was not an Article III injury. In the District Court’s view, Appellants lacked standing because they “do not allege that they did not receive the benefits to which they were entitled under the Plan,” even if they paid too much for prescription drugs. App. 582; R. Doc. 99, at 26; Add. 26.

Judgment was entered March 3, 2026, App. 587; R. Doc. 100, and Appellants timely filed their Notice of Appeal on April 1, 2026, App. 588; R. Doc. 101.

SUMMARY OF ARGUMENT

The District Court was wrong to dismiss Appellants' ERISA claims on Article III standing grounds. Financial injuries such as those alleged here are the “prototypical form of injury in fact.” *Collins v. Yellen*, 594 U.S. 220, 222 (2021). And ERISA provides redress for plan participants who suffer financial injuries from fiduciary breaches. *See Amara*, 563 U.S. at 441-42 (“[C]ourts possess[] the power to provide relief in the form of monetary ‘compensation’ for a loss resulting from a [fiduciary’s] breach of duty.”).

Appellants were financially injured in two ways. First, Wells Fargo’s fiduciary breaches caused them to pay inflated amounts for prescriptions at the point of sale. The District Court recognized this financial harm⁴ but deemed it irrelevant based on a mistaken belief that overcharges do not count as Article III injuries in the ERISA context. In the District Court’s view, as long as plan participants receive their benefits, it does not matter if the defendant’s imprudence caused them to overpay for those benefits. That is not the law: economic injuries are Article III injuries.

Second, Defendant’s fiduciary breaches caused Appellants to pay inflated monthly premium contributions to underwrite the Plan’s excessive spending.

⁴ The District Court stated that Appellants’ overcharge allegations were “compelling and detailed.” App. 278; R. Doc. 57, at 24; Add. 54; *see also* App. 585; R. Doc. 99, at 29; Add. 29 (“To be sure, the price comparisons alleged in Plaintiffs’ [amended] complaint are staggering.”).

Although the District Court found this link “speculative,” it does not tax the imagination to connect these two dots—and the Amended Complaint certainly plausibly connects them. Anyone who has seen their healthcare premiums rise year after year can understand the causal relationship between plan spending and participant premiums, and the Amended Complaint confirms that relationship with (1) Plan data showing that Wells Fargo consistently made Plan participants pay a quarter of the Plan’s costs, (2) a wealth of academic research and government studies, and (3) an expert report confirming this link specifically for the Wells Fargo Plan. The only thing that is “speculative” is the District Court’s unsupported hypothesis that lower Plan costs *might not* have resulted in lower employee premiums—a hypothesis that directly contradicts the Amended Complaint’s allegations. And the District Court’s reasoning collapses entirely as to Appellant McKinley. Her COBRA premiums included *both* the employer and employee share, so Wells Fargo’s discretion over the employer/employee split has no relevance to her claims.

Finally, redressability poses no obstacle for either injury. As to Appellants’ direct out-of-pocket payments, redressability is not in dispute: the surcharge remedy under Section 1132(a)(3) would make participants whole. As to premium contributions, the relief Appellants seek runs to the Plan by operation of law: Section 1109 makes a breaching fiduciary liable to “make good to the plan” its losses, and

Braden confirms that participants may sue to recover them. 588 F.3d at 593-94. The District Court nonetheless deemed that relief speculative, reasoning that even if Wells Fargo was ordered to repay the Plan, “nothing would prevent Wells Fargo from ‘offset[ting] its own contributions’ going forward ‘while making no reduction to the contributions it require[s]’ from Plaintiffs.” App. 581; R. Doc. 99, at 25; Add. 25. That reasoning fails twice over. A plan sponsor cannot point to its employer contributions to offset the losses it caused as a fiduciary. *See Brotherston v. Putnam Invs., LLC*, 907 F.3d 17, 29 (1st Cir. 2018). And in any event, a hypothetical future reduction in Wells Fargo’s contributions would not affect Appellants at all, as they no longer participate in the Plan.

If accepted, the District Court’s analysis would make it impossible for healthcare plan participants to ever bring a claim *other* than a claim for outright denial of benefits, wiping out entire swaths of substantive protections and remedies that Congress wrote into ERISA. And if the link between a plan’s costs and employee premiums is too “speculative” on *this* record, plaintiffs could never pursue relief for egregious plan overspending that comes right out of their paychecks, month after month. Indeed, as to Appellants’ direct out-of-pocket overpayments for prescription drugs, no causal inference is even required—the higher the price, the more they paid.

Wells Fargo admitted in its prior briefing that “[l]ower pharmacy prices benefit participants.” R. Doc. 30, at 23. The corollary follows: *increased* pharmacy costs *harm* participants, and they have standing to bring suit to remedy the harm.

STANDARD OF REVIEW

This Court reviews the grant of a Rule 12(b)(1) motion to dismiss for lack of Article III standing de novo, “accepting the material allegations in the complaint as true and drawing all inferences in plaintiffs’ favor.” *In re SuperValu, Inc.*, 870 F.3d 763, 768 (8th Cir. 2017);⁵ *accord Braden*, 588 F.3d at 591. The standing inquiry is not “an assessment of the merits of a plaintiff’s claim.” *Red River Freethinkers v. City of Fargo*, 679 F.3d 1015, 1023 (8th Cir.2012). Rather, in determining whether Article III standing exists, courts must “assume that on the merits the plaintiffs would be successful in their claims.” *Am. Farm Bureau Fed’n v. United States EPA*, 836 F.3d 963, 968 (8th Cir. 2016).

ARGUMENT

Article III standing requires Appellants to plausibly allege: (1) an injury in fact; (2) that was likely caused by the defendant; (3) that would likely be redressed by judicial relief. *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021). All three requirements are satisfied here. Appellants allege that they suffered financial harm

⁵ Wells Fargo also raises a facial attack to standing here. *See* App. 570; R. Doc. 99, at 14; Add. 14 (“[T]he Court construes Wells Fargo’s motion as a facial challenge to Plaintiffs’ standing”).

in two ways: first, from inflated drug prices they personally paid at the point of sale, and second, from excessive premium contributions they were required to make to underwrite the Plan’s inflated expenses. Appellants allege that these inflated costs are the result of Wells Fargo’s failure to monitor ESI and its drug charges and administrative fees. And Appellants’ injuries are redressable through retrospective monetary relief and other relief under ERISA. The District Court erred in concluding that monetary harm is not a redressable Article III injury.

I. Appellants Have Article III Standing to Seek Relief for Their Prescription Drug Overcharges

While the District Court’s standing analysis has many flaws, it is most clearly erroneous regarding Appellants’ allegations of financial harm from the prescription drug overcharges they paid directly out of their own pockets at the point of sale.

A. Injury-In-Fact

1. Appellants Plausibly Allege an Injury-in-Fact from their Overpayments

The first element of Article III standing is “straightforward” as to Appellants’ out-of-pocket drug payments because they are “economic.” *Wallace v. ConAgra Foods, Inc.*, 747 F.3d 1025, 1029 (8th Cir. 2014). A “pocketbook injury” is a “prototypical form of injury in fact.” *Collins*, 594 U.S. at 222. Thus, this Court has repeatedly held that an alleged overpayment for a good or service constitutes an injury in fact. *See Carlsen v. GameStop, Inc.*, 833 F.3d 903, 908-09 (8th Cir. 2016)

(holding district court erred in finding “overpayment theory insufficient to establish injury”); *Kuhns v. Scottrade, Inc.*, 868 F.3d 711, 716 (8th Cir. 2017) (plaintiff’s “actual economic injury” was the “difference between the amount he paid and the value of the services received”); *George v. Omega Flex, Inc.*, 874 F.3d 1031, 1032 (8th Cir. 2017) (per curiam) (“George’s assertions of paying more than CSST is worth ... [is an] economic injury sufficient to establish Article III standing”).

There is no exception to that rule for ERISA cases. *See Thole v. U.S. Bank N.A.*, 590 U.S. 538, 547 (2020) (“There is no ERISA exception to Article III.”); *Cunningham v. Cornell Univ.*, 604 U.S. 693, 698 (2025) (holding that plaintiffs stated a claim by alleging that the defendant’s misconduct caused them to overpay for recordkeeping services by about \$100-150 annually). And there is no exception to that rule for prescription-drug overcharges. *See, e.g., Blue Cross & Blue Shield of N.C. v. Rite Aid Corp.*, 519 F.Supp.3d 522, 532 (D. Minn. 2021) (“Plaintiffs (obviously) plead an injury in fact” where they “allege that they were overcharged” for prescription drugs); *In re Express Scripts/Anthem ERISA Litig.*, 285 F.Supp.3d 655, 672 (S.D.N.Y. 2018) (“Because Plaintiffs have alleged that they overpaid for certain prescription drugs as a result of inflated pricing set through the PBM Agreement, they have adequately alleged injury-in-fact.”). These cases confirm that Appellants have standing to pursue their overpayment allegations here.

Appellants allege that Wells Fargo allowed ESI to charge them unreasonable amounts for their prescriptions, and identify the specific transactions and specific overcharges at issue. App. 387-90; R. Doc. 64, at ¶¶ 220, 222, 224, 226, 228. Accepting these allegations as true—which the District Court was obligated to do at this stage, *see SuperValu*, 870 F.3d at 768; *supra* at 20—there is no question that these overpayments are Article III injuries. “For standing purposes, a loss of even a small amount of money is ordinarily an ‘injury.’” *Demarais v. Gurstel Chargo, P.A.*, 869 F.3d 685, 693 (8th Cir. 2017) (quoting *Czyzewski v. Jevic Holding Corp.*, 580 U.S. 451, 464 (2017)).

2. The District Court’s Analysis Was Flawed.

In holding that these monetary harms do not count as injury-in-fact, the District Court adopted an incorrect categorical rule: no deprivation of benefits, no injury. Because Appellants received their prescriptions, the District Court reasoned, it does not matter how much they had to pay: “[I]t fundamentally cannot be the case that participants in a plan like the one at issue here are injured any time the contractually defined benefits to which they are entitled are available at lower cost.” App. 585; R. Doc. 99, at 29; Add. 29; *see also* App. 583; R. Doc. 99, at 27 (holding that Appellants lacked standing because “they allege only that they ... should have paid less for those benefits” and “do not allege that their *benefits* under the Plan were diminished”). Ignoring established case law holding that monetary harms are Article

III injuries, the District Court declared that the only cognizable injury under ERISA is where plaintiffs are not “receiv[ing] the benefits to which they are entitled under the Plan[.]” *Id.*

That is not the law. When fiduciary imprudence causes plan participants to overpay for their benefits, those overpayments constitute Article III injuries and are recoverable under ERISA. This Court’s decision in *Braden* makes that clear. In *Braden*, Wal-Mart promised its 401(k) plan participants an assortment of investment options. 588 F.3d at 589-90. The plaintiff received access to those investment options and was able to invest his money in whichever options he selected. Nevertheless, he stated a claim (and had Article III standing to do so, *see id.* at 593) by alleging that plan fiduciaries agreed to “significantly higher fees” on those investments than were reasonable, and that he had to pay those higher fees. *Id.* at 595. This case is no different: Appellants obtained the prescription drugs they were promised, but had to pay significantly more than was reasonable. Whether Wells Fargo’s inattentiveness to these excessive costs was due to a “failure of competence, effort, or loyalty,” the excessive costs caused by its inattentiveness is a cognizable Article III injury. *Id.* at 591-93, 595-96.

The District Court’s attempt to distinguish *Braden* fails. According to the District Court, the “crucial distinction” is that “the plaintiff in *Braden* alleged that his employer’s mismanagement resulted in losses ... to the ... value of his specific,

individual investment account—that is, one of his benefits under the plan,” whereas “Plaintiffs here do not allege that their *benefits* under the Plan were diminished; they allege only that they ... should have paid less for those benefits.” App. 583; R. Doc. 99, at 27; Add. 27. There is no such distinction. The plaintiff in *Braden* did not allege that his dividends were diminished; he alleged that the fees he paid to maintain his investments were too high, causing him a pocketbook injury. 588 F.3d at 590. Likewise here, Appellants do not allege that their pills were pilfered, but that the prices they paid to obtain those pills were too high. It makes no difference, legally or economically, that Braden’s fees were debited from his 401(k) account rather than his checking account. In both cases, the plaintiffs received the benefits they were promised (a mutual fund or a medicine) but were overcharged for those benefits. That is a cognizable injury under Article III.

The District Court’s categorical rule also conflicts with the Third Circuit’s decision in *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570 (3d Cir. 2024), an ERISA case alleging imprudence by health plan fiduciaries. The defendant in *Knudsen* argued that under ERISA, there is “no injury unless the plan participants plead that they did not receive promised benefits.” 117 F.4th at 579 (*italics omitted*). The Third Circuit expressly rejected that argument. It held that a “participant in a self-funded healthcare plan [may] bring[] an ERISA suit alleging that mismanagement of plan assets increased his/her out-of-pocket expenses.” *Id.* While it concluded that the

plaintiff in that case (who did not allege out-of-pocket overpayments) did not plausibly allege such a link, it made clear that being forced to overpay for plan benefits constitutes an injury-in-fact. *Id.* Indeed, one of the most vexing aspects of the District Court’s ruling is that it stated (in its first order) that it “agree[d]” with this basic proposition in *Knudsen*, App. 273; R. Doc. 57, at 19; Add. 49, but then failed to properly apply it.

The District Court’s decision is also out-of-step with other district courts addressing similar allegations involving health plan participants. The two courts to address such allegations since the decision below have disagreed with it, holding that participants have standing to bring overpayment claims regardless of whether they received benefits under the plan. *See Barbich v. Nw. Univ.*, 2026 WL 1552506, at *3 (N.D. Ill. Apr. 2, 2026) (“The question is not whether the plaintiffs received the healthcare benefits they were promised. The question is instead whether, in receiving those benefits, they paid too much for them. Alleging that they paid more for the benefits than they should have is an injury sufficient to confer standing.”); *Stern v. JPMorgan Chase & Co.*, No. 1:25-cv-02097, 2026 WL 654714, at *7 (S.D.N.Y. Mar. 9, 2026) (declining to follow District Court’s analysis here, finding allegations of “out-of-pocket overpayments for prescription drugs” were “sufficient to confer standing”); *id.* at *9 (rejecting proposition that plan sponsor’s payment of health benefits “offsets the harm from prescription-drug overpayments”).

Furthermore, it is well-established in the context of defined contribution retirement plans, where participants also bear plan expenses, that participants are harmed when fiduciary breaches cause them to overpay for plan benefits. *See, e.g., Davis*, 960 F.3d at 483 (plaintiffs stated claim by alleging that fiduciaries’ “lack of diligence cost them money” by increasing their investment fees); *Tussey*, 746 F.3d at 336 (affirming judgment against fiduciaries for making participants pay excessive recordkeeping fees); *Boley v. Universal Health Servs.*, 36 F.4th 124 (3d Cir. 2022) (plaintiffs had standing because defendant’s “imprudent investment evaluation process” caused them to they pay an “excessive annual [recordkeeping] fee”). Put simply, “[w]asting beneficiaries’ money is imprudent,” *Tibble v. Edison Int’l*, 843 F.3d 1187, 1198 (9th Cir. 2016), and generates a cognizable injury under Article III.

The District Court departed from these cases based on an apparent overreading of *Thole v. U.S. Bank N.A.*, 590 U.S. 538 (2020), which addressed the unique context of “defined benefit” pension plans. *Thole* held that participants in a defined-benefit *pension* plan lacked standing to sue over the plan’s investment losses. The reason was specific to that kind of plan: a defined-benefit pension pays a fixed monthly amount that “will not change, regardless of how well or poorly the plan is managed.” *Id.* at 543. Because the retirees in *Thole* would receive the same checks no matter what the fiduciaries did, the alleged mismanagement could not cost them anything. The only injury was to the plan’s pool of assets—the depletion of

which did not directly affect participants’ pocketbooks—so the participants had no concrete stake of their own. *Id.* at 541-43.

That reasoning is inapplicable here, for several reasons.

First, the analysis in *Thole* applies to a different type of claim. The plaintiffs in *Thole* claimed that the defendants violated ERISA by “poorly investing the *assets of the plan*.” *Thole*, 590 U.S. at 541 (emphasis added). Without showing that diminishment of the *plan*’s assets affected them, the *Thole* plaintiffs could not show injury-in-fact—*i.e.*, the only harm was to the plan, not to them. In contrast, Appellants’ claims under 29 U.S.C. § 1132(a)(3) relate to inflated costs they were forced to pay out of their own *personal assets* for prescription drugs. Unlike the fixed pension payments in *Thole*, Appellants’ out-of-pocket costs here rose and fell with the very conduct they challenge. It is axiomatic that excessive payments made out of one’s own pocket personally affect them.

Second, the District Court improperly repackaged Appellants’ claims as benefit claims in order to fit them to *Thole*. The District Court initially recognized that “Plaintiffs’ theory is rooted in their assertion that they were required to pay higher prices for certain prescriptions.” App. 581; R. Doc. 99, at 25; Add. 25. However, it then asserted that this is “in effect” a claim that they “‘might have received’ better or different benefits than what they were promised under the Plan’s terms.” App. 582; R. Doc. 99, at 26; Add. 26. Not so. Appellants accept the terms of

the Plan as given, do not dispute that they received their prescription drugs, and do not assert a claim for withheld benefits under 29 U.S.C. § 1132(a)(1)(B). Appellants simply allege that they would have paid less for those drugs if Wells Fargo had properly monitored ESI and not allowed it to overcharge Plan participants.

Finally, the District Court’s application of *Thole* is in tension with that case’s core holding—that “[t]here is no ERISA exception to Article III.” 590 U.S. at 547. *Thole* invoked this principle to hold that a plaintiff who did not allege concrete harm did not have Article III standing, even if he had statutory standing under ERISA. *Id.* But this principle applies the other way too: when fiduciary imprudence inflicts financial harm on a plan participant, that injury generates Article III standing to pursue claims under ERISA, just as it does in every other context. Yet in response to Appellants’ citation to *Blue Cross*, which held that insurance company plaintiffs alleged an injury-in-fact by pleading they were overcharged for prescription drugs, 519 F.Supp.3d at 532, the District Court distinguished the case as follows: “But that case is inapposite because it did not involve ERISA in any way.” App. 585; R. Doc. 99, at 29; Add. 29. This obvious error—differentiating the standing analysis because the claims here are asserted under ERISA—directly contradicts *Thole* and is emblematic of the District Court’s misguided analysis.

Appellants allege they were overcharged at the point of sale for prescription drugs. That alleged monetary harm is a “straightforward” Article III injury, *Wallace*, 747 F.3d at 1029, and nothing about ERISA changes that conclusion.

B. Appellants’ Alleged Injury Is Traceable to Wells Fargo’s Failure to Monitor ESI

The traceability (i.e., causation) element of Article III standing is also satisfied. Appellants expressly allege that their higher out-of-pocket drug payments were the “result of Wells Fargo’s inattentiveness to prescription drug costs and other fiduciary failures.” App. 385; R. Doc. 64, at ¶ 217. Appellants also explain *why* imprudent fiduciary conduct leads to higher out-of-pocket costs for Plan participants: they must pay the full cost for drugs until meeting their deductible (and then part of the cost thereafter), and the prices they pay are those agreed to by Wells Fargo. App. 335; R. Doc. 64, at ¶ 106.

The District Court did not hold otherwise. The traceability requirement was not addressed in the relevant portions of its motion to dismiss orders. The District Court’s analysis of the § 1132(a)(3) claim in Part II.A.2 of its first order focused on injury and redressability, App. 279-82; R. Doc. 57, at 25-28; Add. 55-58, and its analysis of out-of-pocket costs in Part III.B of its second motion to dismiss order focused exclusively on injury, App. 581-586; R. Doc. 99, at 25-30; Add. 25-30. Notably, Wells Fargo did not contest the traceability requirement with respect to out-

of-pocket costs in its briefing on either motion. *See* R. Docs. 30, 79. This element was undisputed.

C. Appellants Have a Remedy Under ERISA

Finally, the redressability requirement is also satisfied. Appellants expressly pleaded surcharge as a remedy for their out-of-pocket injuries, *see* App. 385, 416; R. Doc. 64, at ¶¶ 217, 314, and the availability of this remedy under 29 U.S.C. § 1132(a)(3) is confirmed by binding Supreme Court and Circuit caselaw. *See Amara*, 563 U.S. at 441-42; *Silva*, 762 F.3d at 722. Although the District Court initially held that such relief was not available, it later “acknowledge[d] its error” and conceded the availability of retrospective monetary relief. App. 567; R. Doc. 99, at 11 n.3; Add. 11.

Wells Fargo likewise did not dispute the availability of the surcharge remedy for past financial injuries. It also focused on the injury requirement and merely contended that “Plaintiffs have not plausibly alleged actual harm as required to obtain equitable surcharge.” R. Doc. 91, at 8 n.6.

Because Appellants plausibly alleged a financial injury in connection with their prescription drug overpayments for the reasons stated above (*supra* at § I.A), and the other elements of Article III standing were undisputed by Wells Fargo and the District Court, Appellants should be allowed to pursue their claims relating to their drug overpayments on the merits.

II. Appellants Have Standing to Seek Relief for the Plan's Overpayments

Appellants also have Article III standing to pursue their claims relating to excessive costs paid by the Plan, which were then partially passed through to them in the form of increased premiums. Appellants allege that (1) they were injured by the Plan's overpayments because increased Plan expenses resulted in them being forced to make increased premium contributions to the Plan; (2) the Plan's overpayments are traceable to Wells Fargo's failure to monitor ESI and the expenses it charges; and (3) ERISA provides a plan-wide loss remedy under 29 U.S.C. § 1109, which is enforceable by participants under 29 U.S.C. § 1132(a)(2). The District Court erred by failing to properly credit these allegations and concluding that standing was lacking as to Appellants' § 1132(a)(2) claims on behalf of the plan. *See Braden*, 588 F.3d at 593 (finding standing to pursue relief on behalf of plan under § 1132(a)(2) where plaintiff was injured by conduct at issue).

A. Appellants Are Injured by the Plan's Overpayments

The Amended Complaint alleges that both the prescription drug prices and administrative fees paid by the Plan were unreasonably high. *See* App. 334-57; R. Doc. 64, at ¶¶ 101-49 (excessive drug prices); App. 360-04; R. Doc. 64, at ¶¶ 155-62 (excessive administrative fees). The Amended Complaint also alleges that Wells Fargo consistently made Plan participants finance a quarter of all Plan spending through monthly premiums deducted from their paychecks. App. 392, 394-95; R.

Doc. 64, at ¶¶ 233-34, 240, 242. On that allegation, which the District Court was bound to accept, higher Plan spending meant higher premiums: a larger Plan bill produced a larger quarter-share for participants to fund. App. 395-96; R. Doc. 64, at ¶¶ 243-44. Because Plaintiffs plausibly alleged that participant “contributions [were] calculated as a pro rata share of the total benefits cost,” they have Article III standing. *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 525 (9th Cir. 2023); *see also Knudsen*, 117 F.4th at 579-80 (recognizing Article III standing is satisfied by “allegations, that if proven, would establish that [plaintiffs] have or will pay more in premiums”).

1. The District Court Erred in Concluding that Appellants’ Allegations of Injury from Increased Employee Premiums Were “Too Speculative”

The District Court determined that Appellants’ allegations of increased premiums were “too speculative” to support standing. App. 581; R. Doc. 99, at 25: Add. 25. This conclusion turned the applicable pleading standard on its head: it failed to accept Appellants’ extensive and detailed allegations, ignored Ms. Albritton’s expert report, and defied common sense and a wealth of government and scholarly research. It was not Appellants’ allegations, but rather the District Court’s unsupported inference that participant premiums are untethered to Plan costs, that was “speculative.”

a. The Injury Is Borne Out by the Plan's Funding Arrangement

In some health plans, the employer bears the full cost of providing coverage. For example, in *Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450 (3d Cir. 2003), the employer “pa[id] all premiums ... and [did] not make any specific healthcare deductions from employees’ paychecks.” *Id.* at 452. In that circumstance, the Third Circuit held that the plaintiff’s allegation that plan savings would somehow filter through to plan participants was “too speculative to serve as the basis for a claim of individual loss.” *Id.* at 457.

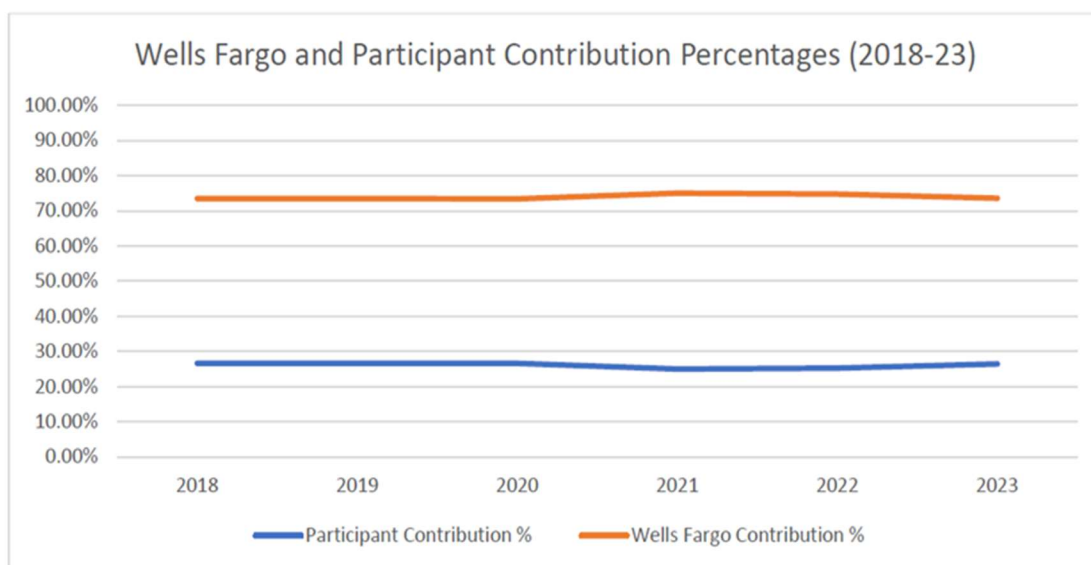
However, the Wells Fargo Plan functions differently. As noted above, the Plan’s expenses are shared by both Wells Fargo *and* its employees, not borne by Wells Fargo alone. *See supra* at 7-8. Moreover, because the Plan is self-funded, there is no third-party intermediary available to pick up the tab. Accordingly, it is entirely plausible—and certainly not speculative—that the level of Plan expenses impacts the level of employee premiums. And the Complaint amply demonstrates that connection in the context of this specific Plan. App. 391-96; R. Doc. 64, at ¶¶ 230-44. Under the present circumstances, the District Court’s reliance on *Horvath* (App. 578; R. Doc. 99, at 22; Add. 22) was misplaced.

Similarly, in *Knudsen*, the plaintiffs did not plausibly allege that their premium contributions depended on the amount of “rebates” the plan received, so they had not plausibly alleged that they were financially burdened by any alleged

rebate shortfall. *Knudsen*, 117 F.4th at 581-82 & n.91. Here, in contrast, Plaintiffs’ allegations make it more than plausible that participant premiums rose and fell with overall Plan spending.

b. The Injury Is Borne Out by the Plan Data

The District Court found it of “critical importance” that Wells Fargo has discretion to set participant premium contribution rates. App. 575; R. Doc. 99, at 19; Add. 19. However, the manner in which it exercised that discretion shows that increases in Plan costs were always passed through to Plan participants. Specifically, Appellants allege that “Wells Fargo intentionally set participant contributions at 25-26% of overall Plan health care costs.” App. 394; R. Doc. 64, at ¶ 240. In support of this allegation, Appellants included years of historical data showing that Wells Fargo required participants to cover a consistent percentage of Plan spending during the class period:



id., at ¶ 240; *see also* App. 392; R. Doc. 64, at ¶ 234 (listing percentages). Put another way, Wells Fargo did not have a policy of covering all increases in Plan costs itself or of charging participants the same dollar amount each year regardless of Plan spending levels. Instead, it set participant contributions as a consistent share of overall Plan costs, so that participants' premiums rose and fell with Plan spending. It follows, and at a minimum is plausible at the pleading stage, that lower Plan spending would have meant lower contributions—25% of a smaller number is necessarily smaller.

This makes the present case distinguishable from yet another case cited by the District Court. In *Winsor*, 62 F.4th 517, the plaintiffs lacked standing because their employer did **not** “set [participant] contributions based on overall [] costs.” *Id.* at 524. The Ninth Circuit made clear, however, that the plaintiffs would have had standing if “employee contributions [were] calculated as a *pro rata* share of the total benefits cost.” *Id.* at 525. That is exactly what the Complaint alleges (and shows, with historical data) that Wells Fargo does. Similarly, in *Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598 (6th Cir. 2007), the Sixth Circuit held that the plaintiffs would have had standing if they “paid percentage contributions” rather than a “flat-rate.” *Id.* at 608. That is precisely what Appellants allege here.

c. The Injury Is Confirmed by Ms. Albritton's Expert Report

Ms. Albritton's expert report further confirms that increased Plan expenses resulted in increased employee premium contributions. Ms. Albritton noted that "[i]n a self-funded plan, all healthcare costs must be funded by contributions from the sponsoring employer and participating employees." App. 422; R. Doc. 64-1, at 5; *see also* App. 402; R. Doc. 64, at ¶ 263. Based on her extensive experience, she explained that "[f]or most large employers, the contribution split is based on a percentage of total expected costs," meaning that "employers target a fixed percentage for employee contributions." App. 428; R. Doc. 64-1, at 11; *see also* App. 403; R. Doc. 64, at ¶ 266. Ms. Albritton then specifically reviewed the Wells Fargo Plan and found that "like most large employers, Wells Fargo uses percentage-based cost sharing for its employee contributions." App. 432; R. Doc. 64-1, at 15; *see also* App. 404; R. Doc. 64, at ¶¶ 268-69. Further, she analyzed employee contributions and expenses for the Plan from 2018 through 2023 (the last year for which reported data was available), and determined that the total average contributions per participant changed at roughly the same rate as the total average expenses per participant:

Plan Year	Total Average Contributions Per Participant	Annual Change	Total Average Plan Expenses Per Participant	Annual Change
2018	\$11,918		\$11,947	
2019	\$11,775	-1.2%	\$11,880	-0.6%
2020	\$12,189	3.5%	\$12,193	2.6%
2021	\$14,671	20.4%	\$14,659	20.2%
2022	\$14,672	0.0%	\$14,641	-0.1%
2023	\$15,210	3.7%	\$15,373	5.0%

App. 432; R. Doc. 64-1, at 15; *see also* App. 404; R. Doc. 64, at ¶¶ 268-69. Based on the foregoing, Ms. Albritton observed that “employees’ contributions were directly impacted by the plan costs,” and “[a]s plan costs increased, so did the employee contributions.” App. 432; R. Doc. 64-1, at 15; *see also* App. 404; R. Doc. 64, at ¶ 270.

Yet the District Court labeled the premium link “speculative” without ever engaging with this expert analysis. After stating that it would “consider[] the factual information in Plaintiffs’ expert report,” App. 570; R. Doc. 99, at 14: Add.14, the District Court proceeded to disregard that information in the rest of its order (including the section of its order regarding participant contributions). This was error—a report attached to the complaint is part of the pleadings, *see* Fed. R. Civ. P. 10(c); *Meehan v. United Consumers Club Franchising Corp.*, 312 F.3d 909, 913 (8th Cir. 2002), and must be credited at this stage. *See Pub. Pension Fund Grp. v. KV Pharm. Co.*, 679 F.3d 972, 988-89 (8th Cir. 2012) (district court abused its discretion in denying motion to amend where “the proposed amended complaint included an

expert report” that “[t]he district court did not specifically address”).⁶ The court was not free to deem un rebutted expert analysis speculative by ignoring it.

d. The Injury Is Consistent with Numerous Studies

The relationship between increased Plan expenses (including prescription drug expenses) and increased employee premiums is also confirmed by a wealth of government studies and academic research. For example, the Federal Trade Commission found that inflated drug costs “result in higher premiums” for recipients of employer-provided insurance. App. 396; R. Doc. 64, at ¶ 246. A 2023 report by an independent nonpartisan policy institute likewise found that inflated drug prices “ultimately raise[] costs for consumers through higher cost sharing and premiums.” *Id.* ¶ 247. Similarly, in a 2024 report commissioned by the Employee Benefits Security Administration, RAND Corporation found that “[h]igher drug spending will, holding all else constant, lead to higher premiums.” App. 398; R. Doc. 64, at ¶ 251. Although all of these studies and reports (as well as similar ones) were cited in the Amended Complaint, the District Court failed to address them, much less explain how it was *implausible* that Wells Fargo passed on excess Plan costs to participants consistent with this wealth of research.

⁶ Appellants not only attached Ms. Albritton’s expert report, but included specific factual allegations based on her analysis. *See* App. 402-04; R. Doc. 64, at ¶¶ 263-69.

2. Appellants' Allegations Must Be Accepted as True at this Stage, and Even Wells Fargo Did Not Dispute Them

The District Court was obligated to accept Appellants' well-pled allegations and draw all inferences in their favor at this stage. *See In re SuperValu, Inc.*, 870 F.3d at 768; *Braden*, 588 F.3d at 591. Instead, it did exactly the opposite. It disregarded many of the allegations in the Amended Complaint, disregarded the historical data, disregarded the expert analysis that was attached to and incorporated into the Amended Complaint, and drew a counter-factual inference *against* Appellants that defies common sense: that employee premiums were somehow unaffected by increases in Plan spending.

There is no support for this fanciful proposition, and the District Court cited none. Indeed, even Wells Fargo never contended as much. In support of its motions to dismiss, Wells Fargo submitted a pair of declarations from its Benefits Director. R. Doc. 31, App. 442; R. Doc. 81. Notably, neither declaration disputed Appellants' allegation that Wells Fargo passed on increased Plan expenses to employees through increased premium contributions. If Wells Fargo had a basis for contesting Appellants' allegations about how employee premiums are set, it presumably would have done so in these declarations.

3. The Number of Variables Is Irrelevant to the Causal Relationship.

The District Court acknowledged “[i]t seems possible that if the price of drugs from the PBM goes down, the participants’ [premium] contributions would go down” as well. App. 21; R. Doc., 99 at 21. However, it still considered Appellants’ allegations of injury from increased premiums to be speculative because “Plaintiffs’ [premium] contributions are used to cover *overall* Plan expenses, not specifically or exclusively their prescription drug benefits or ESI’s administrative fees.” *Id.*

This ignores basic math. If total expenses (T) are the sum of administrative expenses (A), drug expenses (D), and other expenses (O), *i.e.*,

$$A + D + O = T,$$

any increase in A or D will cause T to also increase relative to what it otherwise would have been. *See* App. 163; R. Doc., 64-1 at 5 (“The level of prescription drug spending directly affects total plan spending”). For purposes of the causal relationship between A and D (on the one hand) and T (on the other hand), it makes no difference that there is another variable or even more than one other variable. And Plaintiffs plausibly alleged that employees’ premiums were consistently 25% of T, meaning that an increase in T (by virtue of an increase in A or D) plausibly raised their premiums.

To the extent other variables account for a share of total plan costs, this may diminish the *degree* to which the A and D variables impact T, but the causal

relationship will still fundamentally be the same. The District Court erred by failing to recognize this basic causal relationship simply because Plan costs are affected by multiple factors. *See, e.g., Enterprise Fin. Group, Inc. v. Podhorn*, 930 F.3d 946, 950 (8th Cir. 2019) (defendant’s conduct remained “fairly traceable” to plaintiff’s injury where intervening third-party conduct was not the “sole cause” of the harm); *Brown v. Medtronic, Inc.*, 628 F.3d 451, 459 (8th Cir. 2010) (in evaluating traceability, courts “are neither analyzing damages nor requiring a plaintiff to prove proximate cause”); *Adam v. Barone*, 41 F.4th 230, 235 (3d Cir. 2022) (“[T]here may be more than one but for cause of a loss”).

For the same reason, it makes no difference that “participant contribution amounts *may* be affected by several factors having nothing to do with prescription drug benefits.” App. 577; R. Doc. 99, at 21: Add. 21 (emphasis added). As Ms. Albritton explained, “[t]he level of prescription drug spending directly affects total plan spending and claim costs and is an increasingly large driver of such costs. As such, prescription drug spending plays a significant role in the calculation of premium contributions.” App. 422; R. Doc. 64-1, at 5; App. 402; R. Doc. 64, at ¶ 263.⁷

⁷ “While [employee premium] contributions for self-funded plans may be based on a number of factors, the largest factor by far is actual and anticipated claim costs.” App. 422; R. Doc. 64-1, at 5; App. 402; R. Doc. 64, at ¶ 263. Any “granular” adjustments based on individual factors (e.g., tobacco use) are applied only after the

The Fifth Circuit’s recent decision in *Wilson v. Centene Mgmt. Co., L.L.C.*, 168 F.4th 217 (5th Cir. 2026), is instructive. In *Wilson*, the plaintiffs alleged that their healthcare premiums were inflated because of the defendant insurance companies’ inaccurate provider lists. *Id.* at 221. Even though the list of providers was not the only (or even a major) factor affecting premiums, *id.* at 224, the Fifth Circuit held that “the Plaintiffs have alleged ... an injury in fact (overcharges for a health insurance policy that contained materially inaccurate and insufficient provider lists).” *Id.* at 229. The Fifth Circuit expressly rejected the district court’s holding that harm was insufficiently pled just because there were “other factors which impact the cost of premiums.” *Id.* at 224; *see also, e.g., In re Ins. Brokerage Antitrust Litig.*, 579 F.3d 241, 264 (3d Cir. 2009) (in antitrust case, plaintiffs had standing because they “alleged that they paid supra-competitive prices for their insurance policies” due to kickbacks, even though kickbacks were not the only input into premiums); *Acosta v. Bd. of Trs. of Unite Here Health*, No. 22-C-1458, 2023 WL 2744556, at *3 (N.D. Ill. Mar. 31, 2023) (plaintiffs had standing in case involving health plan expense charges because they “alleged that the conduct of defendants impacted their end of the bargain, including in ... higher cost-sharing”).

“the overall employer/employee contribution level” is set. App. 428; R. Doc. 64-1, at 11.

This Court should reach the same result. Appellants specifically allege that [1] “[p]rescription drug expenditures ... exert significant influence on overall plan costs,” App. 403; R. Doc. 64, at ¶ 265 (citing R. Doc. 64-1 at 7); and [2] prescription drug spending also has “a relatively large effect on employer-sponsored health insurance premiums,” App. 397; R. Doc. 64, at ¶ 250; *see also* App. 402; R. Doc. 64, at ¶ 263(3) (citing R. Doc. 64-1). Indeed, Ms. Albritton noted the strength of the relationship between prescription drug costs and premium contributions, while explicitly recognizing that there are multiple “components of contributions calculations.” App. 426; R. Doc. 64-1, at 9. The District Court’s injury analysis missed the forest by focusing on the number of trees.

4. The District Court Erred in Concluding that McKinley’s Allegations of Injury from Increased COBRA Contributions Were Speculative

Whatever unsupported justifications the District Court may have had for finding that Appellants’ injury from increased *employee* premiums was speculative, there is utterly no support for its conclusion that the link between *COBRA* premiums and Plan costs is speculative.

COBRA amended ERISA to allow beneficiaries of employer-sponsored health plans to continue their coverage upon termination of employment or other “qualifying events.” *Geissal v. Moore Med. Corp.*, 524 U.S. 74, 79-80 (1998) (citing 29 U.S.C. § 1163). Continuation coverage under COBRA is “identical to what the

plan provides to plan beneficiaries who have not suffered a qualifying event.” *Id.* at 80 (citing 29 U.S.C. § 1162(1)). However, the beneficiary who makes the election must pay the *full* cost of coverage—up to 102 percent of the “applicable premium”—with the former employer bearing none of the payment responsibility. *Id.* (citing 29 U.S.C. § 1162(3)). Importantly, the “‘applicable premium’ is usually the cost to the plan of providing continuation coverage, *regardless of who usually pays for the insurance benefit.*” *Id.* at 81 (emphasis added) (citing 29 U.S.C. § 1164).

Consistent with this statutory framework, Appellant McKinley paid 100% of the premium contribution for her COBRA coverage (both the employer and employee share), plus a 2% administrative fee. App. 301, 400, 401; R. Doc. 64, at ¶¶ 18, 257, 259. Because McKinley paid all of the premium, there can be no question whether her share of the COBRA premium was impacted by Plan costs. As explained in the Amended Complaint, the statute *requires* that costs be factored into the COBRA premium (which McKinley fully paid). App. 400; R. Doc. 64, at ¶ 258 (citing 29 U.S.C. § 1164(2)). Thus, higher drug costs and higher administrative fees paid by the Plan result in higher premium costs for McKinley and others with COBRA continuation coverage. *Id.*

There is no issue regarding whether Wells Fargo passed along these costs to the “employee share” of the premium because McKinley paid *both* the employee and employer share under COBRA. And there is no issue regarding whether Plan

costs were built into the premium because the law requires it and because the Plan was self-funded. Accordingly, the District Court's ruling that McKinley's injury from increased COBRA premiums was speculative is particularly egregious.

The primary rationale offered by the District Court for its conclusion was that Wells Fargo has "'sole discretion' to set participant contribution rates" and there is "no requirement that Wells Fargo make any contributions" of its own. App. 579; R. Doc. 99, at 23; Add. 23. But as noted above, the COBRA premium is the sum of the employee contribution and employer contribution. Whether the employee/employer split is 25%/75% (the historical allocation), 50/50, or even 100/0 makes no difference because the COBRA share will *always* be 100 percent. And because the Plan is self-funded and COBRA mandates that Plan costs be factored into COBRA premiums, increases in Plan costs necessarily result in increases in COBRA premiums.

The District Court also repeated its assertion that "the Plan's overall expenses account for more than [prescription drug expenses and ESI's administrative fees] and that participant contributions are 'affected by several factors having nothing to do with prescription drug benefits.'" App. 580; R. Doc. 99, at 24; Add. 24. However, as noted above, the existence of more variables does not change the mathematical relationship: even when multiple expense categories exist, overcharges in any one of them inflate the aggregate cost. If you buy eggs, milk, and butter at the store, but

only the price of eggs is inflated, your grocery bill is still higher in the aggregate because of the inflated price of eggs. The District Court was not free to disregard the financial injury associated with overcharges for certain items (prescription drugs and administrative services) simply because they did not constitute all charges for all items in the Plan's shopping basket.

5. The District Court Did Not—and Could Not— Question the Underlying Overpayment Allegations

The District Court did not question the merit of the underlying overcharge allegations. To the contrary, it found that Appellants “forcefully set forth” their allegations regarding excessive prescription drug charges, App. 282; R. Doc. 57, at 28; Add. 58, and described their allegations as “compelling and detailed,” App. 558; R. Doc. 99, at 2; Add. 2; *see also* App. 585; R. Doc. 99, at 29; Add. 29 (“To be sure, the price comparisons alleged in Plaintiffs’ complaint are staggering.”).

The only quibble the District Court had with Appellants’ overcharge allegations for 260 drugs is that Appellants did not offer even *more* of them. *See* App. 576; R. Doc. 99, at 20; Add. 20; App. 276; R. Doc. 57, at 22; Add. 52 (describing markups as pertaining to “a subset of prescription drugs in the Plan’s formulary”). But “[t]he full formulary is not available Plaintiffs,” App. 341; R. Doc. 64, at ¶ 118, and the district court was required to “take account of [plaintiffs’] limited access to crucial information.” *Braden*, 588 F.3d at 598; *see id.* (warning that ERISA’s “remedial scheme ... will fail” if courts require plaintiffs to “plead[] facts

which tend systemically to be in the sole possession of defendants”). The Amended Complaint did as much as it could with public information: it analyzed Wells Fargo’s “Preferred Formulary,” which is “the most comprehensive formulary” that is publicly available and contains “a list of the most commonly prescribed drugs.” *Id.*⁸ Based on an analysis of *every* generic drug on the Preferred Formulary for which price comparison data was available, Appellants determined that the average markup was over 100%. *See* App. 341-42; R. Doc. 64, at ¶¶ 120-21. This was more than sufficient to support their claims at the pleading stage. Indeed, for purposes of standing, the District Court was required to “*assume* that on the merits the plaintiffs would be successful in their claims.” *Am. Farm Bureau Fed’n*, 836 F.3d at 968 (emphasis added).

Regardless, allegations related to only a “subset” of drugs would suffice to state a claim. “Fiduciaries cannot shield themselves from liability—much less discovery—simply because the alleged imprudence inheres in fewer than all ... options.” *Sacerdote v. N.Y. Univ.*, 9 F.4th 95, 109 (2d Cir. 2021). Thus, in the retirement plan context, “[a] fiduciary cannot avoid liability for offering imprudent investments merely by including them alongside a larger menu of prudent

⁸ To the extent the full formulary is more expansive than the Preferred Formulary, that is mostly because it includes different dosages or delivery forms (e.g. tablet vs. capsule) of the same drugs, not thousands of different drugs. *See* App. 357, R. Doc. 64, at ¶ 146.

investment options.” *Pfeil v. State St. Bank & Tr. Co.*, 671 F.3d 585, 597 (6th Cir. 2012), *abrogated on other grounds by Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409 (2014); *see also DiFelice v. U.S. Airways, Inc.*, 497 F.3d 410, 423 (4th Cir. 2007) (“[T]he prudence of investments ... must be judged individually.”). Likewise here, Wells Fargo cannot avoid liability (much less discovery) for imprudently allowing overcharges for certain drugs merely because it is theoretically possible that reasonable prices could have been charged for certain other drugs. Indeed, the Amended Complaint expressly alleges that the “extraordinarily high prices for generic drugs purchased through the Plan are not offset by special discounts from Express Scripts for other kinds of drugs.” App. 357; R. Doc. 64, at ¶ 145.

B. The Plan’s Overpayments Are Traceable to Wells Fargo’s Failure to Monitor ESI

Appellants also satisfied the traceability requirement by tying both the Plan’s injury (increased expenses) and their personal injury (increased premiums) to Wells Fargo’s unlawful conduct. Consistent with established law, the Amended Complaint alleges that Wells Fargo has a fiduciary duty to “carefully monitor the Plan’s PBM and prescription drug costs and administrative fees.” App. 411; R. Doc. 64, at ¶ 291; *accord Braden*, 588 F.3d at 590, 595-96; *Tussey*, 746 F.3d at 336 (affirming district court’s finding that “the [plan’s] fiduciaries breached their duties to the Plan by failing diligently to investigate Fidelity and monitor Plan recordkeeping costs.”). The Amended Complaint further alleges that “Wells Fargo’s breaches of fiduciary

duty increased the amounts that the Plan paid for prescription drugs and in fees, and also increased the amounts that Plaintiffs and members of the class were required to pay in premiums[.]” App. 409; R. Doc. 64, at ¶ 286; *see also* App. 390, 399, 413; R. Doc. 64, at ¶¶ 229, 254, 300. Nothing further is required at this stage.

The District Court did not address traceability separately from injury-in-fact. To the extent it addressed traceability at all, any adverse ruling as to traceability rests entirely on its conclusion (discussed above) that Appellants’ injuries from increased premiums were speculative. Likewise, Wells Fargo did not make any unique arguments below with respect to traceability, arguing only that Appellants’ supposed “failure to plead a connection between the plan’s costs and participants also can be understood as a failure to plead causation.” R. Doc. 79, at 12. For the reasons above, that argument is wrong—participants’ premium contributions are directly related to Plan spending. *See supra* at § II.A. Accordingly, Plaintiffs plausibly allege that Wells Fargo’s fiduciary breaches caused an injury to them and not just the Plan.

C. ERISA Provides a Remedy for the Plan’s Overpayments that Will Benefit Affected Participants

Finally, redressability is satisfied. ERISA expressly provides for restoration of “losses to the plan” in the event of a fiduciary breach, 29 U.S.C. § 1109(a), and grants Plan participants a statutory right to seek such relief. *See* 29 U.S.C. § 1132(a)(2) (authorizing “participant” to bring an action for “relief under section 1109”). Appellants plead this form of relief in their Amended Complaint, *see* App.

410, 413, 415; R. Doc. 64, at ¶¶ 287, 301, 313, and *Braden* confirms their standing to do so. *See Braden*, 588 F.3d at 591-94.

The District Court erred in finding that redressability was lacking. For the most part, its analysis failed to address the loss remedy in 29 U.S.C. § 1109(a), and focused on *other* remedies such as restoration of “ill-gotten profits”⁹ and “prospective[]” relief. *See* App. 581; R. Doc. 99, at 25; Add. 25. The District Court’s only discussion of the loss remedy appears in a single sentence at the end of its analysis, where it speculated that Wells Fargo might “offset” any required repayment of Plan losses by reducing its future contributions to the Plan. *See id.* (“[E]ven if the Court ordered Wells Fargo to remit a one-time payment to the Plan to remedy any purported past overcharges, nothing would prevent Wells Fargo from ‘offset[ting] its own contributions’ going forward ‘while making no reduction to the contributions it require[s]’ from Plaintiffs.”). This was a non-sequitur for several reasons.

First, the District Court’s analysis conflates retrospective relief (i.e., recovery of losses to the Plan) with the prospective funding of the Plan. What Wells Fargo may or may not do in funding the Plan *going forward* has no bearing on whether a court can remedy overpayments the Plan has *already* made. Redressability asks whether the past injury can be repaired, not whether the defendant might later make

⁹ Appellants do not contend that Wells Fargo profited from its fiduciary breaches or that ESI (a non-party here) was a fiduciary to the Plan.

offsetting decisions of its own. If Wells Fargo is ordered to restore the Plan’s losses, that will redress the overpayments that have already been made by the Plan, and “any recovery made ‘on behalf of the plan’ must be paid out to the injured participant[s].” *Graden v. Conexant Sys., Inc.*, 496 F.3d 291, 296 n.6 (3d Cir. 2007); *see also Evans v. Akers*, 534 F.3d 65, 74 (1st Cir. 2008) (“[I]f the plaintiffs are ultimately successful in this suit, the fiduciaries should, in accord with their statutory duty of care, strive to allocate any recovery to the affected participants in relation to the impact the fiduciary breaches had on [them].”). In an analogous situation involving insurance premium rebates, the Department of Labor (“DOL”) has instructed employers who receive such rebates that they may not use the rebate share attributable to participant contributions for their own account, and should allocate it “for the benefit of participants and beneficiaries.” *See* Technical Release No. 2011-4 (Dec. 2, 2011).¹⁰ The same process should apply here. *See* App. 410, 414; R. Doc. 64, at ¶¶ 288, 302.

Second, the offset concern has no possible application to four of the five named Appellants. Because Navarro, Gamage, Bulla, and Kinsella are no longer enrolled in the Plan, Wells Fargo cannot recoup any award by shifting more Plan costs onto them. In the event of a Plan recovery, they will receive their proportional

¹⁰ Available at <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/11-04> (last visited May 25, 2026).

share of the overpayments, without any possible corresponding reduction in benefits or premium increases going forward.

Third, plan sponsors are not permitted to point to their plan contributions (as employers) to offset losses they cause to the plan (as fiduciaries). The First Circuit directly addressed this issue in *Brotherston v. Putnam Invs., LLC*, 907 F.3d 17 (1st Cir. 2018). In that case, court held that discretionary contributions to a retirement plan for the benefit of participants are “irrelevant to the analysis” and a plan sponsor “cannot point to those contributions to offset funds” improperly charged to the plan and its participants. *Id.* at 29. As the court explained, employers cannot “claw back” their employer contributions as a consequence of their fiduciary misdeeds. *Id.* To hold otherwise would eviscerate the protections that ERISA provides to participants of employee benefit plans because almost all employers contribute to ERISA-sponsored plans.¹¹

Finally, the District Court’s suggestion that Wells Fargo will reduce its future employer contributions to the Plan by exactly the amount of any loss award under

¹¹ The District Court cited *Winsor* and *Horvath* in support of its novel offset theory, but neither case supports its analysis for the reasons explained above. In *Horvath*, the court made no mention of any offset. It simply held that there was no reason to believe that the plan sponsor “would have passed [through] savings on to its employees,” 333 F.3d at 457, where the plan sponsor already paid 100% of the cost of health coverage, *see supra* at 34. In *Winsor*, the court stated that the result would have been different if the employees paid a pro rata percentage of the total premium, which Appellants did here. *See supra* at 36.

§ 1132(a)(2) is entirely hypothetical and speculative. There is no evidence that Wells Fargo will do so, let alone on a precise dollar-for-dollar basis. Indeed, any such maneuver designed to undermine the loss restoration remedy would likely not even be lawful. *See Evans*, 534 F.3d at 74 (“We doubt that such a decision would be consistent with the fiduciaries’ duty to act in the interest of participants.”). A defendant’s hypothetical future conduct cannot render its past breaches non-redressable.

CONCLUSION

For the above reasons, the District Court’s judgment should be reversed.

Dated: June 25, 2026

Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the type-volume limit of Fed. R. App. P. 32(a)(7)(B) and that this brief contains 12,904 words, excluding the parts of the brief exempted by Fed. R. App. P. (32)(f), based on the word count feature of the word processing program used to prepare the brief.

2. I certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Office 365 Word in Times New Roman 14 point font.

3. The undersigned certifies pursuant to Eighth Circuit Rule 28A(h) that this document has been scanned for viruses and the brief is virus-free.

Dated: June 25, 2026

/s/ Kai Richter
Counsel for Plaintiffs-Appellants

CERTIFICATE OF SERVICE

The undersigned certifies that on this 25th day of June 2026, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: June 25, 2026

/s/ Kai Richter
Counsel for Plaintiffs-Appellants

**UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT**

SERGIO NAVARRO, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans; THERESA GAMAGE, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans; DAYLE BULLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans; JANE KINSELLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans; ERICA MCKINLEY, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans, *Plaintiffs – Appellants*

v.

WELLS FARGO & COMPANY, *Defendant - Appellee*

On Appeal from the United States District Court
for the District of Minnesota, Honorable Laura M. Provinzino
24-cv-3043 LMP/DLM

PLAINTIFFS-APPELLANTS' ADDENDUM

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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

SERGIO NAVARRO, THERESA
GAMAGE, DAYLE BULLA, JANE
KINSELLA, and ERICA McKINLEY,
*on their own behalf, on behalf of all
others similarly situated, and on behalf
of the Wells Fargo & Company Health
Plan and its component plans,*

Plaintiffs,

v.

WELLS FARGO & COMPANY,

Defendant.

Case No. 24-cv-3043 (LMP/DLM)

**ORDER GRANTING
DEFENDANT'S
MOTION TO DISMISS**

Kai H. Richter, **Cohen Milstein Sellers & Toll, PLLC, Minneapolis, MN**; Michelle C. Yau and Allison Pienta, **Cohen Milstein Sellers & Toll, PLLC, Washington, D.C.**; Michael B. Eisenkraft, **Cohen Milstein Sellers & Toll, PLLC, New York, NY**; Jamie Crooks and Michael D. Lieberman, **Fairmark Partners LLP, Washington, D.C.**; and Daniel E. Gustafson and Daniel J. Nordin, **Gustafson Gluek PLLC, Minneapolis, MN**, for Plaintiffs.

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Carl F. Engstrom, **Engstrom Lee, Minneapolis, MN**, for Amicus Curiae Amy B. Monahan.

Plaintiffs Sergio Navarro, Theresa Gamage, Dayle Bulla, and Jane Kinsella (the “Original Plaintiffs”), former employees of Defendant Wells Fargo & Company (“Wells Fargo”) and former participants in the Wells Fargo & Company Health Plan (the “Plan”), filed the initial complaint in this matter, alleging that Wells Fargo breached its fiduciary

duties under the Employee Retirement Income Security Act (“ERISA”) by mismanaging the Plan’s prescription drug benefits program. ECF No. 1. Wells Fargo moved to dismiss the Original Plaintiffs’ complaint for lack of standing and for failure to state a plausible claim for relief. ECF No. 28. Upon review of the initial complaint, this Court found that “[w]hile compelling and detailed, Plaintiffs’ allegations are simply too speculative to show concrete individual harm, too tenuous to show causation, and too conjectural to show redressability.” ECF No. 57 at 25. The Court therefore concluded that the Original Plaintiffs lacked standing and granted Wells Fargo’s motion. *Id.* at 29.

With leave of Court, the Original Plaintiffs filed an amended complaint supplementing their factual allegations, asserting the same claims, and adding Plaintiff Erica McKinley (collectively with the Original Plaintiffs, “Plaintiffs”), who is a former Wells Fargo employee and current Plan participant. ECF No. 64. Wells Fargo moves to dismiss the amended complaint on the same grounds. ECF No. 77. For the reasons discussed here, the Court again concludes upon review of the amended complaint that Plaintiffs have not demonstrated standing to bring their claims, grants Wells Fargo’s motion, and dismisses Plaintiffs’ amended complaint.

FACTUAL BACKGROUND

The factual allegations in Plaintiffs’ amended complaint largely mirror the allegations in the initial complaint. *Compare* ECF No. 64, *with* ECF No. 1; *see* ECF No. 64-2; *see also* ECF No. 57 at 2–9. The Court will cover the facts alleged in the amended complaint for the benefit of context. In addition, the Court notes that for purposes of assessing Wells Fargo’s motion to dismiss, the Court accepts the factual allegations in

Plaintiffs’ amended complaint as true. *Gorog v. Best Buy Co.*, 760 F.3d 787, 792 (8th Cir. 2014).

I. The Plan

The Plan is a self-funded employee welfare benefit plan established to provide medical and prescription drug benefits to Wells Fargo employees who choose to enroll. *See* ECF No. 64 ¶¶ 21–22. Wells Fargo is the sponsor and a fiduciary of the Plan and retains decision-making authority with respect to the Plan’s management. *Id.* ¶ 24. The Original Plaintiffs are each former Wells Fargo employees and former Plan participants. *Id.* ¶¶ 14–17. McKinley is also a former Wells Fargo employee, but as of the filing of the amended complaint, she remains a participant in the Plan because she elected to continue her coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) after her employment with Wells Fargo ended. *Id.* ¶ 18.

Because the Plan is self-funded, its expenses—including payment for participants’ covered medical expenses and administrative fees—are shared by Wells Fargo and Plan participants. *Id.* ¶¶ 22, 30. To cover those expenses, Wells Fargo established the Wells Fargo & Company Employee Benefit Trust (the “Trust”). *Id.* ¶ 22. The Trust is funded almost entirely by a combination of Wells Fargo and Plan-participant contributions, and it is responsible for all the Plan’s expenses. *Id.* As such, any increases in Plan spending must be covered by increases in contributions to the Trust. *See id.* ¶ 32.

Wells Fargo retains “sole discretion” to set and modify participant contribution amounts. ECF No. 31-3 at 9; *see also* ECF No. 31-2 at 22 (“The Plan Sponsor may establish different contribution rates for different classes of Participants . . . for any Benefit

Option.”). Between 2018 and 2023, Wells Fargo required Plan participants to contribute approximately 25% of the Plan’s overall costs, with Wells Fargo contributing the remaining 75%. ECF No. 64 ¶ 240.

II. The Plan’s Prescription Drug Program

A. Pharmacy Benefit Managers Generally

Fiduciaries of employer-sponsored health plans like the Plan often contract with third-party pharmacy benefit managers (“PBMs”) to administer their plans’ prescription drug benefits. *See* ECF No. 64 ¶ 53. PBMs offer various services, including processing participant claims; negotiating with pharmacies to establish a plan’s pharmacy networks; managing a plan’s formulary, which is a list of the prescription drugs the plan covers; and negotiating with prescription drug manufacturers to secure rebates or discounts for those manufacturers’ products. *Id.* ¶¶ 49, 53. Generally, when a plan participant obtains a prescription drug from a pharmacy in the plan’s network, the participant pays the portion, if any, for which they are responsible under the terms of their plan (like a co-pay or deductible), the PBM pays the pharmacy for the remainder of the cost as negotiated by the PBM, and the PBM is later reimbursed by the plan. *See id.* ¶¶ 54, 57, 106. In short, PBMs serve as intermediaries between plans (and by extension, plan participants) and pharmacies. *See id.* ¶¶ 53–55.

Two dominant PBM models have emerged: “pass-through” and “traditional” PBMs. *Id.* ¶ 56. Pass-through PBMs generate profit exclusively by charging administrative fees for the services they provide to plans. *Id.*; *see id.* ¶ 73. Traditional PBMs, on the other

hand, generate profit through a combination of “spread pricing,”¹ pharmacy rebates, administrative fees, and ownership of their own pharmacies. *Id.* ¶ 56. Traditional PBMs also negotiate with plan fiduciaries the prices the PBMs will be reimbursed for various prescription drugs. *Id.* ¶ 57. As such, traditional PBMs are incentivized to negotiate with a plan the highest price for a prescription drug to which the plan will agree to maximize the “spread.” *Id.* ¶ 67.

Some PBMs and plan fiduciaries structure their agreements by setting prices for groups of drugs by reference to a benchmark price rather than negotiating the price for each drug individually. *Id.* ¶ 58. One such benchmark, the National Average Drug Acquisition Cost (“NADAC”), tracks the average cost pharmacies pay to obtain many prescription drugs. *Id.* ¶ 59. Another, the “Average Wholesale Price” (“AWP”), purports to do the same thing as NADAC, but according to Plaintiffs, it is not truly representative of actual market prices and is susceptible to industry manipulation. *Id.* ¶ 61.

B. The Plan’s Agreement with Express Scripts, Inc.

Wells Fargo entered an agreement with Express Scripts, Inc. (“ESI”), a PBM that operates under the traditional model and one of the three largest PBMs in the U.S., to serve as the Plan’s PBM. *Id.* ¶¶ 88, 110. Wells Fargo did not conduct an open bid process before retaining ESI but rather engaged a broker which evidently identified and recommended ESI. *See id.* ¶¶ 111, 113. The agreement between Wells Fargo and ESI is not publicly

¹ “Spread pricing” refers to a practice in which a PBM negotiates with a pharmacy a lower price for a particular prescription drug than the price a plan agreed to pay the PBM as part of the plan’s contract with the PBM, then retains the difference as profit. *See* ECF No. 64 ¶¶ 57, 64, 66.

available, but ESI’s standard contract with other plans suggests that Wells Fargo would have agreed to various terms regarding drug pricing, formulary management, pharmacy networks, and administrative services. *Id.* ¶¶ 110, 114. ESI’s standard contract also expressly states that the plan sponsor—here, Wells Fargo—retains discretionary authority and control over decisions relating to plan management. *Id.* ¶ 112.

The Plan’s formulary designates approximately 300 of the most commonly prescribed generic drugs as “preferred alternatives,” meaning Plan participants are encouraged to use those generic versions rather than their brand-name equivalents. *Id.* ¶¶ 118–19. NADAC information is publicly available for 260 of those drugs. *Id.* ¶ 120. The Plan’s formulary uses the AWP as a benchmark, however, and NADAC information for those 260 drugs reveals that the prices Wells Fargo negotiated with ESI for these “preferred alternative” drugs were approximately 115% above the pharmacy acquisition cost on average. *Id.* ¶¶ 115, 121.

The Plan’s agreement with ESI also requires Plan participants to acquire so-called “generic-specialty” drugs from ESI’s wholly owned mail-order pharmacy, Accredo. *Id.* ¶ 124. NADAC information is publicly available for 38 of the 95 generic-specialty drugs on the Plan’s formulary, which shows that the Plan agreed to pay, on average, 383% above the pharmacy acquisition cost for those 38 drugs. *Id.* ¶ 125. In some cases, the prices the Plan agreed to pay ESI for certain generic-specialty drugs exceeds the cost an uninsured person would be required to pay at a retail pharmacy. *See id.* ¶¶ 126–37, 140–43.

After the Original Plaintiffs filed the initial complaint, Wells Fargo “appears to have . . . renegotiated its prices with [ESI] to lower them substantially.” *Id.* ¶ 166. As of

the filing of the amended complaint, Wells Fargo “has more favorable pricing on 158 of the 260 drugs” on the Plan’s formulary, and the Plan’s drug prices “are now 11% lower than they were” when the initial complaint was filed. *Id.* In any event, regardless of the type or cost of any particular prescription drug, a Plan participant is required to pay some portion, if not all, of the cost themselves until they meet their annual deductible. *See id.* ¶ 106. After meeting their annual deductible, a participant may still be responsible for some out-of-pocket costs, like coinsurance payments. *See id.*

Separately, the administrative fees the Plan agreed to pay ESI exceed the fees paid by other large plan sponsors for comparable services. *See id.* ¶ 155. In 2022, for example, the Plan had 188,798 participants and paid ESI \$25,639,955 in administrative fees, or \$135.81 per participant. *Id.* ¶ 157. By comparison, the Railroad Employees National Health and Welfare Plan (“RENHWP”), who also contracted with ESI as its PBM that year, had 213,981 participants and paid \$4,250,101 in administrative fees, or \$19.86 per participant. *Id.* The Plan’s and the RENHWP’s respective Form 5500s from that year show two of the same three service codes.² *Id.*

III. Plaintiffs’ Amended Complaint

The essence of Plaintiffs’ amended complaint remains essentially unchanged from the initial complaint, and their allegations can be sorted into three main categories.

² A Form 5500 explains what third-party services were provided to a plan and “discloses the aggregate payments made” by the plan to the service provider—here, ESI. *Matousek v. MidAmerican Energy Co.*, 51 F.4th 274, 279 (8th Cir. 2022).

First, Plaintiffs allege that because ESI uses AWP as a benchmark, the Plan agreed to pay to ESI prices for certain drugs that exceed NADAC prices, prices charged by pass-through PBMs, and prices an uninsured person would pay at a retail pharmacy for the same drugs. *See id.* ¶¶ 110, 114–43, 150–54. Plaintiffs contend these prices would have been lower and that they would have paid lower contributions and out-of-pocket expenses had Wells Fargo negotiated prices with ESI based on NADAC, retained a pass-through PBM, or retained a different PBM entirely that did not steer Plan participants to its own pharmacy. *See id.* ¶¶ 71, 108, 115, 121, 150–54, 219–28. Plaintiffs supplement these allegations in the amended complaint by alleging that: (1) other PBMs—and, indeed, ESI—offer drug pricing to other plans that are “based on the lowest of three benchmarks, one of which is NADAC,” *id.* ¶ 60; (2) the “thousands” of other drugs covered by the Plan for which NADAC information is not publicly available mostly are “different dosages or delivery forms” of the drugs identified in the amended complaint, which are the “most commonly prescribed drugs” under the Plan, *id.* ¶¶ 146–47; and (3) Wells Fargo negotiated lower prescription drug prices with ESI after the Original Plaintiffs filed the initial complaint, *id.* ¶ 166.

Second, Plaintiffs allege that Wells Fargo paid excessive administrative fees to ESI. *See id.* ¶¶ 155–62. Plaintiffs assert that if Wells Fargo had “adequately negotiated” with ESI regarding these administrative fees, “the Plan and its participants/beneficiaries would have saved millions of dollars.” *Id.* ¶ 169. Here, Plaintiffs supplement the allegations made in the initial complaint by adding the fees the Plan paid to ESI in 2023 and including

the relevant service codes from the Plan's and comparator plans' 2022 and 2023 Form 5500s. *See id.* ¶¶ 157–61.

Third, Plaintiffs allege that because of the Plan's excessive payments to ESI for administrative services and prescription drugs, they and other Plan participants effectively received "lower wages" or experienced "limited wage growth." *Id.* ¶ 285. Plaintiffs contend that these harms would have been avoided had Wells Fargo more diligently monitored the Plan's prescription drug program. *See id.* These allegations are unchanged from the initial complaint. *Compare id.*, with ECF No. 1 ¶ 181.

Altogether, Plaintiffs allege that Wells Fargo's "inattentiveness to prescription drug costs and other fiduciary failures" caused Plaintiffs to pay more in contributions and out-of-pocket costs than they otherwise would have paid, which Plaintiffs assert constitutes a breach of Wells Fargo's fiduciary duties under 29 U.S.C. § 1104(a). *See* ECF No. 64 ¶¶ 229, 282–94. Plaintiffs contend that had Wells Fargo acted as a prudent fiduciary, it could or should have: (1) wielded its "substantial bargaining power" to "demand and obtain substantially better contractual terms" with ESI "relating to prices and the way in which prices are determined" under the Plan, *id.* ¶ 164; (2) "solicit[ed] bids from pass-through PBMs," which "would have made clear that the Plan would save a substantial amount of money for itself and its participants" by contracting with a pass-through PBM instead of entering or renewing its contract with ESI, *id.* ¶ 170; and (3) considered "carving out the specialty-drug program" from its contract with ESI, *id.* ¶ 176. Plaintiffs also allege that Wells Fargo engaged in prohibited transactions under 29 U.S.C. § 1106(a)(1) because "the compensation Wells Fargo agreed to pay [ESI] was not reasonable." *Id.* ¶¶ 12, 295–309.

Plaintiffs bring claims on behalf of the Plan under 29 U.S.C. § 1132(a)(2), *id.* ¶¶ 282–88, 295–302, and on behalf of a putative class of Plan participants under 29 U.S.C. § 1132(a)(3), *id.* ¶¶ 289–94, 303–09. They seek injunctive and other equitable relief in the form of: (1) removing the Plan’s fiduciaries and appointing an independent fiduciary to run the Plan; (2) removing and replacing ESI as the Plan’s PBM or, alternatively, requiring a search for another PBM to replace ESI; (3) requiring Wells Fargo to “make good to the Plan all losses to the Plan” and to “restore the Plan to the position it would have occupied but for” the alleged fiduciary breaches and prohibited transactions; and (4) awarding “fiduciary surcharge, equitable restitution, and/or other make-whole equitable relief to Plaintiffs” and the putative class they represent. *Id.* ¶¶ 312–16.

PROCEDURAL BACKGROUND

The Original Plaintiffs filed the initial complaint on July 30, 2024, ECF No. 1, and Wells Fargo moved to dismiss the initial complaint for lack of standing and for failure to state a claim, ECF No. 28. On March 24, 2025, the Court entered an order concluding that the Original Plaintiffs had not demonstrated standing, ECF No. 57, and entered judgment dismissing the initial complaint, ECF No. 58.

The Court, however, did not address the Original Plaintiffs’ request—made in a footnote at the end of their brief in opposition to Wells Fargo’s first motion to dismiss, *see* ECF No. 38 at 50 n.26—for an opportunity to amend their complaint in the event the Court granted Wells Fargo’s motion. The Original Plaintiffs subsequently sought the Court’s permission to file a motion for reconsideration of the dismissal order, citing their unaddressed request for leave to amend the initial complaint and contending that the Court

erroneously relied upon abrogated case law in reaching its decision.³ See ECF No. 59 at 1–2. Over Wells Fargo’s objection, see ECF No. 60, the Court vacated the judgment dismissing the initial complaint and granted the Original Plaintiffs leave to file an amended complaint, see ECF No. 62.

Plaintiffs—now including McKinley—filed their amended complaint on May 8, 2025, ECF No. 64, with an expert report attached as an exhibit to support their factual allegations, ECF No. 64-1. Wells Fargo filed a motion to dismiss the amended complaint, ECF No. 77. After Plaintiffs filed their response to Wells Fargo’s motion, but before Wells Fargo filed its reply to Plaintiffs’ response, Professor Amy B. Monahan, an unrelated third party, filed a motion seeking leave to file a brief of amicus curiae, ECF No. 86, and a proposed amicus brief, ECF No. 88-1, in support of Plaintiffs’ opposition to Wells Fargo’s motion.

³ In analyzing the Original Plaintiffs’ claims under 29 U.S.C. § 1132(a)(3) in the first dismissal order, the Court stated that “much of the retrospective equitable relief Plaintiffs request bears the characteristics of monetary or compensatory relief” and that such relief is “not available” under that provision, relying upon case law from multiple circuits, including the Eighth Circuit, and the Supreme Court. See ECF No. 57 at 27–28. The cases on which the Court relied, however, were decided before the Supreme Court’s decision in *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), which held that equitable remedies that are monetary or compensatory in nature “fall within the scope of the term ‘appropriate equitable relief’” under Section 1132(a)(3). *Id.* at 442; see also *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 724 (8th Cir. 2014) (acknowledging that “*Amara* changed the law” as the Eighth Circuit “had previously interpreted it” pertaining to equitable remedies available in ERISA cases). Although that portion of the first dismissal order was not exclusively (or even primarily) the basis for the Court’s conclusion that the Original Plaintiffs lacked standing to pursue their Section 1132(a)(3) claims, see ECF No. 57 at 25–28, the Court acknowledges its error.

ANALYSIS

Wells Fargo challenges Plaintiffs’ standing under Federal Rule of Civil Procedure 12(b)(1) and the sufficiency of their pleadings under Rule 12(b)(6). *See generally* ECF No. 79. Article III standing is a jurisdictional issue and, accordingly, “is the threshold question in every federal case.” *Becker v. N.D. Univ. Sys.*, 112 F.4th 592, 595 (8th Cir. 2024) (quoting *Warth v. Seldin*, 422 U.S. 490, 498 (1975)); *see Carlsen v. GameStop, Inc.*, 833 F.3d 903, 908 (8th Cir. 2016) (citation omitted) (“[I]f a plaintiff lacks standing to sue, the district court has no subject-matter jurisdiction.”). The Court therefore must address whether Plaintiffs have demonstrated standing before it may consider whether they have stated plausible claims for relief. *See Brownback v. King*, 592 U.S. 209, 218 (2021).

As discussed above, the Court dismissed the initial complaint in this matter for lack of standing. *See* ECF No. 57 at 12–28. Upon careful consideration of the allegations in the amended complaint and the parties’ arguments, the Court concludes that Plaintiffs have not remedied the deficiencies identified in the Court’s previous order and dismisses the amended complaint for lack of standing.

I. Legal Standard

Article III of the U.S. Constitution “restricts federal courts to the resolution of cases and controversies.” *Davis v. FEC*, 554 U.S. 724, 732 (2008). “For there to be a case or controversy under Article III, the plaintiff must have a ‘personal stake’ in the case—in other words, standing.” *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021) (citation omitted). To demonstrate standing, a plaintiff must plausibly allege: (1) they suffered an injury in fact; (2) the injury is fairly traceable to the defendant’s conduct; and (3) the injury

is likely to be redressed by a favorable judicial decision. *Arc of Iowa v. Reynolds*, 94 F.4th 707, 710 (8th Cir. 2024) (citing *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016)). To establish a cognizable injury, the plaintiff “must show that he or she suffered ‘an invasion of a legally protected interest’ that is ‘concrete and particularized’ and ‘actual or imminent, not conjectural or hypothetical.’” *Scott v. UnitedHealth Grp., Inc.*, 540 F. Supp. 3d 857, 861 (D. Minn. 2021) (quoting *Spokeo*, 578 U.S. at 339). Plaintiffs, as the parties invoking federal court jurisdiction, bear the burden of establishing these elements, *Spokeo*, 578 U.S. 338, and they must do so “for each claim that they press and for each form of relief that they seek,” *TransUnion*, 594 U.S. at 431.

Because standing implicates a court’s subject-matter jurisdiction, challenges to a plaintiff’s standing are analyzed under Federal Rule of Civil Procedure 12(b)(1). *Mekhail v. N. Mem’l Health Care*, 726 F. Supp. 3d 916, 931 (D. Minn. 2024). The Court’s analysis under Rule 12(b)(1) depends on whether the challenger raises a “facial” or “factual” attack. *Scott*, 540 F. Supp. 3d at 861. In a facial challenge, the Court “restricts itself to the face of the pleadings” and “the non-moving party receives the same protections as it would defending against a motion brought under Rule 12(b)(6).” *Osborn v. United States*, 918 F.2d 724, 729 n.6 (8th Cir. 1990). By contrast, in a factual challenge, the Court “considers matters outside the pleadings.” *Id.* Here, the Court need not look further than the amended complaint and the Plan documents submitted by Wells Fargo, which are “necessarily embraced by the complaint.” *Rossi v. Arch Ins. Co.*, 60 F.4th 1189, 1193 (8th Cir. 2023) (citation omitted). And because “documents ‘necessarily embraced by the complaint’ are not matters outside the pleading,” *Enervations, Inc. v. Minn. Mining & Mfg.*

Co., 380 F.3d 1066, 1069 (8th Cir. 2004) (citations omitted), the Court construes Wells Fargo’s motion as a facial challenge to Plaintiffs’ standing and applies the standard for reviewing motions to dismiss under Rule 12(b)(6), *see Osborn*, 918 F.2d at 729 n.6.

The Court accepts the factual allegations in the amended complaint as true and draws all reasonable inferences in Plaintiffs’ favor. *Gorog*, 760 F.3d at 792. The Court will not, however, give the benefit of “unreasonable inferences,” *Brown v. Medtronic, Inc.*, 628 F.3d 451, 461 (8th Cir. 2010), and is “not bound to accept as true a legal conclusion couched as a factual allegation,” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citation omitted). Although the amended complaint need not contain “detailed factual allegations,” it must contain facts with enough specificity to state a claim that is “plausible on its face” and to “raise a right to relief above the speculative level.” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555, 570 (2007).

II. Plaintiffs’ Expert Report and Amicus Brief in Support of Plaintiffs

Before turning to the specific issues raised in Wells Fargo’s motion to dismiss, the Court first will address whether, and to what extent, it considers Plaintiffs’ expert report and Professor Monahan’s proposed amicus brief. Wells Fargo asks the Court to disregard or to accord little weight to both filings. *See* ECF No. 79 at 21–22; ECF No. 91 at 13–14.

Beginning with Plaintiffs’ expert report, the Court applies the standard for assessing motions under Federal Rule of Civil Procedure 12(b)(6) to Wells Fargo’s motion for the reasons discussed above, so the Court considers the factual information in Plaintiffs’ expert report to the extent it is alleged in the amended complaint. *See* ECF No. 64 ¶¶ 263–70; *see also Rossi*, 60 F.4th at 1193 (citation omitted) (explaining that courts deciding a Rule 12(b)

motion may consider “documents whose contents are alleged in a complaint”). The Court accords no weight, however, to the expert report’s conclusory opinions. *See Lerner v. Nw. Biotherapeutics*, 273 F. Supp. 3d 573, 590 (D. Md. 2017) (“Plaintiffs may not substitute factual allegations with the speculation of their expert witness.”); *In re MannKind Sec. Actions*, 835 F. Supp. 2d 797, 820 (C.D. Cal. 2011) (citation omitted) (“Conclusory allegations and speculation carry no additional weight merely because a plaintiff placed them within the affidavit of a retained expert.”); *see also Fin. Acquisition Partners LP v. Blackwell*, 440 F.3d 278, 285–86 (5th Cir. 2006) (noting that considering an expert opinion for purposes of a Rule 12(b)(6) motion “might require ruling on the expert’s qualifications,” which is “inappropriate at the pleading stage”).

As for Professor Monahan’s proposed amicus brief, “[t]here is no formal rule governing the standard by which to evaluate whether to grant a motion requesting leave to file an amicus curiae brief,” and the decision whether to grant or refuse leave is a matter committed to the Court’s discretion. *Larson v. Allina Health Sys.*, No. 17-cv-3835 (SRN/TNL), 2020 WL 583082, at *2 (D. Minn. Feb. 6, 2020). The Court has reviewed and considered the proposed amicus brief and Wells Fargo’s arguments in response to it in deciding Wells Fargo’s motion and, in its discretion, grants Professor Monahan’s motion.⁴

III. ERISA Claims

ERISA imposes “twin duties of loyalty and prudence” upon fiduciaries of ERISA-governed plans which require them “to act ‘solely in the interest of [plan] participants and

⁴ The Court considers the proposed brief (ECF No. 88-1) to be properly filed. Professor Monahan need not re-file her proposed brief as a “final” version.

beneficiaries’ and to carry out their duties ‘with the care, skill, prudence, and diligence under the circumstances then prevailing’ that a prudent [person] ‘acting in a like capacity and familiar with such matters would use.’” *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 595 (8th Cir. 2009) (first alteration in original) (quoting 29 U.S.C. § 1104(a)(1)). In the first dismissal order, the Court noted the “decisive importance” to the standing analysis of determining whether the Plan is a defined-benefit or defined-contribution plan:

A defined-benefit plan is “in the nature of a contract.” [*Thole v. U.S. Bank N.A.* (“*Thole II*”), 590 U.S. 538, 542–43 (2020)]. Such plans are typically “funded by employer or employee contributions, or a combination of both,” and consist of “a general pool of assets rather than individual dedicated accounts.” *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 439 (1999); see *Scott*, 540 F. Supp. 3d at 862. . . . Defined-contribution plans, by contrast, “provide[] for an individual account for each participant and for benefits based solely upon the amount contributed to the participant’s account, and any income, expenses, gains and losses.” *Scott*, 540 F. Supp. 3d at 862 (quoting 29 U.S.C. § 1002(34)).

The key difference, as courts have explained, is that “in a defined-contribution plan, such as a 401(k) plan, the [participants’] benefits are typically tied to the value of their accounts,” *Thole II*, 590 U.S. at 540, while “benefits under a defined-benefit plan ‘do not fluctuate with the value of the plan or because of the plan fiduciaries’ good or bad investment decisions,” *Scott*, 540 F. Supp. 3d at 862 (quoting *Thole II*, 590 U.S. at 540); see also *Thole II*, 590 U.S. at 543 (“The plan participants’ benefits are fixed and will not change, regardless of how well or poorly the plan is managed.”). Thus, “a necessary predicate to a participant bringing broader claims on behalf of [a defined-benefit] plan is a showing of a concrete and particularized injury to the participant herself,” not just the plan, and that individual harm must “affect [the participant’s] benefits” to confer standing to sue. *Scott*, 540 F. Supp. 3d at 865; see also *Thole II*, 590 U.S. at 542–43.

ECF No. 57 at 14–15. The Court concluded that the Plan is “closely analogous to the defined-benefit plan at issue in *Thole [II]*” because Plaintiffs were (or are) “entitled to their contractually defined benefits regardless of the value of the [Plan’s] assets.” *Id.* at 15

(alterations in original) (quoting *Scott*, 540 F. Supp. 3d at 864). Plaintiffs do not dispute—and, if anything, tacitly accept—this conclusion, *see* ECF No. 85 at 45, and the Court sees no reason to depart from it now.⁵

Under Section 1132(a)(2), a plan participant may seek only the relief provided by 29 U.S.C. § 1109. 29 U.S.C. § 1132(a)(2). Section 1109, in turn, provides that plan fiduciaries found to have breached their duties “shall be personally liable to make good to

⁵ Professor Monahan contends that because “welfare plans,” like the Plan, are not “pension plans,” they “are not subject to the legal distinctions between ‘defined benefit’ and ‘defined contribution’ plans that were central to the Supreme Court’s analysis” in *Thole II*. ECF No. 88-1 at 4. It certainly is true that welfare plans are distinct from pension plans in several respects. *See Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 579–80 (3d Cir. 2024). Even so, Professor Monahan’s attempt to avoid the import of *Thole II* is unpersuasive.

Although welfare plans do not fall neatly into the defined-benefit or defined-contribution categories, this Court and other courts have concluded that welfare plans like the Plan are “closely analogous to the defined-benefit plan at issue” in *Thole II*. ECF No. 57 at 15 (quoting *Scott*, 540 F. Supp. 3d at 864); *see Smith v. Med. Benefit Adm’rs Grp., Inc.*, 639 F.3d 277, 283 (7th Cir. 2011) (“The plan at issue here . . . is a group health insurance plan, which is the kind of defined benefit plan that . . . typically holds no assets in trust for any individual participant.”); *see also Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 528 (9th Cir. 2023) (“Although the Tech Benefits Program is not a defined-benefit pension plan, it similarly provides a fixed set of benefits as promised in plan documents.”).

Professor Monahan argues that “the better analogy is to section 401(k) plan fee litigation.” ECF No. 88-1 at 8. But those kinds of cases typically involve defined-contribution plans; indeed, despite contending that the Plan is not subject to the legal distinctions between defined-benefit and defined-contribution plans, the individual cases on which Professor Monahan relies involved defined-contribution retirement plans. *See Hughes v. Nw. Univ.*, 595 U.S. 170, 173 (2022) (involving “two retirement plans” that were “defined-contribution plans”); *Davis v. Wash. Univ. in St. Louis*, 960 F.3d 478, 481 (8th Cir. 2020) (involving a “retirement-savings plan[]” that was “a defined-contribution plan”); *Larson v. Allina Health Sys.*, 350 F. Supp. 3d 780, 788 (D. Minn. 2018) (involving “403(b) and 401(k) Plans” that were “defined contribution plans”). For the reasons discussed in Part III.B of the Analysis, these kinds of cases are distinguishable and inapplicable—and not merely because they involve defined-contribution plans.

[the] plan any losses . . . resulting from each such breach, and to restore to [the] plan any profits . . . which have been made through use of assets of the plan.” 29 U.S.C. § 1109(a). A Section 1132(a)(2) plaintiff “acts ‘in a representative capacity on behalf of the plan as a whole,’ because § 1109 is designed to ‘protect the entire plan,’” and relief under Section 1132(a)(2) therefore must “inure[] to the be benefit of the plan as a whole.” *Pilger v. Sweeney*, 725 F.3d 922, 926 (8th Cir. 2013) (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140, 142, 142 n.9 (1985)); *see* 29 U.S.C. § 1109(a). And when a defined-benefit plan is at issue, Section 1132(a)(2) “does not provide a remedy for individual injuries distinct from plan injuries.” *Pilger*, 725 F.3d at 926 (quoting *LaRue v. DeWolff Boberg & Assocs., Inc.*, 552 U.S. 248, 256 (2008)).

By contrast, a participant who brings a claim under Section 1132(a)(3) may seek “to enjoin any act or practice which violates” ERISA or “to obtain other appropriate equitable relief” to redress a violation for which Section 1132 otherwise does not provide an adequate remedy. 29 U.S.C. § 1132(a)(3); *see Varity Corp. v. Howe*, 516 U.S. 489, 510–12 (1996) (describing Section 1132(a)(3) as a “‘catchall’ provision[]” which offers “relief for injuries caused by violations that [Section 1132] does not elsewhere adequately remedy”). Such equitable relief may include surcharge—that is, individual “monetary compensation for a loss resulting from a [fiduciary’s] breach of duty.” *CIGNA Corp. v. Amara*, 563 U.S. 421, 441 (2011) (internal quotation marks omitted) (citation omitted).

Whether a plan participant proceeds under Section 1132(a)(2) or (a)(3), “[t]here is no ERISA exception to Article III.” *Thole II*, 590 U.S. at 547. Accordingly, to recover for breach of fiduciary duty under ERISA, the participant “must show actual injury,” both

individually and to the plan. *Thole v. U.S. Bank, Nat’l Ass’n*, 873 F.3d 617, 630 (8th Cir. 2017); *see Amara*, 563 U.S. at 444 (holding that relief under Section 1132(a)(3) is available “only upon a showing of actual harm” caused by a fiduciary’s breach of duty).

Plaintiffs present the same theory of standing now as they did initially: (1) Plaintiffs individually were injured by paying higher contributions for their insurance coverage and out-of-pocket costs for their prescription drugs than they should have, and the Plan was injured by Wells Fargo causing it to pay inflated prices for prescription drugs and excessive administrative fees; (2) those injuries are traceable to Wells Fargo’s purported fiduciary breaches, namely Wells Fargo’s failure to closely monitor the Plan’s prescription drug costs and to negotiate a better deal with ESI; and (3) the injuries will be redressed and prevented from recurring by the relief Plaintiffs seek. *See* ECF No. 85 at 17–32. As discussed below, despite the supplemented factual allegations in Plaintiffs’ amended complaint, their theory of standing—whether premised on higher contributions or increased out-of-pocket costs—still falls short for essentially the same reasons the Court previously identified: “their alleged harm is speculative and, ultimately, not redressable.” ECF No. 57 at 12.

A. Participant Contributions

“Of critical importance” to the Court’s analysis in the first dismissal order was that the Plan vests Wells Fargo with “sole discretion” to set participant contribution rates. ECF No. 57 at 20 (quoting ECF No. 31-3 at 9); *see also* ECF No. 31-2 at 22. Not only that, but participant contribution amounts “may be affected by several factors having nothing to do with prescription drug benefits, like whether a participant uses tobacco, whether a participant obtains coverage for her spouse or children in addition to herself, and a

participants’ ‘compensation category.’” ECF No. 57 at 20–21 (quoting ECF No. 31-3 at 9). The Court noted that “the Plan authorizes Wells Fargo to require participants to fund *all* Plan expenses, not just expenses related to their own individual benefits,” but the Plan does not require *any* contribution from Wells Fargo, “notwithstanding that Wells Fargo supplied the bulk of Plan funding during the relevant period.” ECF No. 57 at 21; *see* ECF No. 31-2 at 22 (providing that “[p]articipants *shall be* responsible for payment of applicable premiums and contributions to the Plan,” but that Wells Fargo “*may* pay such contributions to the Plan” (emphasis added)). Finally, the Court observed that “Plaintiffs’ selective allegations regarding the markups on a subset of prescription drugs in the Plan’s formulary” represented “only a subset of the total benefits whose costs Plan participants’ contributions may be used to cover” were “not sufficient to establish a causal connection between Plaintiffs’ increased costs and ESI’s administrative fees.” ECF No. 57 at 22. As a result, the Court concluded that “it is speculative that the allegedly excessive fees” or allegedly higher prices for prescription drugs paid by the Plan to ESI “had any effect at all on Plaintiffs’ contribution rates.” *Id.* at 21 (internal quotation marks omitted) (citation omitted).

Nothing in Plaintiffs’ amended complaint meaningfully addresses, much less cures, these issues. As an initial matter, Plaintiffs “d[o] not allege that they were denied any health benefits promised under the Plan, nor d[o] they allege that the Plan was insolvent or otherwise incapable of continuing to provide covered health benefits.” *Gonzales de Fuente v. Preferred Home Care of N.Y. LLC*, 858 F. App’x 432, 434 (2d Cir. 2021). Instead, they assert that had Wells Fargo negotiated a better deal with ESI or retained a different PBM

altogether, the Plan’s spending would have decreased, which necessarily would have reduced the amount they were required to pay in contributions. *See* ECF No. 85 at 12–15. But “these allegations are general in nature and do not solve the variable of [Wells Fargo’s] discretion in setting employee contribution rates.” *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 524 (9th Cir. 2023).

Plaintiffs rely heavily on their allegation that “Wells Fargo intentionally set participant contributions at 25–26% of overall Plan health care costs,” ECF No. 85 at 23 (quoting ECF No. 64 ¶ 240), which “inherently cause[s]” participant contributions to “rise and fall in lockstep with Plan spending,” *id.* This is superficially seductive. It seems possible that if the price of drugs from the PBM goes down, the participants’ contributions would go down by the same amount. But this gets precisely at the core of the problem with Plaintiffs’ theory: Plaintiffs’ contributions are used to cover *overall* Plan expenses, not specifically or exclusively their prescription drug benefits or ESI’s administrative fees. It is not a one-to-one relationship. And the Plan documents clearly show that “participant contribution amounts may be affected by several factors having nothing to do with prescription drug benefits.” ECF No. 57 at 20–21. As the Court explained before, “[t]here are simply too many variables in how Plan participants’ contribution rates are calculated” to infer that Wells Fargo’s payments to ESI for prescription drug payments or administrative fees were the but-for cause of any increases in Plaintiffs’ required contributions. *Id.* at 22; *see Winsor*, 62 F.4th at 524–25 (holding plaintiffs failed to plead injury-in-fact because their allegation that the employer set contributions “based on overall premium costs” was not plausible given the employer’s “broad discretion” to set employee

contribution rates, which were calculated based on “various factors and discussion” rather than “a specific formula or set of factors”); *see also Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 574, 581–82 (3d Cir. 2024) (holding it was “speculative” that the employer’s “alleged misappropriation of drug rebate money,” which plan documents provided were to be applied to plan expenses, “resulted in Plaintiffs paying more for their health insurance or had any effect at all”); *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 457 (3d Cir. 2003) (concluding that whether plan savings would pass to plan participants was “too speculative to serve as the basis for a claim of individual loss”).

Further, there is no plausible allegation in the amended complaint to suggest that this exercise of Wells Fargo’s total discretion to set participant contribution rates violates the terms of the Plan. *See Gonzalez de Fuente*, 858 F. App’x at 433–34 (quoting *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 101 (2013)) (“ERISA . . . requires fiduciaries to discharge their duties ‘in accordance with the documents and instruments governing the plan’ rather than any particular accounting formula.”). The Court previously noted that it does not read *Thole II* “to hold, as a matter of law, that a plaintiff suing a fiduciary of an ERISA-governed defined-benefit health plan cannot ever establish standing on a theory of harm premised on excessive . . . costs.” ECF No. 57 at 19. But that reading of *Thole II* is contingent upon there being some specific underlying misconduct—for example, “breaching the terms of the plan[],” *id.*—that can be plausibly connected to the purported harm. There are no allegations from which the Court can infer such misconduct occurred here, much less that it was the but-for cause of Plaintiffs’ alleged injury. *See Knudsen*,

117 F.4th at 581–82; *cf. McCutchen*, 569 U.S. at 100 (explaining that ERISA protects “contractually defined benefits”).

The addition of McKinley as a Plaintiff does not change the analysis. It is true that McKinley’s status as a current Plan participant would make certain prospective relief available to her that would not be available to the Original Plaintiffs—assuming, of course, that she could demonstrate a cognizable injury. *See* ECF No. 85 at 21; ECF No. 57 at 26–27. To that point, Plaintiffs emphasize that because McKinley is a participant in the Plan through COBRA, she is required to pay “both the employer share and the employee share” of premium contributions, ECF No. 64 ¶ 18, which must “be based on total plan expenses,” ECF No. 85 at 22 (first citing ECF No. 64 ¶ 258; and then citing 29 U.S.C. § 1164(2)). But that fact does not move the needle here given the discretion the Plan confers on Wells Fargo to set contribution amounts. What is of critical importance here, again, is that the Plan “vests Wells Fargo with ‘sole discretion’ to set participant contribution rates.” ECF No. 57 at 20. And the Plan documents permit Wells Fargo to require *all* Plan participants—not just those who, like McKinley, are participants through COBRA—to pay contributions sufficient to cover *all* Plan expenses, with no requirement that Wells Fargo make any contributions. *See* ECF No. 31-2 at 22. If Wells Fargo exercised its discretion in this manner and chose to cease its own contributions, that would almost assuredly increase participant contributions, but it would not, by itself, constitute a violation of ERISA. *See Gonzalez de Fuente*, 858 F. App’x at 433–34; *Knudsen*, 117 F.4th at 582. Further, Plaintiffs do not dispute that McKinley’s contributions were calculated based on estimated Plan expenses as required by COBRA. *See* 42 U.S.C. § 1164(2). Plaintiffs instead merely

speculate that a decrease in the Plan’s prescription drug expenses or ESI’s administrative fees necessarily would have resulted in lower contributions. This again overlooks that the Plan’s overall expenses account for more than those specific line items and that participant contributions are “affected by several factors having nothing to do with prescription drug benefits.” ECF No. 57 at 20–21. As with the others, McKinley cannot show “actual or imminent injury to the Plan itself” that causes injury to her interests in the Plan to establish standing. *Id.* at 26 (citation omitted). And there is no allegation that McKinley did not get all the benefits to which she was entitled. *See* ECF No. 64 ¶ 228; *see also Scott*, 540 F. Supp. 3d at 862 (finding ERISA plaintiffs had not demonstrated injury because they did “not allege that they have been denied any benefits to which they are entitled”).

Finally, Plaintiffs’ theory of redressability does not demonstrate that “it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.” *Friends of the Earth, Inc. v. Laidlaw Env’t Servs. (TOC), Inc.*, 528 U.S. 167, 180–81 (2000). As noted, Plaintiffs contend that Plan expenses necessarily would have been reduced and that they consequently would have been required to pay less in contributions if Wells Fargo had negotiated a better deal with ESI or retained a different PBM. *See* ECF No. 85 at 12–15. But as the Court already explained, Plaintiffs’ argument “assumes that Wells Fargo would maintain the 75-25 employer-employee contribution ratio” even though “nothing in the Plan *requires* Wells Fargo to do so.” ECF No. 57 at 23; *cf. Pendleton v. QuikTrip Corp.*, 567 F.3d 988, 993 (8th Cir. 2009) (“Whether an employee is entitled to benefits under ERISA is controlled by the plan documents and not the customs of a company.”). Plaintiffs dismiss this reasoning as “legally irrelevant,” ECF No. 85 at 29, but they do not “explain

how a court could place [Wells Fargo's or ESI's] ill-gotten profits directly into plaintiffs' pockets when plaintiffs have not alleged how a court could identify the discrete profits supposedly owed to them, given [Wells Fargo's] discretion in setting employee contribution amounts and the manner in which [Wells Fargo] exercised this discretion," *Winsor*, 62 F.4th at 526 (internal quotation marks omitted). Nor do Plaintiffs advance any persuasive argument that ERISA authorizes the Court to order Wells Fargo to lower participant contribution amounts prospectively when the Plan's terms give Wells Fargo the exclusive authority to set those amounts.⁶ And even if the Court ordered Wells Fargo to remit a one-time payment to the Plan to remedy any purported past overcharges, nothing would prevent Wells Fargo from "offset[ing] its own contributions" going forward "while making no reduction to the contributions it require[s]" from Plaintiffs. *Id.* at 527; *see also Horvath*, 333 F.3d at 457.

For these reasons, the Court concludes that Plaintiffs' allegations relating to excessive participant contributions are too speculative and conjectural to confer standing.

B. Out-of-Pocket Costs

Plaintiffs' theory of standing as it pertains to out-of-pocket costs fails for essentially the same reasons, but it presents additional issues worth addressing. Plaintiffs' theory is rooted in their assertion that they were required to pay higher prices for certain prescriptions than pharmacies paid, on average, to acquire those drugs. *See* ECF No. 64

⁶ Although reformation is an available remedy in equity, it has traditionally been "used to prevent fraud." *Amara*, 563 U.S. at 440. Plaintiffs raise no allegations of fraud or that Wells Fargo (or ESI, for that matter) provided "false or misleading information" relating to the Plan. *Id.*

¶¶ 220, 222, 224, 226, 228. While these allegedly excessive costs are more readily quantifiable, Plaintiffs’ argument is, in effect, another way of asserting injury on the basis that Plaintiffs “might have received” better or different benefits than what they were promised under the Plan’s terms, which is insufficient to confer standing. *See Gonzalez de Fuente*, 858 F. App’x at 433–34; *cf. Burgio & Campofelice, Inc. v. N.Y. State Dep’t of Lab.*, 107 F.3d 1000, 1007 (2d Cir. 1997) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981)) (“Under ERISA, ‘private parties, not the Government, control the level of benefits.’”). Again, Plaintiffs do not allege that they did not receive the benefits to which they were entitled under the Plan or that the Plan was ever at risk of insolvency or inability to provide participant benefits. *See Gonzalez de Fuente*, 858 F. App’x at 434; *Scott*, 540 F. Supp. 3d at 862. This is important because, as already discussed, the Plan is “closely analogous” to a defined-benefit plan in which “participants are entitled to their *contractually defined* benefits regardless of the value of the [Plan’s] assets.” *Scott*, 540 F. Supp. 3d at 864 (emphasis added); *see Thole II*, 590 U.S. at 542–43. There is no allegation that Plaintiffs’ benefits were ever diminished or that they were required to pay more than they were promised or what is authorized by the Plan’s terms. *See Scott*, 540 F. Supp. 3d at 863; *see also Gonzalez de Fuente*, 858 F. App’x at 433–34; *cf. McCutchen*, 569 U.S. at 100 (explaining that ERISA protects “contractually defined benefits”).

The cases on which Plaintiffs rely are distinguishable either because they involved defined-contribution plans, were later abandoned, or did not involve ERISA claims. For instance, Plaintiffs rely on *Braden v. Wal-Mart Stores* to support their argument that the allegedly excessive prices they were required to pay for certain prescription drugs

constitute a cognizable injury. ECF No. 85 at 19. In that case, the Eighth Circuit held that the plaintiff, a participant with an individual investment account in his employer’s defined-contribution 401(k) plan, had standing under ERISA to sue for breach of fiduciary duty because of his employer’s alleged mismanagement of the plan, including allegations that the plan fiduciaries agreed to pay excessive fees to a third-party service provider and failed to wield the plan’s “substantial bargaining power” to secure more favorable and cost-effective benefits. *See Braden*, 588 F.3d at 589–90, 592. The crucial distinction, however, is that the plaintiff in *Braden* alleged that his employer’s mismanagement resulted in losses both to the plan itself and to the value of his specific, individual investment account—that is, one of his benefits under the plan. *See id.* Plaintiffs here do not allege that their *benefits* under the Plan were diminished; they allege only that they and the Plan should have paid less for those benefits. *See* ECF No. 64 ¶¶ 220, 222, 224, 226, 228. Even assuming as true that the Plan’s assets diminished because of Wells Fargo’s alleged mismanagement and overpayments to ESI, that would constitute an injury only to the Plan, not to Plaintiffs, because Plaintiffs “do not have any claim” to the Plan’s assets. *Scott*, 540 F. Supp. 3d at 863; *see Jacobson*, 525 U.S. at 439–40 (explaining that a defined-benefit plan “consists of a general pool of assets” and that “no plan member has a claim to any particular asset that composes a part of the plan’s general asset pool”). Instead, Plaintiffs’ “only claim is to receive the benefits to which they are entitled” under the Plan, *Scott*, 540 F. Supp. 3d at 863, and Plaintiffs do not dispute that they received their benefits, *see* ECF No. 64 ¶¶ 219–28.

Plaintiffs also rely on *Lewandowski v. Johnson & Johnson* (“*Lewandowski I*”), No. 24-cv-671 (ZNQ) (RLS), 2025 WL 288230 (D.N.J. Jan. 24, 2025), where the court was confronted with nearly identical allegations. *See id.* at *1–2. The court in that case concluded that the plaintiff had “suffered an injury-in-fact” based on her assertion that she “pa[id] higher prices for drugs” under her employer’s health plan, “causing her to pay more out-of-pocket.” *Id.* at *5; *see* ECF No. 85 at 18. That court nevertheless dismissed the plaintiff’s claim for lack of standing because it concluded her alleged injury was not redressable.⁷ *Lewandowski I*, 2025 WL 288230, at *5. After granting the plaintiff leave to amend her complaint, however, that court later dismissed her claims again for lack of standing and adopted this Court’s reasoning in the earlier dismissal order entered in this case, including as it relates to the remaining standing elements. *See Lewandowski v. Johnson & Johnson* (“*Lewandowski II*”), No. 24-cv-671 (ZNQ) (RLS), 2025 WL 3296009, at *4–7 (D.N.J. Nov. 26, 2025) (“This Court finds *Navarro* persuasive and applies that court’s reasoning.”).

Plaintiffs also cite *Blue Cross & Blue Shield of N.C. v. Rite Aid Corp.*, 519 F. Supp. 3d 522 (D. Minn. 2021), which held that the plaintiffs had alleged an injury in fact by pleading that they were “overcharged” for prescription drugs. *Id.* at 532; *see* ECF No. 85

⁷ For context, the court in *Lewandowski I* found the plaintiff’s injury was not redressable because she had “reached her prescription drug cap for each year she assert[ed]” in her complaint. 2025 WL 288230, at *5. As a result, the court concluded that even if the defendants “were to reimburse [her] for her out-of-pocket costs on a given drug—that is, the higher amount of money she spent as a result of Defendants’ breaches—that money would be owed to her insurance carrier to reimburse it for its expenditures on *other* drugs that same year.” *Id.*

at 18. But that case is inapposite because it did not involve ERISA in any way; rather, it dealt with allegations by various insurance companies that a retail pharmacy company “fraudulently inflated” the prices for certain prescription drugs. *Blue Cross & Blue Shield*, 519 F. Supp. 3d at 532. As a result, the insurance companies allegedly paid more for those drugs than the amount the insurance companies should have paid based on a formula the parties had contractually negotiated. *Id.* Plaintiffs here raise no allegations of fraud or that Wells Fargo and ESI calculated the Plan’s drug prices using a method that was not authorized or disclosed by the Plan.

To be sure, the price comparisons alleged in Plaintiffs’ complaint are staggering. *See* ECF No. 64 ¶¶ 125–37, 140–43. But it fundamentally cannot be the case that participants in a plan like the one at issue here are injured any time the contractually defined benefits to which they are entitled are available at lower cost to non-participants, absent any express promise by the plan fiduciary to provide those benefits at that lower cost or any specific allegations that the fiduciary’s misconduct diminished those benefits or rendered the plan unable to provide them. *See Scott*, 540 F. Supp. 3d at 863–65; *Gonzalez de Fuente*, 858 F. App’x at 434. That is, at bottom, the premise upon which Plaintiffs’ allegations rest but “pleadings must be something more than an ingenious academic exercise in the conceivable” to meet the Article III standing threshold. *United States v. Students Challenging Regul. Agency Procs.*, 412 U.S. 669, 688 (1973); *see also Iqbal*, 556 U.S. at 678 (quoting *Twombly*, 550 U.S. at 557) (“Where a complaint pleads facts that are ‘merely consistent with’ a defendant’s liability, it ‘stops short of the line between possibility and plausibility of entitlement to relief.’” (internal quotation marks omitted))).

As a result, the Court concludes that Plaintiffs’ allegations are insufficient to confer standing, and their amended complaint is dismissed.⁸ *See Lewandowski II*, 2025 WL 3296009, at *6–7; *Knudsen*, 117 F.4th at 582 (holding that pleadings rooted in speculation and conjecture “are not sufficient to support Article III standing”).

ORDER

Based on the foregoing, and on all the files, records, and proceedings in this matter, **IT IS HEREBY ORDERED** that:

1. Professor Amy B. Monahan’s Motion for Leave to File a Brief of Amicus Curiae (ECF No. 86) is **GRANTED**;
2. Wells Fargo’s Motion to Dismiss the Amended Class Action Complaint (ECF No. 77) is **GRANTED**; and
3. Plaintiffs’ Amended Complaint (ECF No. 64) is **DISMISSED** for lack of jurisdiction.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: March 3, 2026

s/Laura M. Provinzino

Laura M. Provinzino
United States District Judge

⁸ Because the Court dismisses Plaintiffs’ amended complaint for lack of standing, the Court need not address Wells Fargo’s alternative basis for dismissal under Rule 12(b)(6). *See Brownback*, 592 U.S. at 218 (quoting *Steel Co. v. Citizens for a Better Env’t*, 523 U.S. 83, 101–02 (1998)) (“[A] court cannot issue a ruling on the merits ‘when it has no jurisdiction’ because ‘to do so is, by very definition, for a court to act ultra vires.’”).

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

SERGIO NAVARRO, THERESA
GAMAGE, DAYLE BULLA, and
JANE KINSELLA, *on their own
behalf, and on behalf of all others
similarly situated, and on behalf of the
Wells Fargo & Company Health Plan
and its component plans,*

Case No. 24-cv-3043 (LMP/DTS)

Plaintiffs,

**ORDER GRANTING DEFENDANT'S
MOTION TO DISMISS**

v.

WELLS FARGO & COMPANY,¹
MICHAEL BRANCA, MARK
HICKMAN, DREW WINELAND,
DAVID GALLOREESE, BEI LING,
and DOES 1–20,

Defendants.

Kai H. Richter and Eleanor E. Frisch, **Cohen Milstein Sellers & Toll, PLLC, Minneapolis, MN**; Michelle C. Yau and Allison Pienta, **Cohen Milstein Sellers & Toll, PLLC, Washington, DC**; Michael B. Eisenkraft, **Cohen Milstein Sellers & Toll, PLLC, New York, NY**; Jamie Crooks and Michael D. Lieberman, **Fairmark Partners, LLP, Washington, DC**; and Daniel E. Gustafson and Amanda M. Williams, **Gustafson Gluek PLLC, Minneapolis, MN**, for Plaintiffs.

Russell L. Hirschhorn, Joseph E. Clark, and Sydney L. Juliano, **Proskauer Rose LLP, New York, NY**; and Jeffrey P. Justman, and Kiera Murphy, **Faegre Drinker Biddle & Reath LLP, Minneapolis, MN**, for Defendants.

¹ Wells Fargo & Company agreed to assume responsibility for “all acts or omissions relating to the allegations and claims in this action” and for “any judgment entered in this action,” and Plaintiffs agreed to dismiss all claims asserted against all defendants without prejudice except Wells Fargo. ECF No. 27 ¶¶ 2–4. Accordingly, the Court herein refers to Wells Fargo & Company as the Defendant in this case.

Plaintiffs Sergio Navarro, Theresa Gamage, Dayle Bulla, and Jane Kinsella (collectively, “Plaintiffs”) are former employees of Defendant Wells Fargo & Company (“Wells Fargo”), and former participants in the Wells Fargo & Company Health Plan (the “Plan”). Plaintiffs allege that Wells Fargo mismanaged the Plan’s employee prescription drug benefits program, resulting in Plaintiffs and other Plan participants paying substantially more in premiums and out-of-pocket costs for certain prescription drug benefits than they would have absent Wells Fargo’s mismanagement. Plaintiffs contend this mismanagement constitutes a breach of Wells Fargo’s fiduciary duties to Plan participants in violation of the Employee Retirement Income Security Act (“ERISA”). Wells Fargo moves to dismiss Plaintiffs’ complaint for lack of Article III standing or, alternatively, for failure to state a claim upon which relief can be granted. Because Plaintiffs are unable to show concrete individual harm, causation, and redressability, the Court finds that Plaintiffs lack standing to bring their claims.

FACTUAL BACKGROUND²

I. The Plan

The Plan is an employee welfare benefit plan³ established to provide medical benefits to Wells Fargo employees who choose to enroll. *See* ECF No. 1 ¶ 20. Wells Fargo,

² For purposes of assessing Wells Fargo’s motion to dismiss, the Court must accept the factual allegations in Plaintiffs’ complaint as true. *L.H. v. Indep. Sch. Dist.*, 111 F.4th 886, 892 (8th Cir. 2024). As such, the Factual Background here is drawn largely from the complaint.

³ As relevant here, an “employee welfare benefit plan” is “any plan, fund, or program which was . . . established or maintained by an employer . . . for the purpose of providing

as the Plan sponsor and a fiduciary of the Plan, is responsible for appointing and removing the individual administrators of the Plan, among whom are several Wells Fargo executives. *Id.* ¶ 22–23. As such, Wells Fargo retains decision-making authority with respect to the management of the Plan. *Id.* Plaintiffs are each former employees of Wells Fargo and former participants⁴ in the Plan. *Id.* ¶¶ 14–17.

To cover the expenses incurred in administering benefits to Plan participants, Wells Fargo established the Wells Fargo & Company Employee Benefit Trust (the “Trust”). *Id.* ¶ 21. The Trust is funded by a combination of employer and employee contributions, along with unspecified amounts of investment income. *Id.* From 2018 to 2022, Wells Fargo consistently required participants to contribute, in the form of premiums, approximately 25% of the Plan’s costs annually, with Wells Fargo contributing the remaining 75%. *Id.* ¶ 206. Wells Fargo nevertheless retains “sole discretion” to set and modify participant contribution amounts. ECF No. 31-3 at 9; *see also* ECF No. 31-2 at 22 (“The Plan Sponsor may establish different contribution rates for different classes of Participants . . . for any Benefit Option.”). The Trust’s funds, regardless of their source, are considered assets of the Plan. ECF No. 1 ¶ 21.

for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.” 29 U.S.C. § 1002(1).

⁴ A “participant” is “any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer.” 29 U.S.C. § 1002(7).

II. The Plan’s Prescription Drug Program

A. Pharmacy Benefit Managers Generally

Many employer-sponsored prescription drug plans, including the Plan, retain third-party service providers called pharmacy benefit managers (“PBMs”) to administer the plans’ prescription drug benefits. *Id.* ¶ 52. PBMs handle the day-to-day administrative tasks for a plan’s prescription drug program, like processing claims, and typically offer other services like negotiating with pharmacies to establish coverage networks and determining which prescription drugs a plan will cover (and the extent to which they are covered). *Id.* ¶¶ 52–53. Generally, when a plan participant is prescribed a drug and fills that prescription at a pharmacy, the participant pays the portion for which she is responsible—like her co-pay or deductible—and the PBM pays the pharmacy the remaining balance and is later reimbursed by the Plan. *Id.* ¶ 53. The overall price of the prescription drug is negotiated by the PBM and the plan fiduciaries, *id.* ¶ 56, while the portion for which the participant is responsible is typically dictated by the terms of the plan, *see, e.g., id.* ¶ 97.

PBMs are typically for-profit entities, and the largest PBMs tend to be publicly traded companies. *Id.* ¶ 54. As such, two dominant PBM models have emerged: (1) “traditional” PBMs, which generate profit through some mix of spread pricing,⁵ rebates

⁵ “Spread pricing” is a practice whereby a PBM negotiates a price with pharmacies for a particular prescription drug that is lower than the price the PBM charges the plan for that drug, then retains the difference as profit. ECF No. 1 ¶ 62. For example, if a PBM negotiates a price of \$10 for a participant’s prescription with the pharmacy, it may (if its

they negotiate with pharmacies, administrative fees charged to the plans they serve, and ownership of their own pharmacies; and (2) “pass-through” PBMs that generate profit through charging administrative fees alone. *Id.* ¶¶ 54–55. According to Plaintiffs, traditional PBMs are incentivized, to some degree, to charge the highest price to which a plan’s administrators will agree for prescription drugs, regardless of the price pharmacies charge the PBM for the same drugs. *Id.* ¶ 65. Plaintiffs assert that traditional PBMs that own their own pharmacies also may be able to represent to plans that they are not engaging in spread pricing which, while technically true, could be misleading since they are effectively negotiating with themselves for pricing. *See id.* ¶ 69. In other words, a PBM-owned pharmacy may quote an artificially high price for a certain drug to the PBM, and the PBM may then represent that it is charging the same price to the plans it serves—that is, with no markup—but the effect is that the plans pay a higher price for the drug, and the PBM generates a windfall. *See id.*

Traditional PBMs and plan fiduciaries negotiate the prices that the plan will pay the PBM for various prescription drugs. *Id.* ¶ 56. Given the sheer volume of prescription drugs available today, however, it would be impractical for PBMs and plan fiduciaries to negotiate pricing for each drug individually, so some PBMs and plan fiduciaries structure their agreements to create formularies⁶ that set prices for groups of drugs by reference to

agreement with the plan at issue permits) charge the plan \$15 for that prescription and retain the \$5 difference. *See id.*

⁶ A “formulary,” in this context, is a list of prescription drugs that a health plan agrees to cover. *See Formulary*, Black’s Law Dictionary (12th ed. 2024).

an external benchmark price. *See id.* ¶ 57. Such benchmarks include the National Average Drug Acquisition Cost (“NADAC”), which is generated by the Centers for Medicare and Medicaid Services using survey data to determine the average cost to pharmacies to acquire certain prescription drugs; and the Average Wholesale Price (“AWP”), which purports to do the same thing as NADAC, but which Plaintiffs allege is inaccurate and susceptible to industry manipulation. *Id.* ¶¶ 58–59.

B. Wells Fargo’s Agreement with Express Scripts, Inc.

Wells Fargo entered an agreement with Express Scripts, Inc. (“ESI”), a traditional PBM, to serve as the Plan’s PBM. *Id.* ¶ 100. ESI, along with CVS Caremark and OptumRx, is one of the “Big 3” PBMs. *Id.* ¶ 86. Wells Fargo did not conduct an open bid process before it decided to retain ESI. *Id.* ¶ 101. Rather, Wells Fargo engaged an employee benefit consultant to identify potential PBM candidates for the Plan. *See id.* ¶ 103. The agreement between Wells Fargo and ESI is not publicly available, but ESI’s standard contract with other companies and plans typically spells out various terms regarding prescription drug pricing, formulary management, pharmacy networks, and administrative services. *Id.* ¶¶ 100, 104. ESI’s standard contract also makes clear that plan sponsors and fiduciaries like Wells Fargo, not ESI, have final authority over decisions relating to plan management and assets. *Id.* ¶ 102.⁷

⁷ Wells Fargo does not dispute the substance of Plaintiffs’ allegations regarding the details of its agreement with ESI.

The Plan’s formulary includes a list of approximately 300 generic drugs that are designated as “preferred alternatives,” meaning participants are encouraged to use those generic versions rather than the brand-name versions. *See id.* ¶ 108. The prices ESI negotiated with the Plan for those drugs, using AWP as a benchmark—rather than NADAC, for example—are substantially higher than the acquisition costs paid by pharmacies. *See id.* ¶¶ 105, 108–09. A comparison between the pharmacy acquisition cost for the 260 “preferred alternative” drugs for which NADAC information is available shows that, on average, ESI charges the Plan more than twice as much as what pharmacies paid to acquire those “preferred alternative” drugs. *Id.* ¶ 109.

The agreement between ESI and the Plan requires Plan participants to acquire so-called “generic-specialty” drugs exclusively from ESI’s wholly owned pharmacy, Accredo. *Id.* ¶ 112. For example, abiraterone acetate, a prescription drug used to treat prostate cancer, is designated as a “generic-specialty” drug in the Plan’s formulary and has an average pharmacy acquisition cost of \$82.80 for a ninety-count prescription. *See id.* ¶ 116. Under the terms of Wells Fargo’s agreement with ESI, however, ESI charges the Plan \$1,881.00 for the same prescription, more than a 2,100% markup over the acquisition cost. *Id.* A Plan participant would be required to pay the full cost for that prescription—that is, \$1,881.00—out of pocket until the participant met his annual deductible. *Id.* ¶ 33. By contrast, an uninsured person filling the same prescription could obtain it from various retail pharmacies for between \$90.50 and \$115.30. *Id.* ¶ 117.

The administrative fees ESI charges to the Plan exceed the fees paid by other large plan sponsors for seemingly comparable or equivalent services. *Id.* ¶ 141. In 2019, the

Plan had about 218,000 participants and paid about \$9.2 million in administrative fees to ESI, or roughly \$42 per participant. *See id.* ¶¶ 140, 205. Just three years later, despite the Plan’s enrollment decreasing to about 189,000 participants in 2022, the Plan paid about \$25.6 million in administrative fees—about \$136 per participant. *Id.* ¶ 141. Wells Fargo acknowledges that the services offered by the Plan were unchanged throughout this period. ECF No. 30 at 26 n.11. For comparison, the Railroad Employees National Health and Welfare Plan, for which ESI is the PBM, paid roughly \$4.25 million in administrative fees for its 214,000 participants in 2022, or about \$20 per participant. ECF No. 1 ¶ 141.

III. Plaintiffs Allege Breach of Fiduciary Duty

While they were enrolled in the Plan, Plaintiffs each paid premiums, co-pays, and out-of-pocket costs related to prescription drugs they purchased under the Plan’s coverage. *See id.* ¶¶ 196–203. Plaintiffs allege that these costs were excessive and that a prudent plan fiduciary would have carefully monitored those costs and taken action to keep them reasonable. *E.g., id.* ¶¶ 223–24. According to Plaintiffs, Wells Fargo could or should have wielded its substantial bargaining power, derived from the size of the Plan, to negotiate better terms, *id.* ¶¶ 8–10; conducted a more diligent and thorough search through an open bidding process for a PBM which may have resulted in a better deal, *id.* ¶ 11; steered participants toward lower-cost alternatives to Accredo for generic-specialty drugs, *see id.* ¶ 10; or retained a PBM structured under a different model, like a pass-through PBM, *id.* ¶¶ 10, 223–24.

Plaintiffs bring claims on behalf of the Plan under 29 U.S.C. § 1132(a)(2), and individually and on behalf of a putative class of Plan participants under both 29 U.S.C.

§ 1132(a)(2) and (a)(3). *Id.* ¶¶ 221–46. Plaintiffs allege that Wells Fargo’s failure to monitor costs or to proactively seek ways to keep them low constitutes a breach of Wells Fargo’s fiduciary duties under 29 U.S.C. § 1104(a). *See id.* ¶¶ 221–32. Plaintiffs also allege that Wells Fargo breached its fiduciary duties by causing the Plan to engage in prohibited transactions with ESI, a party in interest under ERISA. *See id.* ¶¶ 233–46. Plaintiffs assert that the compensation, including the administrative fees, Wells Fargo agreed to pay ESI was unreasonable, resulting in increased premiums and out-of-pocket costs to Plaintiffs and other Plan participants and losses to the Plan generally. *Id.* ¶¶ 238, 245. Plaintiffs seek various forms of monetary and equitable relief, including recovery of losses to the Plan, restitution, disgorgement, surcharge, and permanent injunctive relief such as removal of the current Plan fiduciaries, replacement of ESI as the Plan’s PBM, and appointment of an independent Plan fiduciary. *Id.* ¶¶ 226, 232.

Wells Fargo denies Plaintiffs’ allegations and moves to dismiss Plaintiffs’ complaint in its entirety under Federal Rule of Civil Procedure 12(b)(1) for lack of standing or, in the alternative, for failure to state a claim upon which relief may be granted under Rule 12(b)(6). ECF No. 28; ECF No. 30 at 1–3.

ANALYSIS

I. Legal Standard

Challenges to a plaintiff’s Article III standing implicate the court’s subject matter jurisdiction and thus are analyzed under Federal Rule of Civil Procedure 12(b)(1). *Mekhail v. N. Mem’l Health Care*, 726 F. Supp. 3d 916, 931 (D. Minn. 2024). A defendant may raise either a “facial” or a “factual” challenge to a court’s jurisdiction under Rule 12(b)(1).

Scott v. UnitedHealth Grp., Inc., 540 F. Supp. 3d 857, 861 (D. Minn. 2021). On a facial challenge “the court restricts itself to the face of the pleadings” and “the non-moving party receives the same protections as it would defending against a motion brought under Rule 12(b)(6).” *Osborn v. United States*, 918 F.2d 724, 729 n.6 (8th Cir. 1990). By contrast, “[i]n a factual attack, the court considers matters outside the pleadings.” *Id.*

Wells Fargo raises a facial challenge to Plaintiffs’ standing, so the Court applies the standard for reviewing motions to dismiss under Rule 12(b)(6).⁸ *See Osborn*, 918 F.2d at 729 n.6. In reviewing such motions, “the court must accept all factual allegations in the complaint as true and draw all inferences in the plaintiff’s favor.” *L.H. v. Indep. Sch. Dist.*, 111 F.4th 886, 892 (8th Cir. 2024) (internal quotation marks omitted) (citation omitted). However, “the Court will not give the plaintiff the benefit of unreasonable inferences . . . and is not bound to accept as true a legal conclusion couched as a factual allegation.” *Harris v. Medtronic Inc.*, 729 F. Supp. 3d 869, 877 (D. Minn. 2024) (internal quotation marks omitted) (citations omitted). To overcome a motion to dismiss, a complaint must contain “enough facts to state a claim to relief that is plausible on its face.” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). A complaint need not contain “detailed factual

⁸ Generally, courts may not consider matters outside the pleadings on a motion to dismiss under Rule 12(b)(6). *Enervations, Inc. v. Minn. Mining & Mfg. Co.*, 380 F.3d 1066, 1069 (8th Cir. 2004). However, a court may consider documents that are “necessarily embraced by the complaint,” including documents “whose contents are alleged in a complaint and whose authenticity no party questions, but which are not physically attached to the pleadings.” *Rossi v. Arch Ins. Co.*, 60 F.4th 1189, 1193 (8th Cir. 2023) (citation omitted). Here, the Court need not look further than the pleadings and the Plan documents submitted by Wells Fargo, which are “necessarily embraced by the complaint,” and thus the Court construes Wells Fargo’s motion as a facial attack on Plaintiffs’ standing. *See id.*

allegations,” but it must contain facts with enough specificity “to raise a right to relief above the speculative level.” *Id.* at 555.

II. Article III Standing

“Standing to sue under Article III ‘is the threshold question in every federal case because it determines the power of the court to entertain the suit.’” *Becker v. N.D. Univ. Sys.*, 112 F.4th 592, 595 (8th Cir. 2024) (cleaned up) (quoting *Warth v. Seldin*, 422 U.S. 490, 498 (1975)). To establish standing, Plaintiffs must plead facts showing they have (1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision. *Arc of Iowa v. Reynolds*, 94 F.4th 707, 710 (8th Cir. 2024) (citing *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016)). “Plaintiffs, as the parties invoking federal court jurisdiction, bear the burden of establishing these elements.” *Id.* And “standing is not dispensed in gross,” so Plaintiffs “must demonstrate standing for each claim that they press and for each form of relief that they seek.” *TransUnion LLC v. Ramirez*, 594 U.S. 413, 431 (2021).

To establish injury in fact, a plaintiff “must show that he or she suffered ‘an invasion of a legally protected interest’ that is ‘concrete and particularized’ and ‘actual or imminent, not conjectural or hypothetical.’” *Scott*, 540 F. Supp. 3d at 861 (quoting *Spokeo*, 578 U.S. at 339). Whether a plaintiff has shown injury-in-fact “often turns on the nature and source of the claim asserted.” *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 591 (8th Cir. 2009) (quoting *Warth*, 422 U.S. at 500). This typically means, practically speaking, that “a plaintiff’s standing tracks his cause of action. That is, the question whether he has a cognizable injury sufficient to confer standing is closely bound up with the question of

whether and how the law will grant him relief.” *Id.* But “[i]t is crucial . . . not to conflate Article III’s requirement of injury in fact with a plaintiff’s potential causes of action, for the concepts are not coextensive.” *Turtle Island Foods, SPC v. Thompson*, 992 F.3d 694, 699 (8th Cir. 2021) (citation omitted).

Plaintiffs’ theory of standing is fairly straightforward: (1) Plaintiffs individually were harmed in the form of high out-of-pocket costs and increased monthly premiums for their healthcare coverage, and the Plan was harmed by Wells Fargo causing it to pay excessive fees to ESI; (2) both harms are traceable to Wells Fargo’s purported breaches of fiduciary duty; and (3) the relief Plaintiffs request will both redress the past harms and prevent them from recurring. *See* ECF No. 38 at 9. In challenging Plaintiffs’ pleadings, Wells Fargo largely attacks Plaintiffs’ alleged harm as insufficient to confer standing and asserts that, to the extent Plaintiffs’ harm qualifies as injury-in-fact, the relief Plaintiffs request would not redress it. *See* ECF No. 30 at 9–20.

The Court agrees with Plaintiffs—in theory—that the individual harm they allege could constitute injury-in-fact for standing purposes. But on the actual facts Plaintiffs allege, these Plaintiffs cannot satisfy Article III’s standing requirements because their alleged harm is speculative and, ultimately, not redressable.

A. Breach of Fiduciary Duty Under ERISA

Plaintiffs bring claims under both 29 U.S.C. § 1132(a)(2) and (a)(3). Section 1132(a)(2) provides that a plan participant may bring a civil action “for appropriate relief under section 1109 of this title.” 29 U.S.C. § 1132(a)(2). Section 1109, in turn, makes fiduciaries of an ERISA-governed plan personally liable for breaches of “any of the

responsibilities, obligations, or duties imposed upon fiduciaries” by ERISA. *Id.* § 1109(a). Among the duties ERISA imposes are the duties to act “solely in the interest of the participants and beneficiaries” of the plan, and to act “with the care, skill, prudence, and diligence” of a prudent person “acting in a like capacity and familiar with such matters.” *Id.* § 1104(a)(1). Fiduciaries are also prohibited from causing a plan to engage in certain transactions with a “party in interest.” *Id.* § 1106(a)–(b). ERISA fiduciaries found liable for breach of fiduciary duty can be required to “make good” any losses to the plan that results from a breach of fiduciary duty, and to “restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary.” *Id.* § 1109(a). Section 1109 also empowers courts to award “such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.” *Id.*

Section 1132(a)(3), meanwhile, provides that a plan participant may bring a civil action to enjoin a plan fiduciary from engaging in any act that violates ERISA or the terms of the plan at issue, or to obtain other equitable relief redressing such violations or enforcing the provisions of ERISA or the terms of the plan. *Id.* § 1132(a)(3). In other words, Section 1132(a)(3) “is a ‘catch-all’ provision that ‘act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that [§ 1132] does not elsewhere adequately remedy.’” *Thole v. U.S. Bank, Nat’l Ass’n* (“*Thole I*”), 873 F.3d 617, 629 (8th Cir. 2017) (alterations in original) (quoting *Soehnlen v. Fleet Owners Ins. Fund*, 844 F.3d 576, 583 (6th Cir. 2016)), *aff’d sub nom. Thole v. U.S. Bank N.A.*, 590 U.S. 538 (2020).

Whether claims are brought under Section 1132(a)(2) or (a)(3), “[t]here is no ERISA exception to Article III.” *Thole v. U.S. Bank N.A.* (“*Thole II*”), 590 U.S. 538, 547 (2020). Thus, “the plaintiffs must show actual injury . . . to fall within the class of plaintiffs whom Congress has authorized to sue under [ERISA].” *Thole I*, 873 F.3d at 630.

1. Claims Under 29 U.S.C. § 1132(a)(2) (Counts I and III)

Key to the standing analysis is whether Plaintiffs have pleaded a concrete and particularized injury that can be remedied by this Court. In the context of Plaintiffs’ allegations here, whether Plaintiffs have established standing requires the Court first to determine whether the Plan is a defined-benefit or a defined-contribution plan. *See Thole II*, 590 U.S. at 540 (explaining the “decisive importance” that the plan at issue was a “defined-benefit” plan, as opposed to a “defined-contribution” plan). A defined-benefit plan is “in the nature of a contract.” *Thole II*, 590 U.S. at 542–43. Such plans are typically “funded by employer or employee contributions, or a combination of both,” and consist of “a general pool of assets rather than individual dedicated accounts.” *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 439 (1999); *see Scott*, 540 F. Supp. 3d at 862. “The structure of a defined benefit plan reflects the risk borne by the employer. Given the employer’s obligation to make up any shortfall, no plan member has a claim to any particular asset that composes a part of the plan’s general asset pool.” *Hughes Aircraft*, 525 U.S. at 440. Defined-contribution plans, by contrast, “provide[] for an individual account for each participant and for benefits based solely upon the amount contributed to the participant’s account, and any income, expenses, gains and losses.” *Scott*, 540 F. Supp. 3d at 862 (quoting 29 U.S.C. § 1002(34)).

The key difference, as courts have explained, is that “in a defined-contribution plan, such as a 401(k) plan, the [participants’] benefits are typically tied to the value of their accounts,” *Thole II*, 590 U.S. at 540, while “benefits under a defined-benefit plan ‘do not fluctuate with the value of the plan or because of the plan fiduciaries’ good or bad investment decisions,” *Scott*, 540 F. Supp. 3d at 862 (quoting *Thole II*, 590 U.S. at 540); *see also Thole II*, 590 U.S. at 543 (“The plan participants’ benefits are fixed and will not change, regardless of how well or poorly the plan is managed.”). Thus, “a necessary predicate to a participant bringing broader claims on behalf of [a defined-benefit] plan is a showing of a concrete and particularized injury to the participant herself,” not just the plan, and that individual harm must “affect [the participant’s] benefits” to confer standing to sue. *Scott*, 540 F. Supp. 3d at 865; *see also Thole II*, 590 U.S. at 542–43.

The Plan in this case is “closely analogous to the defined-benefit plan at issue in *Thole [II]*, as participants are entitled to their contractually defined benefits regardless of the value of the [Plan’s] assets.” *Scott*, 540 F. Supp. 3d at 864. In *Scott*, the plaintiffs were participants in a defined-benefit health plan administered by UnitedHealth Group (“UHG”). *Id.* The plaintiffs challenged UHG’s practice of “cross-plan offsetting,” whereby UHG used assets of the plaintiffs’ plan to recoup alleged overpayments made by a different UHG plan in which the plaintiffs were not participants. *See id.* at 859–60. The plaintiffs alleged that this cross-plan offsetting constituted harm to the plan and a breach of UHG’s fiduciary duties under ERISA. *Id.* at 861. As to their individual harm, the plaintiffs asserted that UHG “misus[ed] their payroll contributions” and “caus[ed] them financial injury” when it used the plaintiffs’ plan’s assets to cover another plan’s losses. *Id.*

at 862. The court rejected the plaintiffs’ argument, explaining that the plaintiffs relinquished any individual interest in their contributions once those contributions became part of the plan’s “general pool of assets,” and that “[a] diminution of those assets [did] not affect plaintiffs’ entitlement to benefits in any way and therefore [did] not cause plaintiffs any injury.” *Id.* (citation omitted). The court, citing *Thole II*, ultimately concluded that “an injury to a plan that does not affect a plaintiff’s benefits does not give that plaintiff standing to sue on behalf of the plan.” *Id.* at 865.

Wells Fargo relies on *Scott* to assert that Plaintiffs do not plead a concrete injury sufficient to confer standing. Specifically, Wells Fargo emphasizes that Plaintiffs have not alleged that they did not receive all the benefits to which they were entitled while they were members of the Plan. *See* ECF No. 30 at 10–12. But while instructive, *Scott* is distinguishable from the facts and allegations in this case. In *Scott*, the plaintiffs’ theory of individual harm was premised on their allegations that the plan at issue mismanaged plan assets, including the plaintiffs’ contributions, but that argument was expressly foreclosed by the Supreme Court’s decision in *Thole II*. *See Scott*, 540 F. Supp. 3d at 862–63. The *Scott* plaintiffs did not specifically allege that the contributions they were required to pay were excessive, as Plaintiffs do here. And the *Scott* court was explicit that the plaintiffs in that case lacked standing because they had only alleged the defendants’ breaches of fiduciary duty “caused injury to the *plan*—and not injury to [the] *plaintiffs themselves*.” *Id.* at 861. Importantly, the *Scott* court did not reach the issue of whether “additional or replacement contributions” could satisfy the injury-in-fact requirement for Article III

purposes because the *Scott* plaintiffs “[did] not allege that they personally had to make” such contributions. *See id.* at 863 n.4.

Plaintiffs here avoid that pitfall—at least to some extent. They assert that the contributions and out-of-pocket costs they were required to pay under the Plan’s terms were excessively high given Wells Fargo’s alleged breaches of fiduciary duty. *See, e.g.*, ECF No. 1 ¶ 208. Unlike the *Scott* plaintiffs, Plaintiffs here do not premise their theory of individual harm *solely* on Wells Fargo’s purported misuse of participant contributions after Plaintiffs relinquished any legal interest in them. And the hypothetical “additional or replacement contributions” discussed in *Scott* are analogous to the excessive contributions Plaintiffs allege here. *See id.* (“[Plaintiffs] paid more in premiums than they would have paid absent [Wells Fargo’s] fiduciary breaches.”).

A more recent Third Circuit case on which Plaintiffs rely, *Knudsen v. MetLife Group, Inc.*, provides a closer analogy. 117 F.4th 570 (3d Cir. 2024). There, the plaintiffs were participants in an employee-sponsored defined-benefit health plan that retained a PBM—coincidentally, ESI—to manage its prescription-drug benefits. *Id.* at 573–74. As part of that agreement, ESI negotiated volume discounts and rebates with drug manufacturers, and under the plan’s terms, MetLife was to apply those rebates toward plan expenses. *Id.* at 574. The plaintiffs alleged that MetLife directed the rebates to itself instead and that they would have received “multiple benefits,” including lower contributions and out-of-pocket costs, had MetLife applied the rebates to plan expenses. *Id.* at 574–75. Citing *Thole II*, MetLife argued, and the district court agreed, that “a beneficiary of an ERISA regulated defined-benefit plan has no injury unless the plan participants plead that they did not

receive promised benefits . . . or that there is a substantial likelihood that the plan will default.” *Id.* at 579.

On appeal, the *Knudsen* plaintiffs convincingly distinguished the employee-sponsored health plan in their case with the pension plan at issue in *Thole II*:

[Plaintiffs] point out that benefits in pension plans accrue over years, and once earned, the benefits, i.e., pension payments, are fixed and paid at regular intervals. In contrast, participants in a self-funded health plan pay for their benefits through payroll deductions in the form of premiums, and the plan sponsor can annually change both the amount of the premium (and other out-of-pocket costs) and the benefits to which a participant is entitled.

Id. The Third Circuit agreed with the plaintiffs as a “purely theoretical proposition”:

[W]e decline to hold that *Thole [II]* . . . require[s] dismissal, under Article III, *whenever* a participant in a self-funded healthcare plan brings an ERISA suit alleging that mismanagement of plan assets increased his/her out-of-pocket expenses. While MetLife is correct that sponsors of self-funded health insurance plans, like pension plans, bear all the risk of distributing benefits to beneficiaries, we cannot ignore a more fundamental tenet of injury-in-fact: financial harm, even if only a few pennies, is a concrete, non-speculative injury. A contrary conclusion, would mean that MetLife could charge Plan participants thousands of dollars more in premiums than is allowed under Plan documents, resulting in potential ERISA violations, and Plan participants would have no judicial recourse to seek return of their overpayments. *Thole [II]* . . . command[s] no such result, and in a different case, a plaintiff may well establish such a financial injury sufficient to satisfy Article III.

Id. at 579–80 (citations omitted). Still, despite its theoretical agreement with the plaintiffs’ argument, the Third Circuit concluded that the plaintiffs had not alleged concrete financial harm because “it is speculative that MetLife’s alleged misappropriation of drug rebate money resulted in Plaintiffs paying more for their health insurance or had any effect at all.”

Id. at 582.

The Court agrees with the Third Circuit’s “purely theoretical proposition” in *Knudsen*. *Thole II* controls this case, as it controlled in *Scott*, 540 F. Supp. 3d at 862. But the Court does not read *Thole II* to hold, as a matter of law, that a plaintiff suing a fiduciary of an ERISA-governed defined-benefit health plan cannot ever establish standing on a theory of harm premised on excessive out-of-pocket costs. As the *Knudsen* court explained, such a conclusion would lead to absurd results where fiduciaries of defined-benefit plans could flagrantly violate ERISA, up to and including plainly breaching the terms of the plans they serve, while effectively enjoying immunity from any liability so long as participants receive the benefits to which they are entitled. Such an outcome would frustrate ERISA’s core purpose: to “protect contractually defined benefits.” *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100 (2013) (citation omitted); *see also, e.g., Boggs v. Boggs*, 520 U.S. 833, 845 (1997) (“The principal object of [ERISA] is to protect plan participants and beneficiaries.”). And more broadly, it would undermine the well-established principle that “[f]or standing purposes, a loss of even a small amount of money is ordinarily an ‘injury.’” *Demarais v. Gurstel Chargo, P.A.*, 869 F.3d 685, 693 (8th Cir. 2017) (quoting *Czyzewski v. Jevic Holding Corp.*, 580 U.S. 451, 464 (2017)); *cf. Thole II*, 590 U.S. at 547 (“There is no ERISA exception to Article III.”).

Unfortunately for Plaintiffs, that is not the end of this Court’s agreement with the *Knudsen* court, and the Third Circuit’s theoretical proposition runs aground when confronted with the facts alleged here, just as it did there. The underlying argument Plaintiffs advance, while different in the specifics, is essentially the same as in *Knudsen*: had Wells Fargo more closely monitored the Plan’s prescription drug costs and negotiated

a better deal with ESI, replaced ESI with a different PBM,⁹ or adopted a different model altogether, the Plan would have paid less in administrative fees and other compensation to ESI, which would have resulted in lower participant contributions and out-of-pocket costs. Plaintiffs’ theory appears tempting at first blush, but it withers upon closer scrutiny.

To begin, the connection between what Plan participants were required to pay in contributions and out-of-pocket costs, and the administrative fees the Plan was required to pay ESI, is tenuous at best. Of critical importance here is that the Plan vests Wells Fargo with “sole discretion” to set participant contribution rates. ECF No. 31-3 at 9; *see also* ECF No. 31-2 at 22. The Plan’s terms are clear that participant contribution amounts may be affected by several factors having nothing to do with prescription drug benefits, like

⁹ On this point, the Court struggles to see how Wells Fargo selecting ESI as the Plan’s PBM could form a basis for a claim of breach of fiduciary duty under ERISA on the facts alleged here. Plaintiffs themselves acknowledge that ESI is one of the “Big 3” PBMs. *See* ECF No. 1 ¶ 86. Even if Wells Fargo had conducted an “open RFP process,” as Plaintiffs insist it should have, *id.* ¶ 82, it appears quite plausible that Wells Fargo still would have selected ESI—as many other companies evidently have, *see id.* ¶ 86—leaving Plaintiffs in precisely the same situation. Further, Plaintiffs do not offer any meaningful or relevant comparison between ESI and the other two of the “Big 3” PBMs—CVS Caremark and OptumRx. *See id.* Plaintiffs allege that other large companies generally “use the specialty carve-out model for their prescription-drug plans,” which purportedly “offer[s] substantial savings to plans and their participants,” and cite two specific companies who implemented such carve-outs in their agreements with CVS Caremark and OptumRx. *Id.* ¶ 90. But these allegations, even accepted as true, are missing critical information. Plaintiffs do not allege facts regarding the relative size and scope of those companies’ plans or explain how much those companies’ plans saved by implementing those carve-outs. Indeed, Plaintiffs do not clearly or specifically allege that the carve-outs reduced those plan participants’ contributions or out-of-pocket costs *at all*. Nor do Plaintiffs offer specific facts relating to *why* those companies chose to implement carve-outs. Ultimately, Plaintiffs’ allegation that such a carve-out in Wells Fargo’s agreement with ESI necessarily would have resulted in lower contributions and out-of-pocket costs is speculative and conclusory.

whether a participant uses tobacco, whether a participant obtains coverage for her spouse or children in addition to herself, and a participant’s “compensation category.” ECF No. 31-3 at 9. And notwithstanding that Wells Fargo supplied the bulk of Plan funding during the relevant period, *see* ECF No. 30 at 4 n.1, the Plan authorizes Wells Fargo to require participants to fund *all* Plan expenses, not just expenses related to their own individual benefits. *See* ECF No. 31-2 at 22 (emphasis added) (providing that “[p]articipants *shall* be responsible for payment of applicable premiums and contributions to the Plan,” but that “[Wells Fargo] *may* pay such contributions to the Plan”); ECF No. 31-2 at 22 (emphasis added) (“*All fees and expenses* incurred in connection with the operation and administration of the Plan *may be paid out of the Trust or any other Plan asset . . .*”).

Taken together, it is speculative that the allegedly excessive fees the Plan paid to ESI “had any effect at all” on Plaintiffs’ contribution rates and out-of-pocket costs for prescriptions. *Knudsen*, 117 F.4th at 582. And Plaintiffs’ attempts to establish a direct connection between their increased costs and the increases in administrative fees paid by the Plan to ESI are unconvincing. For example, Plaintiffs offer comparisons between the purchase prices for certain prescription drugs under the Plan vis-à-vis the prices an uninsured person would pay at retail pharmacies for the same prescriptions or the acquisition costs paid by the pharmacies to obtain those drugs. *See* ECF No. 1 ¶¶ 114–31. But as Wells Fargo notes, those comparisons relate to only 260 of the drugs in the Plan’s formulary, a relatively narrow subset of the “thousands” of drugs in the Plan’s full formulary. ECF No. 30 at 7. And a Plan participant is only responsible for the full out-of-

pocket costs for prescription drugs—whether “preferred alternative,” “generic-specialty,” or otherwise—until the participant meets their annual deductible, after which the Plan covers most of the costs for that participant’s prescription drugs for the remainder of the year. *See* ECF No. 1 ¶ 33. Plaintiffs’ selective allegations regarding the markups on a subset of prescription drugs in the Plan’s formulary, ECF No. 1 ¶¶ 108–31, which itself represents only a subset of the total benefits whose costs Plan participants’ contributions may be used to cover, ECF No. 31-2 at 22, are not sufficient to establish a causal connection between Plaintiffs’ increased costs and ESI’s administrative fees. There are simply too many variables in how Plan participants’ contribution rates are calculated to make the inferential leaps necessary to elevate Plaintiffs’ allegations from merely speculative to plausible. *See Harris*, 729 F. Supp. 3d at 877.

Knudsen is instructive on this point as well. There, the plaintiffs asserted they would have received “multiple benefits” had the defendant not breached its fiduciary duties:

First, it may have been consistent with its fiduciary duties for [MetLife] to reduce ongoing contributions on account of the rebates collected by the Plan. *Second*, [MetLife] may have . . . reduced co-pays and co-insurance for pharmaceutical benefits. *Third*, [MetLife] may have distributed rebates to participants in proportion to their contributions to the Plan.

Knudsen, 117 F.4th at 582 (alterations in original). The Third Circuit was not convinced, reasoning that “[t]hese allegations readily permit an inference that even if MetLife had not committed ERISA violations, it *may not* have taken any of these listed actions and Plaintiffs’ out-of-pocket costs would have still increased.” *Id.*

Such is the case here. Plaintiffs attempt to avoid *Knudsen*’s conclusion by substituting “may” with “would.” For instance, Plaintiffs allege that “if [Wells Fargo]

stopped causing the Plan to overspend on prescription drugs and related fees by millions of dollars each year[,] employee contributions *would* be lower as well, in order to maintain the same 75-25 split between employer and employee contributions to which [Wells Fargo has] demonstrated [its] commitment.” ECF No. 1 ¶ 207 (emphasis added); *see* ECF No. 38 at 12–13. But this argument assumes that Wells Fargo would maintain the 75-25 employer-employee contribution ratio, and nothing in the Plan *requires* Wells Fargo to do so. *See* ECF No. 31-3 at 9; ECF No. 31-2 at 22. Plaintiffs’ argument also fundamentally misses the point: if Plaintiffs prevailed in this case and received every bit of the relief they request, *see id.* ¶¶ 249–57, Wells Fargo could *still* increase Plan participants’ contribution amounts under the Plan’s terms without any violation of ERISA having occurred. Merely changing “may” to “would” is a semantic sleight of hand that does not make the proposition any more certain or its conclusion any less speculative.¹⁰ *See Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 457 (3d Cir. 2003) (concluding that whether plan savings would have passed to plan participants was “too speculative to serve as the basis for a claim of individual loss”).

Plaintiffs also seem to suggest this Court could alter the terms of the Plan to expressly require Wells Fargo to reduce (or even maintain) participants’ contribution amounts, but the Court is not convinced. The Court is unaware of any mechanism by which

¹⁰ In fact, *Knudsen* characterized the plaintiffs’ allegations in exactly the way Plaintiffs here framed their allegations: “According to Plaintiffs, they *would have* received ‘multiple benefits’ if MetLife had not misallocated drug rebates[.]” *Knudsen*, 117 F.4th at 582 (emphasis added).

it could force Wells Fargo to reduce participant contribution rates. Nor have Plaintiffs identified one.¹¹ Whether “surcharge, restitution, or other make-whole equitable relief,” “[r]emoving the Plan’s fiduciary” and “appointing an independent fiduciary,” “[r]emoving and replacing the Plan’s PBM and/or requiring a search for [an] alternative PBM,” or injunctive relief, ECF No. 1 ¶¶ 251–54, Plaintiffs’ theory of redressability stumbles on the same obstacle: Wells Fargo’s “sole discretion” to set participant contribution rates. ECF No. 31-3 at 9. Simply put, while Plaintiffs’ requested relief *could* result in lower contribution rates and out-of-pocket costs, there is no guarantee that it *would*, and “pleadings must be something more than an ingenious academic exercise in the conceivable” to meet the standing threshold. *United States v. Students Challenging Regul. Agency Procs.*, 412 U.S. 669, 688 (1973). Plaintiffs’ theory is plainly rooted in speculation and conjecture, and “[s]uch pleadings are not sufficient to support Article III standing.” *Knudsen*, 117 F.4th at 582.

While compelling and detailed, Plaintiffs’ allegations are simply too speculative to show concrete individual harm, too tenuous to show causation, and too conjectural to show

¹¹ Reformation, which Plaintiffs do not request, would ostensibly fit the bill, and it is an available remedy under Section 1132(a)(3). *Powell v. Minn. Life Ins. Co.*, 60 F.4th 1119, 1123 (8th Cir. 2023). Reformation is only appropriate, however, in instances of mistake or fraud, neither of which Plaintiffs allege here. *See, e.g., Ibson v. United Healthcare Servs., Inc.*, 877 F.3d 384, 389 (8th Cir. 2017) (alteration in original) (quoting *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 723 (8th Cir. 2014)) (“The ‘reformation remedy available under § 1132(a)(3) . . . allow[s] courts to reform contracts that failed to express the agreement of the parties.’”); *CIGNA Corp. v. Amara*, 563 U.S. 421, 440 (2011) (“The power to reform contracts (as contrasted with the power to enforce contracts as written) is a traditional power of an equity court . . . and was used to prevent fraud.”).

redressability. Accordingly, Plaintiffs lack Article III standing to sue under 29 U.S.C. § 1132(a)(2).

2. Claims Under 29 U.S.C. § 1132(a)(3) (Counts II and IV)

As even Wells Fargo concedes, Plaintiffs’ individual claims under Section 1132(a)(3) “do not suffer from” all the same issues as their representative claims on behalf of the Plan under Section 1132(a)(2).¹² ECF No. 30 at 14. Nevertheless, Plaintiffs cannot establish standing under Section 1132(a)(3) both because they have not alleged concrete individual harm and because these Plaintiffs “have no concrete stake in the lawsuit” regarding any prospective injunctive relief. *Thole II*, 590 U.S. 541–42.

Section 1132(a)(3) “allows an individual plan participant to seek equitable remedies for breach of fiduciary duty in his [or her] individual capacity.” *Knieriem v. Grp. Health Plan, Inc.*, 434 F.3d 1058, 1061 (8th Cir. 2006). Recovery under Section 1132(a)(3), however, is limited to traditional equitable remedies “such as injunctive, restitutionary, or mandamus relief.” *Id.* (quoting *Kerr v. Charles F. Vatterott & Co.*, 184 F.3d 938, 943 (8th Cir. 1999)). Importantly, Section 1132(a)(3) “does not . . . authorize appropriate equitable relief *at large*, but only appropriate equitable relief for the purpose of redressing any violations or . . . enforcing any provisions of ERISA or an ERISA plan.” *Peacock v. Thomas*, 516 U.S. 349, 353 (1996) (cleaned up) (citation omitted).

¹² Wells Fargo largely focuses its argument on the distinction between “fiduciary” and “settlor” acts, contending that the conduct Plaintiffs challenge—“setting premiums, co-pays, and deductibles”—are settlor functions that are not subject to review under ERISA. ECF No. 30 at 15–17. Wells Fargo does not “explain how this analysis goes to the Court’s standing inquiry.” *Sigetich v. Kroger Co.*, No. 1:21-cv-697, 2023 WL 2431667, at *8 (S.D. Ohio Mar. 9, 2023).

Plaintiffs must show “‘actual or imminent injury to the Plan itself’ that caused injury to the plaintiffs’ interests in the Plan” to establish standing under Section 1132(a)(3). *Thole I*, 873 F.3d at 630 (quoting *Soehnlén*, 844 F.3d at 583). The Supreme Court affirmed that approach in *Thole II*, reasoning that the plaintiffs there lacked standing because they had received all benefits to which they were entitled, and “the outcome of [the] suit would not affect their future benefit[s].” *Thole II*, 590 U.S. at 541. *Thole II* instructs that ERISA plaintiffs must “have [a] concrete stake” in the outcome of the suit, as Article III requires of plaintiffs in all cases. *Id.* at 542; *see also id.* at 547 (“There is no ERISA exception to Article III.”).

Again, *Thole II* controls here, and Plaintiffs clearly do not have a stake in any of the prospective equitable relief they request. They are no longer participants in the Plan, *see* ECF No. 1 ¶¶ 14–17, so any changes to the Plan’s structure or administration going forward—like replacing ESI as the Plan’s PBM or removing the Plan’s fiduciaries and appointing an independent fiduciary, *id.* ¶¶ 252–53—will not personally affect them in any way, much less redress the individual harm they allege. *See e.g., DeFazio v. Hollister Emp. Share Ownership Tr.*, 612 F. App’x 439, 441 (9th Cir. 2015) (“The Plan Participants, who have already cashed out of the Plan, lack Article III standing as to redressability vis-à-vis their claims for prospective equitable relief.”); *Trauernicht v. Genworth Fin. Inc.*, No. 3:22-cv-532, 2023 WL 5961651, at *6 (E.D. Va. Sept. 13, 2023) (holding former plan participants lacked standing because “any changes to the process in the future would not affect them, making their claim for prospective injunctive relief non-redressable”); *Peters v. Aetna, Inc.*, No. 1:15-cv-109-MR, 2023 WL 3829407, at *7 (W.D.N.C. June 5, 2023)

(“[T]he Plaintiff’s lack of continued participation in the Mars Plan is fatal to her standing to assert claims for prospective injunctive relief.”); *Savage v. Sutherland Glob. Servs., Inc.*, No. 6:19-cv-6840 EAW, 2024 WL 3982831, at *6 (W.D.N.Y. Aug. 28, 2024) (holding “Plaintiffs lack Article III standing to seek prospective relief” because “none of Plaintiffs are still enrolled in the Plan” and “thus are not in danger of any future injury from the selection of ADP as recordkeeper”).

As it relates to Plaintiffs’ request for non-injunctive (that is, retrospective) equitable relief, Plaintiffs do not dispute that they received all the benefits to which they were entitled when they were participants in the Plan, even if they believe they had to pay more for those benefits than they should have. *See, e.g.*, ECF No. 1 ¶¶ 196–203. And as already discussed, Plaintiffs’ allegations of individual harm are speculative at best and insufficient to establish Article III standing. Other courts have reached the same conclusion in similar circumstances—even before *Thole II* was decided. *See Cox v. Blue Cross Blue Shield of Mich.*, 216 F. Supp. 3d 820, 826 (E.D. Mich. 2016) (finding no standing to seek “restitution, disgorgement, [and] surcharge” under Section 1132(a)(3) because “[a]t most, it is Plaintiffs’ healthcare plans that suffered concrete and particularized injuries when they paid BCBSM the hidden fees” which was “not concrete or particularized harm to Plaintiffs.”). Further, much of the retrospective equitable relief Plaintiffs request bears the characteristics of monetary or compensatory relief. *See* ECF No. 1 ¶¶ 251, 254 (requesting “make-whole” and “monetary” relief). But such relief is not available under Section 1132(a)(3). *See, e.g., Kerr*, 184 F.3d at 943 (“[S]ection 1132(a)(3) recovery . . . does not extend to compensatory damages.”); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993) (holding plaintiffs could

not seek relief under Section 1132(a)(3) because their claims sought “monetary relief for all losses their plan sustained as a result of the alleged breach of fiduciary duties,” which is the “classic form of *legal* relief”); *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1076 (9th Cir. 2009) (finding no standing to sue under Section 1132(a)(3) where plaintiffs requested to be made “whole in the amounts by which their pension benefits have been reduced as a result of [fiduciary] breaches”).

Plaintiffs have no stake in the outcome of this case as it relates to the prospective equitable relief they seek. Nor can they show a concrete and particularized injury sufficient to establish standing to seek retrospective equitable relief, and some of the retrospective equitable relief they request is “foreclosed by Supreme Court precedent.” *Paulsen*, 559 F.3d at 1076; *see also Mertens*, 508 U.S. at 256. Consequently, Plaintiffs lack standing to pursue their claims under 29 U.S.C. § 1132(a)(3).¹³

CONCLUSION

The Court is not unsympathetic to Plaintiffs’ concerns. Prescription drug costs are high—even for those who are insured, as forcefully set forth in Plaintiffs’ complaint. Plaintiffs’ frustration is understandable, and this Court will not tell them otherwise.

But however sympathetic the Court may be, it cannot ignore the law. Under ERISA, as interpreted in decisions that bind this Court, Plaintiffs’ allegations are insufficient to establish Article III standing. As a result, Plaintiffs’ complaint must be dismissed.

¹³ Because the Court dismisses Plaintiffs’ complaint for lack of standing, the Court need not address Wells Fargo’s alternative basis for dismissal under Rule 12(b)(6). *See* ECF No. 30 at 20–31.

ORDER

Based on the foregoing, and on all of the files, records, and proceedings in the above-captioned matter, **IT IS HEREBY ORDERED** that:

1. Wells Fargo's Motion to Dismiss (ECF No. 28) is **GRANTED**; and
2. Plaintiffs' Complaint (ECF No. 1) is **DISMISSED WITHOUT PREJUDICE**.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: March 24, 2025

s/Laura M. Provinzino

Laura M. Provinzino
United States District Judge

UNITED STATES DISTRICT COURT
District of Minnesota

Sergio Navarro, Theresa Gamage, Dayle
Bulla, Jane Kinsella, Erica McKinley,

Plaintiffs,

v.

Wells Fargo & Company,

Defendant.

JUDGMENT IN A CIVIL CASE

Case Number: 24-cv-3043 LMP/DLM

☐ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

☒ **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED THAT:

1. Professor Amy B. Monahan's Motion for Leave to File a Brief of Amicus Curiae (ECF No. 86) is **GRANTED**;
2. Wells Fargo's Motion to Dismiss the Amended Class Action Complaint (ECF No. 77) is **GRANTED**; and
3. Plaintiffs' Amended Complaint (ECF No. 64) is **DISMISSED** for lack of jurisdiction.

Date: 3/3/2026

KATE M. FOGARTY, CLERK

CERTIFICATE OF SERVICE

The undersigned certifies that on this 26th day of June 2026, I electronically filed the foregoing Addendum with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: June 26, 2026

/s/ Kai Richter
Counsel for Plaintiffs-Appellants