UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF NEW YORK

ANNA MOHR-LERCARA, Individually and on Behalf of All Others Similarly Situated, Plaintiff, vs. OXFORD HEALTH INSURANCE, INC., OPTUM, INC., and OPTUM RX, INC., Defendants.	No. 7:18-cv-1427-VB-PD **DEFENDANTS' ANSWER TO AMENDED CLASS ACTION COMPLAINT**

Defendants Oxford Health Insurance, Inc. ("OHI"), Optum, Inc. ("Optum"), and OptumRx, Inc. ("OptumRx"), by and through counsel submit the following Answer to Plaintiff's Amended Class Action Complaint (the "Complaint"). Except as otherwise stated herein, Defendants deny each and every allegation in the Complaint. Plaintiff's Complaint contains numerous headings and sub-headings. Defendants do not consider these to be substantive allegations to which a response is required. However, to the extent that a response is required, Defendants deny any and all allegations within any such heading or sub-heading. In addition, the Complaint contains numerous footnotes, and Defendants have responded to the footnotes as part of the answer to the corresponding paragraph for each footnote.

INTRODUCTION

1. Plaintiff, who received prescription drug benefits through a group health plan issued or administered by Oxford Health Insurance Inc. (the "Plan"), brings this action on behalf of herself and a Class and Subclass of similarly situated persons alleging (a) violations of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., and (b) violations of the Racketeering Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1961, et seq., resulting from Defendants' common fraudulent and deceptive scheme to artificially inflate prescription costs causing consumers to pay more than they otherwise should have paid for medically necessary prescription drugs.

RESPONSE: In response to Paragraph 1, Defendants admit that Plaintiff is a former participant in an employer-sponsored health plan issued by OHI, and that Plaintiff purports to bring the present action as a class action and raise claims under the Employee Retirement Income Security Act of 1974 ("ERISA") and the Racketeering Influenced and Corrupt Organizations Act ("RICO"). Defendants deny the remaining allegations contained in Paragraph 1.

2. About 90% of all United States citizens are now enrolled in private or public health plans that cover some, or all, of the costs of medical and prescription drug benefits. A feature of most of these plans is the shared cost of prescription drugs. Normally, when a patient fills a prescription for a medically necessary prescription drug under his or her health care plan, the plan/insurer pays a portion of the cost and the patient pays the remaining portion of the cost directly to the pharmacy in the form of a copayment (often a set dollar amount), coinsurance (often a percentage of the cost) or deductible payment. Defendants directed the pharmacies to collect these cost-sharing payments on Defendants' behalf from patients at the time the prescription is filled and are not allowed to waive or reduce the amount collected under the Plans.

RESPONSE: Defendants lack knowledge or information sufficient to form a belief as to the truth of the allegations contained in the first three sentences of Paragraph 2 regarding unnamed individuals and such individuals' benefit plans, and on that basis, deny them. The fourth sentence of Paragraph 2 purports to characterize documents, the terms of which speak for themselves, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations to the extent they mischaracterize the documents or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 2.

3. Defendant Oxford Health Insurance, Inc. ("OHI"), provides and administers health and pharmacy benefits to patients. OHI provides these pharmacy benefits in part through Optum, Inc., and Optum Rx, Inc. (collectively, "Optum"), which is a pharmacy benefit manager ("PBM"). Optum's PBM services include, inter alia: managing a network of pharmacies that will serve as participating pharmacies at which OHI patients obtain prescriptions; working with OHI to set and dictate copayment amounts, coinsurance amounts, and deductibles (if applicable) to pharmacies; and processing prescription drug claims and interfacing with patients and pharmacies regarding applicable prescription drug coverage.

RESPONSE: In response to Paragraph 3, Defendants admit that OHI provides and administers health and pharmacy benefits to plan participants. Defendants further admit that OptumRx provides certain pharmacy benefits management services to OHI, including contracting with pharmacies to participate in networks offered to members of plans issued or administered by OHI, and that OptumRx processes certain outpatient prescription drug claims on behalf of OHI. Defendants deny the remaining allegations contained in Paragraph 3.

4. As set forth below, Defendants and their co-conspirators have engaged in a scheme to defraud patients by overcharging patients for the cost of medically necessary prescription drugs. Patients, including Plaintiff and the Class (defined below), paid excessive charges to participating pharmacies for prescription drugs. Under her Plan, Plaintiff's cost-sharing amount was limited to the amount paid to the pharmacy for prescription drugs. Unbeknownst to the Plaintiff and Class members, Defendants forced the pharmacies to misrepresent the cost-sharing amounts for prescription drugs and charge Plaintiff excessive amounts, and forced patients to pay excessive cost-sharing amounts. These excessive payments by patients were then retained by the pharmacies or "clawed back" from the pharmacies by Defendants. This is not a matter of mistaken or innocently erroneous calculations: it is a pervasive, intentional scheme to overcharge Plaintiff and everyone similarly situated in connection with their prescription drug purchases.

RESPONSE: Defendants deny the allegations contained in Paragraph 4.

5. For example, as detailed below, the express language of Plaintiff's 2011-13 Plan with OHI promised that she would not pay more for prescription drugs than Defendants' "contracted fee" with pharmacies (i.e., the amount paid to pharmacies for the covered drugs). Similarly, her 2014-2016 Plans provided that she would not pay more for prescription drugs than the "Allowed Amount," which is "the amount we have negotiated with" the pharmacies for the drugs (again, the amount paid to pharmacies for the covered drugs). Accordingly, Defendants agreed that Plaintiff and the Class would not pay more in cost-sharing than the amount paid to participating pharmacies for Plaintiff's prescription drugs.

RESPONSE: Paragraph 5 purports to characterize and partially quote documents, the terms of which speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 5 which mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 5.

6. With respect to prescription drugs received from in-network pharmacies, the relevant Plans here set limits on cost-share amounts based on the amount that the pharmacy agreed (with Defendants) to be paid for the respective prescription drug. Specifically, under the Plans, copayments and deductible payments may never be more than the amount that the provider agreed to be paid; and coinsurance payments must be a percentage of the amount that the provider agreed to be paid. Contrary to the express language of the Plans, Defendants exercised their unilateral discretion to require network pharmacies to charge Plaintiff and the Class unauthorized and excessive cost-sharing amounts for prescription drugs that were not based on the amount paid to the pharmacies ("Overcharges"), ***sometimes overcharging Plaintiff by more than 250%***.

RESPONSE: Paragraph 6 purports to characterize plan documents, the terms of which speak for themselves, and thus no response is required. To the extent that a response is required, Defendants deny the allegations contained in Paragraph 6 which mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 6.

7. Moreover, Defendants profited from their scheme by "clawing back" some or all of these Overcharges by requiring the pharmacies to pay the Overcharges to Defendants after the pharmacies collected them from Plaintiff and the Class or by paying less than they would have had they followed the Plans.

RESPONSE: Defendants deny the allegations contained in Paragraph 7.

8. For example, on October 30, 2015, Defendants unilaterally determined that Plaintiff had to pay a $15 copayment to a pharmacy to purchase a prescription drug and required the pharmacy to collect this amount from the patient. Unknown to Plaintiff, the $15 copayment Defendants required the pharmacy to collect from her was ***250% more than the contracted fee*** the pharmacy was paid to fill the prescription. Specifically, Defendants' contract with the pharmacy provided that the pharmacy would be paid only $4.19 for the prescription. But, Defendants unilaterally directed and required the pharmacy to charge and collect the $15 copayment from Plaintiff, thereby forcing Plaintiff to pay not only $4.19 contracted cost of the drug, but an additional $10.81. When, like in this example, the cost-share ($15) exceeds the amount paid to the pharmacy ($4.19), the difference is the Spread.

RESPONSE: Defendants admit that on October 30, 2015, Plaintiff had prescription drugs filled pursuant to an employer-sponsored plan insured by OHI and that the terms of her respective plans required Plaintiff to make a copayment of $15 in connection with having those prescriptions filled. Defendants admit that on that date, Plaintiff had four prescriptions filled,

one of which the pharmacy contractually agreed to accept $4.19 for that prescription drug. Defendants deny the remaining allegations contained in Paragraph 8.

9. The court in ruling on a motion to dismiss in *In re United Health Group PBM Litigation*, Case No. 16-cv-3352 (JNE/BRT)(D.Minn.), previously held that Plaintiff properly alleged that she was entitled to pay the contracted rate with the pharmacy if lower than the copayment and that she should not pay any Overcharge. In dismissing Plaintiff's claims without prejudice to re-filing, the court concluded that "[a]lthough the plan does not appear to limit the availability of legal actions, it does designate courts located in New York as the forum for legal disputes related to the plan." This action in New York addresses the Minnesota court's non-prejudicial dismissal on forum grounds and contains additional allegations that provide further support for the claims alleged below.

RESPONSE: Paragraph 9 purports to characterize the District of Minnesota decision in *In re United Health Group PBM Litigation*, Case No. 16-cv-3352, 2017 U.S. Dist. LEXIS 208328 (JNE/BRT) (D. Minn. Dec. 19, 2017), the content of which speaks for itself, and thus no response is required. To the extent that a response is required, Defendants deny the allegations contained in Paragraph 9 to the extent they mischaracterize the decision or are inconsistent or incomplete with respect thereto.

10. Defendants initially allowed pharmacies to keep Spread and other Overcharges. However, during the Class Period, Defendants began requiring the pharmacies to turn over the Spread to Defendants, which payment from the pharmacy to the Defendants is known as a "Clawback."

RESPONSE: Defendants admit that, in some circumstances and at some period during the putative Class Period, Defendants were credited or retained a differential between the amount the pharmacy had contractually agreed to accept for the prescription drug and the amount the participant had paid to the pharmacy for that drug, pursuant to the participant's plan terms. Defendants deny that such amounts are "Overcharges" and deny the remaining allegations contained in Paragraph 10.

11. Had Defendants lived up to their fiduciary, disclosure, and other legal obligations under the Plan, Plaintiff would not have paid more than the $4.19 amount the pharmacy agreed to be paid by Defendants for this prescription drug. Defendants should have and easily could have exercised their unilateral discretion to comply with the terms of Plaintiff's Plan and their

fiduciary duties, and determined that the pharmacy should charge and collect from Plaintiff, at a maximum, only $4.19. Instead, Defendants exercised discretion to impose a mark-up of over 250% beyond the total amount the pharmacy should have charged and required the pharmacy to collect that amount from Plaintiff.

RESPONSE: Defendants deny the allegations contained in Paragraph 11.

12. Defendants violated the Plans and breached their ERISA fiduciary duties by exercising their discretion to secretly determine that patients must pay inflated copayments, coinsurance, and deductible payments and then directing pharmacies to collect those inflated copayments, coinsurance, and deductible payments on their behalf (which Overcharges were then either retained by the pharmacies or remitted to Defendants in the form of Clawbacks).

RESPONSE: Defendants deny the allegations contained in Paragraph 12.

13. Defendants misrepresented to Plaintiff and the Class the cost-sharing amounts under the Plans and that their cost-sharing amounts were based on the amount that the pharmacy agreed to accept for the drugs, when, in fact, patients were charged and paid more than that amount and were charged based on inflated "costs." By engaging in this conduct, Defendants violated ERISA's fiduciary duties and engaged in prohibited transactions. Defendants utilized the U.S. Mail and interstate wire facilities to engage in their fraudulent billing scheme in violation of RICO.

RESPONSE: Defendants deny the allegations contained in Paragraph 13.

14. In order to implement Defendants' fraudulent Overcharge scheme, Defendants' contracts with participating pharmacies required the pharmacies not to disclose the existence of the Overcharges or Clawbacks, or the fact that a patient could, in certain circumstances, be required to pay more for a prescription drug than if the patient did not have any insurance at all. As a result of these "gag clauses," the Overcharges remain hidden from participants and beneficiaries.

RESPONSE: Defendants deny the allegations contained in Paragraph 14.

15. Defendants' fraudulent scheme to artificially inflate the costs for medically necessary prescription drugs by overcharging patients, and then to surreptitiously require pharmacies to collect Overcharges or to take Clawbacks is inconsistent with the purposes of the health care system. For one, patients are paying higher amounts than they otherwise would have paid had Defendants not artificially inflated the payment amounts. Patients are supposed to save money through the use of pharmacy benefits, but in reality, they are charged excessive amounts.

RESPONSE: Defendants deny the allegations contained in Paragraph 15.

16. Indeed, the very purpose of obtaining or participating in a health plan that includes pharmacy benefits is to enable patients to benefit from the insurance company's and PBM's negotiating and buying power with prescription drug manufacturers and pharmacies. This should result in *reduced* costs for prescription drugs. Patients also pay substantial

premiums and other costs and fees, which should cover the other aspects of the prescription drug plans, including their administration. Moreover, PBMs and Plan providers such as Optum and OHI are paid significant fees as compensation for their services that are entirely separate from the Clawbacks at issue here, making the Clawbacks excess, undisclosed profit in exchange for little to nothing. Accordingly, Plaintiff should not have been charged additional secret Overcharges and Clawbacks.

RESPONSE: Defendants deny the allegations contained in Paragraph 16.

17. As a result of Defendants' fraudulent scheme to collect Overcharges, Defendants overcharged Plaintiffs and the other Class members for prescription drugs during the Class Period (defined below). Defendants' misconduct has caused Plaintiff and the other Class members to suffer significant damages. Plaintiffs seek relief by bringing the following claims:

RESPONSE: Defendants deny the allegations contained in Paragraph 17.

18. With regard to ERISA, under Count I, ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), provides that a participant or beneficiary may bring an action to enforce her rights under the terms of the plan or to clarify her rights to future benefits under the terms of the plan. Defendants have violated the ERISA Plans by instructing pharmacies to charge Overcharges and taking Clawbacks and they should not be allowed to continue to do so.

RESPONSE: Paragraph 18 contains legal conclusions to which no response is required.

To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

19. Under Count II, ERISA § 406(a), 29 U.S.C. § 1106(a), provides that a party in interest shall not receive direct or indirect compensation unless it is reasonable and prohibits transfers of plan assets and use of plan assets by or for the benefit of fiduciaries and plan service providers. In setting the amount of and taking excessive undisclosed Overcharge compensation and Clawbacks, each Defendant allowed and received unreasonable compensation and misused the assets of the ERISA Plans, including Plan and employer contributions under coinsurance Plans and Plan contracts, that provided Defendants with the ability and discretion to extract these funds from patients.

RESPONSE: Paragraph 19 contains legal conclusions to which no response is required.

To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

20. Under Count III, ERISA § 406(b), 29 U.S.C. § 1106(b), provides that a fiduciary shall not deal with plan assets in its own interest or for its own account, act in any transaction involving the plan on behalf of a party whose interests are adverse to participants or beneficiaries, or receive any consideration for its own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan. In exercising their control over Plan contracts and to require the pharmacies to charge and collect Overcharges, and to remit back Clawbacks, and over Plan and employer contributions under coinsurance Plans, Defendants dealt with and received plan assets and consideration for their

personal accounts and in their own interest, acted on behalf of parties whose interests are adverse to the interests of the Plans and participants, and received consideration for their own accounts from parties dealing with the Plans in transactions involving the assets of the Plans, in violation of this provision.

RESPONSE: Paragraph 20 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

21. Under Count IV, ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), provides that a fiduciary shall discharge its duties with respect to a plan (1) solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan, (2) 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 in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with Plan documents. By setting the amount of and forcing the pharmacies to collect Overcharges and by taking Clawbacks, Defendants have breached these fiduciary duties.

RESPONSE: Paragraph 21 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

22. Under Count V, ERISA § 405(a), 29 U.S.C. § 1105(a), imposes liability on a fiduciary, in addition to any liability which it may have under any other provision, for a breach of fiduciary responsibility of another fiduciary with respect to the same plan if it knows of a breach and fails to remedy it, knowingly participates in a breach, or enables a breach. The Defendants breached all three provisions.

RESPONSE: Paragraph 22 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

23. Under Count VI, even to the extent any Defendant is not held to be fiduciary, that Defendant had actual or constructive knowledge of and participated in and/or profited from the prohibited transactions and fiduciary breaches alleged in Counts II-IV committed by the Defendants who are found to be fiduciaries, and are liable to disgorge ill-gotten gains and/or plan assets and to provide other appropriate equitable relief, pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

RESPONSE: Paragraph 23 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

24. With regard to RICO, under Count VII, OHI has engaged in a scheme to defraud in violation of RICO, 18 U.S.C. § 1962(c), by overcharging patients for the cost of medically

necessary prescription drugs alleged below and is liable to Plaintiff and the Class for all statutory remedies.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 24 is required.

25. Under Count VIII, Optum has engaged in a scheme to defraud in violation of RICO, 18 U.S.C. § 1962(c), by overcharging patients for the cost of medically necessary prescription drugs as alleged below and is liable to Plaintiff and the Class for all statutory remedies.

RESPONSE: Paragraph 25 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Optum denies the allegations.

26. Under Count IX, Defendants have conspired to engage in a scheme to defraud in violation of RICO, 18 U.S.C. § 1962(d), by agreeing to overcharge and by overcharging patients for the cost of medically necessary prescription drugs as alleged below and are liable to Plaintiff and the Class for all statutory remedies.

RESPONSE: The Court dismissed Count IX of the Complaint as against OptumRx (Dkt. 63), and thus no response to Paragraph 26 by it is required. In any event, Paragraph 26 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, the remaining Defendants deny the allegations.

27. As further alleged below, Plaintiff seeks to represent a nationwide Class of all insureds and plan participants and beneficiaries whose health Plans are insured or administered by OHI and Optum, as well as the ERISA Subclass.

RESPONSE: In response to Paragraph 27, Defendants admit that Plaintiff purports to bring the present action as a putative class action and that Plaintiff purports to define the class as alleged. Defendants deny that class certification is appropriate in this action.

JURISDICTION

28. **Subject Matter Jurisdiction**. This court has subject matter jurisdiction over this action pursuant to (a) 28 U.S.C. § 1331, which provides for federal jurisdiction over civil actions arising under the laws of the United States, including ERISA and RICO; (b) 29 U.S.C. § 1132(e)(1) providing for federal jurisdiction of actions brought under Title I of ERISA; and (c) 18 U.S.C. § 1964 providing for federal jurisdiction to prevent and restrain violations of

18 U.S.C. § 1962. Further, declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202 and Rules 58 and 65 of the Federal Rules of Civil Procedure.

RESPONSE: In response to Paragraph 28, Defendants admit that Plaintiff purports to assert claims against them under ERISA and RICO and that claims arising under those laws are subject to the jurisdiction of the district courts of the United States, but deny the remaining allegations.

29. **Personal Jurisdiction**. ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2) provides for nationwide service of process. Upon information and belief, Defendants are residents of the United States and subject to service in the United States, and this Court therefore has personal jurisdiction over them. Defendants have also conceded jurisdiction in this Court, insofar as Plaintiff's 2014 Plan states that any dispute "*must* be resolved in a court located in the State of New York" (emphasis added). This Court also has personal jurisdiction over all Defendants pursuant to Fed. R. Civ. P. 4(k)(1)(A) because they would be subject to the jurisdiction of a court of general jurisdiction in New York. Defendants may be found in this District and conduct substantial business herein: Defendants are authorized to do business in the State of New York; Defendants conduct business in the State of New York and in this District; Defendants advertise and promote their services in the State of New York and in this District; Defendants have sufficient minimum contacts with the State of New York; Defendants administer health plans and pharmacy benefits under those plans from the State of New York; and/or Defendants otherwise intentionally avail themselves of the markets in the State of New York through the marketing and sale of insurance and related products and services in this State so as to render the exercise of jurisdiction by this Court permissible under traditional notions of fair play and substantial justice.

RESPONSE: Paragraph 29 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants do not dispute jurisdiction but deny the remaining allegations contained in Paragraph 29.

30. **Venue**. Venue is proper in this Court pursuant to 28 U.S.C. § 1391, because Defendants contractually *required* that any actions be venued in this District (as set forth above) and because a substantial part of the events giving rise to the claims herein occurred within this District and/or a substantial part of property that is the subject of the action is situated in this District. Venue is also proper in this District pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because Defendants may be found in this District and some or all of the fiduciary breaches or other violations for which relief is sought occurred in or originated in this District. Venue is also proper in this District pursuant to 18 U.S.C. § 1965, because Defendants are found, have an agent, or transact their affairs in this District, and the ends of justice require that any Defendant residing elsewhere be brought before this Court.

RESPONSE: Paragraph 30 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants do not dispute venue but deny the remaining allegations contained in Paragraph 30.

THE PARTIES

31. Plaintiff Anna Mohr-Lercara ("Plaintiff") is a citizen of Florida. Plaintiff was covered by an OHI health plan, a fully insured health plan provided through her employer. Plaintiff received prescription drug coverage from OHI under a form "G PPO 25/40 F NG OHI" PPO group policy purchased through her employer for her benefit. This policy is a welfare benefit plan subject to ERISA. Upon information and belief, Plaintiff's plan was serviced and administered by Optum. Under the plan, Plaintiff Mohr-Lercara was obligated to pay copayments of $10-$75 per prescription for certain categories of drugs, and copayments of $25-$187.50 after payment of the $100 deductible for other categories of drugs. As a result of Defendants' scheme, Plaintiff Mohr-Lercara has been injured by paying inflated amounts for medically necessary, covered prescription drugs.

RESPONSE: In response to Paragraph 31, on information and belief, Defendants admit that Plaintiff is a resident of Florida. Defendants admit that Plaintiff was a participant in a health plan provided through her employer and issued by OHI, but states that the referenced plan speaks for itself and deny the allegations to the extent they mischaracterize the plan or are inconsistent or incomplete thereto. Defendants deny the remaining allegations contained in Paragraph 31.

32. Defendant OHI is a licensed health insurance company incorporated in New York with its principal place of business in Trumbull, Connecticut. OHI is a wholly-owned subsidiary of UnitedHealth Group, Inc. ("United").

RESPONSE: Defendants admit that OHI is a licensed health insurance company incorporated in New York, New York. Defendants state that OHI's principal place of business is in New York, New York. Defendants further state that OHI is a wholly-owned subsidiary of UnitedHealthcare Insurance Company, which is a wholly-owned subsidiary of UHIC Holdings, Inc., which is a subsidiary of United HealthCare Services, Inc., which is a wholly-owned subsidiary of UnitedHealth Group Incorporated. Defendants deny the remaining allegations contained in Paragraph 32.

33. Defendant Optum, Inc. is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota. Optum, Inc. is a subsidiary of United that manages OHI's pharmacy benefits.

RESPONSE: In response to Paragraph 33, Defendants admit that Optum, Inc. is a Delaware corporation with is principal place of business in Eden Prairie. Defendants deny the remaining allegations contained in Paragraph 33.

34. Defendant OptumRx is a California corporation with its principal place of business located in Irvine, California. OptumRx operates as a subsidiary of Delaware corporation OptumRx Holdings, LLC, which in turn operates as a subsidiary of Optum, Inc. OptumRx serves as a PBM for OHI.

RESPONSE: Defendants admit the allegations contained in Paragraph 34.

SUBSTANTIVE ALLEGATIONS

Health Insurance in the United States

35. Over 90% of health care beneficiaries in the United States have a health care plan (either private or public) that covers all, or a portion of, their medical and pharmaceutical expenses.

RESPONSE: Defendants lack knowledge or information sufficient to form a belief as to the truth of the allegations contained in Paragraph 35, and on that basis, deny them.

36. Health insurance is paid for by a premium paid for medical and prescription drug benefits for a defined period; or through employer plans that either provide benefits by purchasing group insurance policies, or are self-funded but administered by health insurance companies and their affiliates. Premiums and contributions for coverage in all types of plans can be paid by individual plan participants or beneficiaries, employees, unions, employers or other institutions.

RESPONSE: In response to Paragraph 36, Defendants admit that, in general, health insurance is paid for, in part, by a premium for a defined period and admit that there are, in general, two basic funding options for group health plan clients—either an administrative services only funding arrangement or an insured medical plan. Defendants deny the remaining allegations contained in Paragraph 36.

37. If a Plan covers outpatient prescription drugs, the cost for prescription drugs is typically shared between the patient and the Plan. Such cost sharing can take the form of deductible payments, coinsurance payments, and copayments. In general, deductibles are the dollar amounts the patient pays during the benefit period (usually a year) before the Plan starts to make payments for drug costs. Coinsurance generally requires a patient to pay a stated percentage of drug costs. Copayments are generally fixed dollar payments made by a patient toward drug costs.

RESPONSE: In response to the Paragraph 37, Defendants state that the coverage for prescription drugs, including any deductible, copayment, or coinsurance, depends on the specific terms of the individual member's plan, and deny the remaining allegations.

The Pharmacy Benefits Industry and Pharmacy Benefits Managers

38. The pharmaceutical benefits industry consists of complex arrangements between numerous entities, including, but not limited to, drug manufacturers, drug wholesalers, PBMs, pharmacies, health insurance companies, employers, and health plan participants and beneficiaries.

RESPONSE: In response to the allegations contained in Paragraph 38, Defendants state that they lack knowledge or information sufficient to form a belief as to the truth of the allegations regarding the vaguely-referenced "pharmaceutical benefits industry," and on that basis, deny them.

39. On the drug distribution side of the market, the drug manufacturer typically sells drugs to a drug wholesaler, which in turn sells the drugs to a retail pharmacy. Payments for the drugs in turn go from the retail pharmacy to the wholesaler and to the manufacturer. The retail pharmacy then distributes drugs to patients from its inventory. Neither the PBM nor the insurer/administrator is involved in the distribution of prescription drugs by the retail pharmacies, although PBM's may operate mail-order businesses.

RESPONSE: Defendants lack knowledge or information sufficient to form a belief as to the truth of the allegations contained in Paragraph 39, which are not specific to Defendants or any given pharmacy, and on that basis, deny them.

40. The retail payment side of the market for drugs is largely directed and controlled by insurance companies and their contracted or owned PBMs. In most instances where a health plan provides for prescription drug benefits, a PBM is the agent of the insurance company hired to participate in administering the prescription drug component of a health plan. For example,

Optum acted as OHI's agent or delegatee in participating in administering OHI's prescription drug plans during the Class Period.

RESPONSE: The third sentence of Paragraph 40 states a legal conclusion to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the third sentence of Paragraph 40. Defendants deny the remaining allegations contained in Paragraph 40.

41. When a patient presents a prescription at a pharmacy, key information such as the patient's name, drug dispensed and quantity dispensed is input into the pharmacy computer and transmitted via interstate wire to a "switch" that then directs the information to the correct PBM. Accordingly, the pharmacy instantaneously submits the claim to Defendants on behalf of the patient. The prescription is supposed to be processed by the PBM in accordance with a patient's Plan which, as alleged herein, did not occur. The PBM then electronically transmits via interstate wire a message back to the pharmacy indicating whether the drug and patient are covered and, if so, the cost-sharing amount the pharmacy must charge to and collect from the patient as a copayment, coinsurance, or the amount to be paid toward a deductible.

RESPONSE: Defendants lack knowledge or information sufficient to form a belief as to the truth of the allegations contained in Paragraph 41, which are not specific to Defendants or any given pharmacy, and on that basis, deny them.

42. The PBM is supposed to pay the pharmacy any amounts owed to the pharmacy over the copayment, coinsurance or deductible amount paid by the patient. These amounts are aggregated and paid to the pharmacy approximately every two weeks for the claims that were processed by any given pharmacy in the prior two-week period.

RESPONSE: Defendants lack knowledge or information sufficient to form a belief as to the truth of the allegations contained in Paragraph 42, which are not specific to Defendants or any given pharmacy, and on that basis, deny them.

43. If the patient's cost-sharing payment is greater than the amount the pharmacy has agreed to accept, there will be a "negative reimbursement" to the pharmacy for the difference between the patient's payment and the amount the pharmacy receives. The "negative reimbursement" is paid by the pharmacy to Defendants as part of the reconciliation every two weeks.

RESPONSE: Defendants lack knowledge or information sufficient to form a belief as to the truth of the allegations contained in Paragraph 43, which are not specific to Defendants or

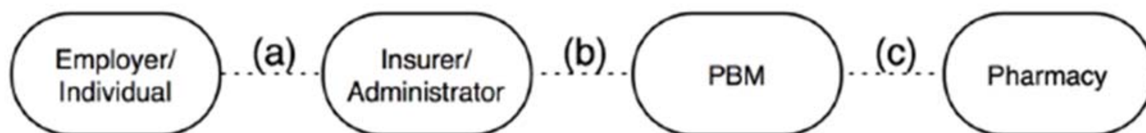
any given pharmacy, and on that basis, deny them. Defendants further state that the coverage for prescription drugs, including any deductible, copayment, or coinsurance, depends on the specific terms of each individual member's plan.

The Relevant Contractual Relationships

44. Contractual relationships exist at three relevant levels: (1) between the employer (or, in the case of non-employer sponsored plans, the individual) and the health insurance company that underwrites and/or administers the plan; (2) between the insurer/administrator and the PBM; and (3) between the PBM and retail pharmacies. An employer or individual buys prescription drug coverage or prescription drug benefit administration services from a health insurance company to provide prescription drug benefits for its employees under health plans. Health insurance companies then hire PBMs to manage the prescription drug benefits offered pursuant to their policies and ASO contracts. PBMs then have relationships with retail pharmacies. Some may be "in-network" and others may be "out of network."

RESPONSE: In response to Paragraph 44, Defendants state that they lack knowledge or information sufficient to form a belief as to the truth of the allegations regarding the vaguely-referenced "contractual relationships," and on that basis, deny them. Defendants further state that the referenced contracts speak for themselves and therefore do not require a response, and deny the allegations to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

45. The following diagram represents (in simplified form) the contractual relationships among the parties:



RESPONSE: In response to Paragraph 45, Defendants deny that the diagram represents the contractual relationships amongst the parties. Defendants further state that the referenced contracts speak for themselves and therefore do not require a response, and deny the allegations to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

46. **Employer/Individual–Insurer Agreements (i.e., Health Plans)**. Employers and individuals buy prescription drug coverage to provide prescription drug benefits. These plans contain uniform provisions that set forth key terms such as the mechanism for and amount of the deductible, copayment, and/or coinsurance that a patient must pay to obtain prescription drug benefits. Plaintiffs and Class members are intended beneficiaries of such agreements and they are participants and beneficiaries in the plans.

RESPONSE: In response to Paragraph 46, Defendants deny that the diagram represents the contractual relationships amongst the parties. Defendants further state that the referenced contracts speak for themselves and therefore do not require a response, and deny the allegations to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

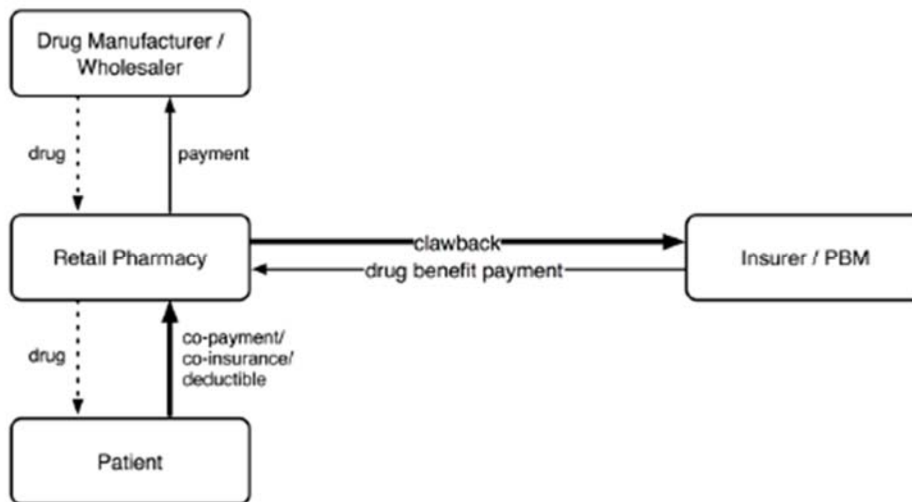
47. **Insurer–PBM Agreements**. Health insurance companies, such as OHI, contract with and/or own PBMs such as Optum, which act as their agents in administering the prescription drug benefits purchased through the health plans that the insurers issue or administer.

RESPONSE: In response to Paragraph 47, Defendants deny that the diagram represents the contractual relationships amongst the parties. Defendants further state that the referenced contracts speak for themselves and therefore do not require a response, and deny the allegations to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

48. **PBM–Pharmacy Agreements**. For "in-network" benefits at issue in this case, PBMs, contract with pharmacies, which serve as providers in the insurers/administrators' pharmacy network. Pursuant to these agreements, the pharmacies fill prescriptions that are health benefits covered under the Plans in exchange for an amount pursuant to the contract with the PBM. Pursuant to these agreements, the pharmacy submits a claim to the PBM on behalf of the patient. In response to this claim, pursuant to these agreements, Defendants exercise ongoing discretionary control as they dictate the cost-sharing amount that a pharmacy must charge and collect from a patient for a prescription drug, including the Overcharge, the amount the pharmacy will be paid for filling the patient's prescription, and the amount of the patient's payment that the pharmacy must send back to Defendants as a Clawback. The pharmacy has no role in setting the amount of the patient's payment or Overcharge and thus must collect and remit to Defendants the amount overcharged as determined by the PBM and insurer in their sole discretion.

RESPONSE: In response to Paragraph 48, Defendants deny that the diagram represents the contractual relationships amongst the parties. Defendants further state that the referenced contracts speak for themselves and therefore do not require a response, and deny the allegations to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

49. The relationship among the parties is shown graphically as follows:



RESPONSE: Defendants deny the allegations contained in Paragraph 49.

50. Pursuant to the health plans, an insurer must ensure that, when it contracts with and directs a PBM to act as its agent to manage prescription drug benefits, the PBM follows the plans' terms, including when dictating to pharmacies the amounts to charge patients in cost-sharing payments. In other words, insurers must ensure that PBMs do not overcharge patients for their prescription drug benefits.

RESPONSE: Paragraph 50 states legal conclusions to which no response is required and purports to characterize plan documents, the terms of which speak for themselves, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations to the extent they mischaracterize plan documents or are inconsistent or incomplete with respect thereto, and deny the remaining allegations contained in Paragraph 50.

51. On the contrary, PBMs, acting as agents and/or in concert with Defendants, routinely require that patients pay substantially higher prices for prescription drugs than are allowed under the plans. As alleged herein, Defendants engaged in such practices with respect to Plaintiff's Plans and the Class by charging Overcharges.

RESPONSE: Defendants deny the allegations contained in Paragraph 51.

Plaintiff's Plans

52. Plaintiff had two different types of Plans during the Class Period. Both Plans precluded Defendants from charging cost-sharing payments that exceed the price pharmacies agreed to be paid, and thus both precluded the collection of Overcharges and the payment of Clawbacks.

RESPONSE: In response to Paragraph 52, Defendants admit that Plaintiff was a participant in an employer-sponsored health plan insured by OHI during a portion of the putative Class Period alleged in the Complaint. Defendants state that Plaintiff's plan documents speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 52 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 52.

53. Plaintiff's 2011-13 Plans provide that Plaintiff's cost-sharing for drugs purchased from Network Pharmacies is the "lower of" (1) "the applicable Out-of-Pocket Expense" or (2) the "Usual and Customary Charge:"

Network Pharmacies: For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:

- the applicable Out-of-Pocket Expense; or
- the Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product.

RESPONSE: In response to Paragraph 53, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 53 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants

deny that the Member Handbook constitutes a plan document or is part of the "Plan" as defined in the footnote to Paragraph 53.

54. "Out-of-Pocket Expense," in turn, is defined as the amounts set forth in the "Summary of Benefits:"

Out-of-Pocket Expenses or Cost-Share: The applicable Copayments, Deductibles and Coinsurance listed in your Summary of Benefits.

RESPONSE: In response to Paragraph 54, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 54 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

55. The "Summary of Benefits" specifically states that "Outpatient Prescription Drugs" purchased from a Network Pharmacy are "Covered Services."

	OXFORD HEALTH INSURANCE, INC.
Covered Services	**In-Network**
Supplemental Coverage	
Outpatient Prescription Drugs	Subject to a separate deductible of $100. The deductible is waived for Tier 1 Drugs.

RESPONSE: In response to Paragraph 55, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 55 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

56. In describing Plaintiff's "Financial Responsibility" for "Covered Services," the 2011-13 Plans state that "Network Providers [such as Network Pharmacies]" have agreed to accept our contract fees as payment in full" and Plaintiff "will not be responsible for any amount billed in excess of the contracted fee":

Your Financial Responsibility For In-Network Benefits

In-Network benefits are typically provided through arrangements with Network Providers. Network Providers have agreed to accept our contracted fees as payment in full for Covered Services. We reimburse the Network Provider directly when you receive Covered Services and you will not be responsible for any amount billed in excess of the contracted fee for the Covered Service.

RESPONSE: In response to Paragraph 56, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 56 as they mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants deny that the quoted language applies to Network Pharmacies.

57. Accordingly, given the "lower of" provision discussed in ¶ 53 above, Plaintiff, under the 2011-13 Plans, should not pay any amount for the "Covered Services" of "in Network" "Outpatient Prescription Drugs" that is "in excess of the contracted fee" Defendants paid "Network Pharmacies."

RESPONSE: In response to Paragraph 57, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 57.

58. Similarly, Plaintiff's 2014-16 Plans state that "in-network benefits are the highest level of coverage available." Accordingly, Plaintiff will pay the "lower of" the "applicable Cost-Sharing" or the "Usual and Customary Charge" for purchases from Network Pharmacies.

Participating Pharmacies: For Prescription Drugs purchased at a retail or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

RESPONSE: In response to Paragraph 58, Defendants state that Plaintiff's 2014-2016 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 58 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

59. Copayments are a form of "Cost-Sharing" in Section IV of the 2014-2016 Plans.

Section IV - Cost-Sharing Expenses And Allowed Amount

Copayments. Except where stated otherwise, after You have satisfied the annual Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits in Section XV – Schedule of Benefits of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

RESPONSE: In response to Paragraph 59, Defendants state that Plaintiff's 2014-2016 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 59 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

60. The Allowed Amount, the maximum Copayment, is the amount paid to the Network Pharmacy.

Allowed Amount. "Allowed Amount" means the maximum amount we will pay to a Provider for the services or supplies covered under this Certificate, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. We determine our Allowed Amount as follows:

- The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

RESPONSE: In response to Paragraph 60, Defendants state that Plaintiff's 2014-2016 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 60 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants deny that the "Allowed Amount" definition quoted applies to outpatient prescription drug benefits.

61. Accordingly, under the 2014-2016 Plans, Plaintiff should not pay a Copayment that is more than the amount Defendants agreed to pay the Network Pharmacy. OHI's Plans Have Standard Terms.

RESPONSE: Defendants deny the allegations contained in Paragraph 61.

OHI's Plans Have Standard Terms

62. Health insurance policies are subject to state regulation. The policy forms typically must be filed with and approved by the appropriate state regulators.

RESPONSE: Defendants admit the allegations contained in Paragraph 62.

63. Because they are approved form plans offered or administered by the same insurance company, the relevant terms of the Plans benefitting Plaintiff are substantively the same as those applicable to the Class. For this reason, upon information and belief, the rights relevant to the claims alleged herein are shared by all members of the Class.

RESPONSE: In response to Paragraph 63, Defendants state that Plaintiff's plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 63 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants further state that they lack knowledge or information sufficient to form a belief as to the truth of any allegations regarding the terms of the benefit plans of members of the putative class, who have not been adequately identified, and on that basis, deny the remaining allegations contained in Paragraph 63. Defendants further deny that class certification is appropriate in this action.

64. Further, OHI uses uniform prescription drug plan terms in their Plan contracts to provide prescription drug coverage. These terms of the Plans — and more importantly how these Plans are administered by OHI and Optum — do not differ materially across Plans. Accordingly, upon information and belief, the rights relevant to the claims alleged herein are shared by all members of the Class, regardless of the funding arrangement underpinning the health Plan benefits that Defendants offer and administer.

RESPONSE: In response to Paragraph 64, Defendants state that Plaintiff's plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 64 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants further state that they lack knowledge or information sufficient to form a belief as to the truth of any allegations regarding the terms of the benefit plans of putative class members, who have not been adequately

identified, and on that basis, deny the remaining allegations contained in Paragraph 64. Defendants further deny that class certification is appropriate in this action.

Plaintiff's Purchases

65. During the time that Plaintiff was covered by the Plans, Plaintiff purchased prescription drugs for which she was required to make copayments, coinsurance, and/or deductible payments in excess of the amounts provided for by her Plans, including at least the following specific purchases:

Filled Date	Usual And Customary	Approved Ingredient Cost	Approved Dispensing Fee	Amount Paid to Pharmacy	Copay	Spread / Clawback
10/30/2015	$160.76	$3.19	$1.00	$4.19	$15.00	($10.81)
10/30/2015	$29.63	$3.74	$1.00	$4.74	$15.00	($10.26)
10/30/2015	$27.50	$3.74	$1.00	$4.74	$15.00	($10.26)
10/30/2015	$164.90	$5.15	$1.00	$6.15	$15.00	($8.85)
10/02/2015	$174.59	$5.15	$1.00	$6.15	$15.00	($8.85)
10/02/2015	$29.63	$5.76	$1.00	$6.76	$15.00	($8.24)
10/02/2015	$27.50	$5.76	$1.00	$6.76	$15.00	($8.24)
10/02/2015	$164.90	$5.76	$1.00	$6.76	$15.00	($8.24)
09/08/2015	$174.59	$0.69	$1.35	$2.04	$10.00	($7.96)
09/08/2015	$164.90	$6.27	$1.00	$7.27	$15.00	($7.73)
09/01/2015	$27.50	$6.27	$1.00	$7.27	$15.00	($7.73)
08/31/2016	$33.20	$6.27	$1.00	$7.27	$15.00	($7.73)
07/26/2016	$27.50	$6.27	$1.00	$7.27	$15.00	($7.73)
04/12/2016	$27.50	$6.38	$1.00	$7.38	$15.00	($7.62)
03/10/2016	$29.63	$6.38	$1.00	$7.38	$15.00	($7.62)
03/10/2016	$27.50	$6.38	$1.00	$7.38	$15.00	($7.62)

<u>RESPONSE</u>: Defendants admit that Plaintiff had prescription drugs filled pursuant to an employer-sponsored plan insured by OHI and that the terms of her respective plans required Plaintiff to make copayments and/or deductible payments in connection with having those prescriptions filled. Defendants admit that, according to records maintained by OptumRx, Plaintiff had prescription drugs filled on the above dates, among others. Defendants state that

because the table excludes certain information, including individual claim numbers, Defendants lack knowledge to admit or deny the specific dollar amounts included for each transaction.

66. As set forth above, Plaintiff was illegally charged Overcharges for these prescription drugs in excess of the amounts permitted by her Plans. Upon information and belief, Defendants then "clawed back" these Overcharges from Plaintiff's pharmacy.

RESPONSE: Defendants deny the allegations contained in Paragraph 66.

Patients Covered By Defendants' Health Plans Pay Undisclosed, Unauthorized and Excessive Fees for Prescription Drugs

67. Defendants have engaged in a scheme to charge Plaintiff and other patients Overcharges in violation of the Plans as alleged above. This is particularly true for many low-cost, high-volume generic prescription drugs.

RESPONSE: Defendants deny the allegations contained in Paragraph 67.

68. Defendants "utilize Optum's technology and service platforms, retail network contracting and claims processing services" to carry out this Overcharge and Clawback Scheme.

RESPONSE: Defendants deny the allegations contained in Paragraph 68.

69. Optum's Provider Manual provides that Optum "acting on behalf of applicable Client or Benefit Plan Sponsor," will process claims for medically necessary prescription drugs dispensed to Plaintiff and Class members.

RESPONSE: Paragraph 69 purports to quote and characterize the 2017 OptumRx Provider Manual, the content of which speaks for itself, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 69 to the extent they mischaracterize the Provider Manual or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 69.

70. The Provider Manual explains the mechanism by which Defendants conducted the scheme.

(a) The Provider Manual "includes the policies and procedures" applicable to all pharmacies participating in Optum's pharmacy network and "is incorporated into and is a part of" the pharmacies' agreements with Optum.

(b) The Provider Manual provides that Optum "shall communicate to [pharmacies] (via the POS System) the Cost-Sharing Amounts (*e.g.*, Co-payment and Deductible) applicable to Covered Prescription Services." Optum directs that pharmacies "shall collect the full Cost-Sharing Amounts" from Plaintiff and Class members purchasing medically necessary prescription drugs. Optum directs that pharmacies "must charge . . . the Cost-Sharing Amount indicated in [Optum's] online response and only this amount." Optum dictates that waiving the Cost-Sharing Amount by pharmacies is "strictly prohibited . . . and is considered a material breach of the Agreement."

(c) The Provider Manual provides that "reimbursement pricing information, as well as prices paid to [pharmacies] . . . are "confidential and proprietary. . . ."

(d) The Provider Manual provides that "[f]ailure to adhere to any of the provisions . . . which includes this [Provider Manual] . . . will be viewed as a breach of the Agreement." Pharmacies are "subject to penalties or sanctions" if Optum determines that the pharmacies "disclosed confidential information. . . ." These penalties include "at a minimum . . . $5,000 per incident," and pharmacies "may be subject to additional actions" by Optum, "up to termination from participation" in Optum's pharmacy network. Pharmacies terminated from participation in Optum's pharmacy network are banned from the pharmacy network for five years and, only after such a period, may apply for reinstatement at Optum's "sole discretion."

RESPONSE: Paragraph 70 and each of its subparts purport to quote and characterize the 2017 OptumRx Provider Manual, the content of which speaks for itself, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 70 to the extent they mischaracterize the Provider Manual or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 70.

71. The Defendants used the Optum platforms to create and implement their unlawful Overcharge Scheme. Defendants exercised their discretion to program and manipulate the Optum technology and service platforms to violate the Plan's term and charge greater Cost-Sharing Amounts than the Plans permitted, and they exercised their discretion to input the excessive and unlawful cost-sharing data into the platform system to enable the system to overcharge patients.

RESPONSE: Defendants deny the allegations contained in Paragraph 71.

72. Defendants further used their discretion to manipulate the Optum systems to misrepresent to patients the "Cost-Sharing Amounts (e.g. Co-payment, Coinsurance and Deductible) applicable to Covered Prescription Services" that were inflated, false and in violation of the Plans. Defendants required the pharmacies to make these misrepresentations to Plaintiff and other patients when they filled their prescriptions. For example, Defendants made these misrepresentations to Plaintiff each time she filled a prescription and was advised of and required to pay an excessive Copayment and Spread as alleged above.

RESPONSE: Defendants deny the allegations contained in Paragraph 72.

73. Defendants further exercised their discretion to direct that pharmacies "shall collect the full [inflated and unlawful] Cost-Sharing Amounts" from patients. Defendants required that pharmacies "must charge . . . the Cost-Sharing Amount indicated in [Optum's] online response and only this amount," which included the excessive and unlawful Overcharges in violation of the Plans that Defendants exercised their discretion to improperly input into the Optum system.

RESPONSE: In response to the Paragraph 73, Defendants state that the quoted language from the OptumRx Provider Manual speaks for itself, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 73 to the extent they mischaracterize the Provider Manual or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 73.

74. Where the patient pays a deductible and/or coinsurance (not a copayment), the patient is overcharged because his or her payment is based on the inflated amount, *not* the lower amount paid to the pharmacy. Defendants implemented the scheme concerning these types of cost-sharing in the same way they executed the scheme concerning copayments.

RESPONSE: Defendants deny the allegations contained in Paragraph 74.

75. Defendants' Overcharge Scheme includes various misrepresentations and omissions of material fact, including, but not limited to: (a) the misrepresentation in the Plans that Plaintiffs would pay a certain cost-share amount for prescription drugs with the knowledge and intent that patients would in fact be charged a higher amount; (b) the misrepresentation of the amount of the cost-sharing payment owed under the Plan terms when a patient purchased a drug; (c) the failure to disclose that a material portion of the "co-payments" were not "co-" payments at all, but were unlawful Overcharges; (d) the failure to disclose that prescription drug payments under deductible portions of health insurance Plans were based on prescription drug prices that exceeded the contracted fee with the pharmacies, in violation of the Plans' plain language; and (e) the failure to disclose that co-insurance payments were based on prescription drug prices that exceeded the contracted fee with the pharmacies, in violation of the Plans' plain language.

RESPONSE: Defendants deny the allegations contained in Paragraph 75.

76. On information and belief, many pharmacists were willing participants in the foregoing scheme while they were allowed to retain the Spread. However, once Defendants began "clawing back" the Spread (rather than allowing pharmacists to retain it), some pharmacists began attempting to alert customers to the existence of the Overcharges and Clawbacks. Defendants affirmatively blocked pharmacists from disclosing the existence of the Overcharges and Clawback scheme and from selling prescription drugs directly to customers for a lower price.

RESPONSE: Defendants deny the allegation in Paragraph 76.

77. For example, according to Doug Hoey ("Hoey") of the National Community Pharmacists Association ("NCPA"), a pharmacist sent him a letter received from Optum. Hoey stated that the letter from "Optum scolded the pharmacist," stating that Optum had '"recently discovered that pharmacy advised members that utilizing a cash price for their prescription is a better deal than using their insurance benefits.'" Optum further stated in the letter that "telling customers a cheaper price exists is a 'violation of the agreement,' [with Optum]," that Optum 'takes these matters very seriously[,]' and that 'failure to timely comply with this notice could result in further disciplinary action, up to and including termination from all Optum pharmacy networks.'" *Id.*

RESPONSE: In response to Paragraph 77, Defendants state that Plaintiff fails to identify the referenced letter allegedly quoted with the requisite particularity for Defendants to respond to the truth of the allegations, and on that basis, Defendants deny the allegations. Defendants further state that the content of the referenced letter, to the extent it exists, speaks for itself, such that no response is required, and deny the allegations contained in Paragraph 77 to the extent they mischaracterize the referenced letter or are inconsistent or incomplete with respect thereto. To the extent that Paragraph 77 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

78. Indeed, a June 28, 2016 press release issued by the NCPA described the "Clawback" practice and how it was impacting pharmacists and consumers throughout the United States. The press release went on to discuss a survey that was conducted by the NCPA of its members between June 2 and June 17, 2016, which disclosed the following:

- "Clawbacks" are relatively common, as 83 percent of pharmacists witnessed them at least 10 times during the past month.

- Two-thirds (67 percent) said the practice is limited to certain PBMs.

- Most (59 percent) said they believe the practice occurs in Medicare Part D plans as well as commercial ones.

- Sometimes PBM corporations impose "gag clauses" that prohibit community pharmacists from volunteering the fact that a medication may be less expensive if purchased at the "cash price" rather than through the insurance plan. In other words, the patient has to affirmatively ask about pricing. Most pharmacists (59 percent) said they encountered these restrictions at least 10 times during the past month.

RESPONSE: In response to Paragraph 78, Defendants state that the content of the referenced press release speaks for itself, such that no response is required, and deny the allegations to the extent they mischaracterize the referenced press release or are inconsistent or incomplete with respect thereto. To the extent that Paragraph 78 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

79. Some of the comments received from the pharmacists who responded to the survey included:

"Got one today. [PBM] charging a patient $125 for a generic drug and take back $65 from the pharmacy. If paid cash the cost to the patient would have been $55."

***

"Simvastatin 90-day charged the patient $30 more than cash price."

***

"[A] patient copay is over $50 and the claw back is over $30 all for a drug while our cash price would only be $15."

***

"The ones that make me the most upset is the Champ/VA claims. Seeing our disabled veterans families paying more than they should is horrific. Many times these fees are multiple times our net margin, even a negative reimbursement at times. One recent copay of $30 while we sent $27.55 back to [PLAN] left our margin at $1.58."

***

"Same patient, same day, five prescriptions. ... Total copay $146.89. Total claw back $134.49. Total price of the five prescriptions $12.40. Our gross profit on these five drugs $3.79. These are all maintenance medications for this patient."

***

"Recently filled a buproprion xl 150 script for 30 tabs. Cost is $17.15. PBM required us to charge a patient $47.10 and then took back $35."

RESPONSE: In response to Paragraph 79, Defendants state that the content of the referenced press release speaks for itself, such that no response is required, and deny the allegations to the extent they mischaracterize the referenced press release or are inconsistent or incomplete with respect thereto. To the extent that Paragraph 79 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

80. Clearly, these examples of Overcharges could not be possible if the true cost of the prescription drug was disclosed and the pharmacy was not prohibited by contract and threat of network termination from disclosing the lower cash-paying price for these drugs.

RESPONSE: Defendants deny the allegations contained in Paragraph 80.

81. Clawback programs are becoming more and more commonplace in the insurance industry and have "the effect of duping average consumers of prescription drugs into unwittingly funding [corporate] profits."

RESPONSE: In response to Paragraph 81, Defendants state that the language in the referenced testimony speaks for itself, such that no response is required, and deny the allegations to the extent they mischaracterize the referenced testimony or are inconsistent or incomplete with respect thereto. To the extent that Paragraph 81 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

82. Lawmakers, customers, and pharmacists have all raised concerns that there is a dangerous lack of transparency, rendering it difficult to assess whether an insurance policy or plan is being administered in compliance with plan or contract terms.

RESPONSE: In response to Paragraph 82, Defendants state that the language in the referenced article speaks for itself, such that no response is required, and deny the allegations to the extent they mischaracterize the referenced article or are inconsistent or incomplete with respect thereto. To the extent that Paragraph 82 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

83. Potential waste and abuse in the administration of these plans has not gone unnoticed by the Department of Labor — which has the authority to enforce ERISA. In response, the ERISA Advisory Council, established under ERISA, held a hearing in August 2014.

RESPONSE: Paragraph 83 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations on that basis, and also because they lack knowledge or information sufficient to form a belief as to the truth of whatever factual allegations may be contained Paragraph 83. Additionally, to the extent that Paragraph 83 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

84. At the hearing, the Council heard testimony regarding "a new PBM phenomenon, called 'clawback'" which takes advantage of the lack of transparency in the PBM industry According to testimony provided to the Council:

> In a "clawback" situation, the patient presents a prescription at a pharmacy. The claim is processed and the pharmacist is instructed to collect $100 as the cost of the drug. The entire prescription is paid for by the patient. Two weeks later, when the pharmacist receives reimbursement from the PBM, his remittance statement shows that the PBM has taken back (clawed-back) $75. This leaves just enough so that the pharmacist may make a few dollars profit on the claim. What happens to the $75 difference? The PBM retains this amount as "spread" paid for by the patient.

RESPONSE: In response to Paragraph 84, Defendants state that the language in the referenced testimony speaks for itself, such that no response is required, and deny the allegations to the extent they mischaracterize the referenced testimony or are inconsistent or incomplete with respect thereto. To the extent that Paragraph 84 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

The Fox 8 Investigation

85. The New Orleans television station FOX 8 investigated "Clawbacks," as part of its Medical Waste investigative series. FOX 8's investigative reporter, Lee Zurik, found that insurance companies were "charging co-pays that exceed the customers' costs for the drug," and that insurers were "clawing back" the excess payments from the customers.

RESPONSE: In response to Paragraph 85, Defendants admit that a New Orleans television station, Fox 8, published a story regarding what it identified as "clawbacks," but deny the truth of the statements made in the Fox 8 story and deny the remaining allegations contained in Paragraph 85. To the extent that Paragraph 85 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

86. FOX 8 published a number of screenshots from a pharmacist's computer system showing, with respect to particular drugs, the amount of the payment that certain health insurance companies (including Defendants) required pharmacists to collect from customers and the amount the pharmacists were required to pay to the health insurance companies as a "Clawback."

RESPONSE: In response to Paragraph 86, Defendants admit that a New Orleans television station, Fox 8, published a story, but lack knowledge or information as to the source of information provided in the referenced screenshots, and on that basis, deny the allegations. To the extent that Paragraph 86 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

87. As part of its investigation, Mr. Zurik requested comment from United, OHI's parent. Notwithstanding the specific provisions in the contract Defendants imposed on pharmacies that barred pharmacists from disclosing the existence of the Spread to customers (as detailed above), the United representative falsely claimed that "we encourage people to ask questions of their pharmacists to ensure they are getting the lowest available price for their prescriptions:"

From: Burns, Matthew A <matt_burns@uhc.com>
Sent: Friday, July 22, 2016 8:46 PM
To: Zurik, Lee
Subject: RE: Part D story

Attribute to me:

Our goal is to help our members get the lowest available price for their prescriptions. Often the lowest price is their plan copay, other times it's our contracted rate with the pharmacy, and sometimes it's the pharmacy's own retail or discount price. Our plans offer members security and peace of mind, and we encourage people to ask questions of their pharmacists to ensure they are getting the lowest available price for their prescriptions.

RESPONSE: Paragraph 87 purports to characterize an email, the content of which speaks for itself, and thus no response is required. To the extent a response is required, Defendants deny the allegations to the extent they mischaracterize the email or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 87.

88. An Optum representative further stated to Mr. Zurik, falsely, that Optum ensures that "the customer pays the lowest amount possible within their plan" and that "there is no new charge for the consumer as a result of" OHI's Overcharge and Clawback scheme, ignoring that the underlying Overcharges violated the Plan language and was illegal:

From: Stearns, Matthew H <matt.stearns@optum.com>
Sent: Thursday, May 05, 2016 8:51 PM
To: Zurik, Lee
Subject: RE: From Optum

Hey – last thing, to be clear: this program ensures the customer pays the lowest amount possible within their plan – there is no new charge for the consumer as a result of this program.

RESPONSE: Paragraph 88 purports to characterize an email, the content of which speaks for itself, and thus no response is required. To the extent a response is required, Defendants deny the allegations to the extent they mischaracterize the email or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 88.

89. The Optum representative also claimed that the Clawback "does not accrue to [Optum's] bottom line:"

From: Stearns, Matthew H [mailto:matt.stearns@optum.com]
Sent: Thursday, May 05, 2016 8:31 PM
To: Zurik, Lee <lzurik@fox8live.com>
Subject: RE: From Optum

Thanks, Lee. Key point here is that this does not accrue to our bottom line.

On information and belief, this statement was false.

RESPONSE: Paragraph 89 purports to characterize an email, the content of which speaks for itself, and thus no response is required. To the extent a response is required, Defendants deny the allegations to the extent they mischaracterize the email or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 89.

90. In response to the disclosure of the "Clawback" practice, Louisiana Insurance Commissioner, James J. Donelon stated: "You could say that, if the customer is paying more than the drug is worth, it's not a copay — it's a 'you-pay'. 'There's no copay,' our pharmacist says, 'that is an absolute, additional premium being paid, that they're paying, that they don't realize.'"

RESPONSE: In response to Paragraph 90, Defendants state that they lack knowledge or information to form a belief as to whether the quoted statement was in fact made, and therefore deny the same, and further deny the truth of the statement made. To the extent that Paragraph 90 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

91. FOX 8 also found that pharmacists were required to charge customers the amount dictated by the insurer or PBM, and were not allowed to give any discounts. According to Randal Johnson, president and CEO of the Louisiana Independent Pharmacies Association, "it's actually costing you more to acquire the drug with your insurance than you could if you walked in off the street and you didn't have insurance."

RESPONSE: In response to Paragraph 91, Defendants admit that a New Orleans television station, Fox 8, published a story regarding what it identified as "clawbacks," but deny the truth of the statements made in the Fox 8 story and deny the remaining allegations contained in Paragraph 91. To the extent that Paragraph 91 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

92. As a result of their deleterious impact on consumers, many states have now outlawed the Overcharges, Clawbacks and/or "gag" clauses alleged herein.

RESPONSE: Paragraph 92 asserts legal conclusions regarding unnamed state laws, the terms of which speak for themselves, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of such laws, and deny the remaining allegations contained in Paragraph 92.

"Clawbacks" Are Most Common With Widely Used Drugs

93. Defendants impose Overcharges and Clawbacks most frequently on widely used, low-cost drugs, and particularly generic drugs, where the cost of the drug is relatively low. This enables Defendants to impose deductible costs, copayments, and coinsurance costs that are higher than the cost of the drug, thereby insuring for themselves a Clawback. These drugs include, but are not limited to the following: Accu-Chek, Acyclovir, Aktob, Albuterol, Alocril, Alprazolam, Amiodarone, Amitriptyline, Amlodipine, Amoxicillin, Amphetamine, Anastrozole, Atenolol, Atorvastatin, Azelastine, Azithromycin, Bactrim, Benazepril, Benzonatate, Betamethasone, Buspirone, Bystolic, Carvedilol, Cefadroxil, Cefdinir, Cephalexin, Cetirizine, Chlorzoxazon, Ciprofloxacn, Citalopram, Clindamycin and Benzoyl Peroxide, Clindamycin, Clonazepam, Clonidine, Clopidogrel, Cyanocobalam, Cyclobenzaprine, Cytomel, Denta, Depo-Testosterone, Diazepam, Dicyclomine, Diltiazem, Doxazosin, Doxycycl, Duloxetine, Enalapril, Ergocalciferol, Escitalopram, Estradiol, Eszopiclone, Feosol, Ferrous, Flonase, Fluconazole, Fluocinonide, Fluoxetine, Fluticasone, Folbee, Folic, Furosemide, Gabapentin, Gemfibrozil, Gentamicin, Gianvi, Glimepiride, Glipizide, Guaifenesin, Hydrochlorot, Hydrocodone/APAP, Hydroxyz, Ibuprofen, Indomethacin, Invokamet, Irbesartan, Isosorbide, Januvia, Lamotrigine, Lantus, Latanoprost, Levetiraceta, Levocetirizi, Levofloxacin, Levothyroxine, Lexapro, Lisinopril And Hydrochlorothiazide, Lisinopril, Lisinopril/hydrochlorothiazide, Lithium, Loratadine, Lorazepam, Losartan, Losartan and Hydrochlorothiazide, Lovastatin, Meloxicam, Memantine, Metformin, Methocarbam, Methylphenidate, Metolazone, Metoprolol, Metronidazol, Minivelle, Mirtazapine, Mometasone, Montelukast, Mupirocin, Naproxen, Nitrofurantoin, Nortriptylin, Nystatin, Omeprazole, Ondansetron, Oxcarbazepin, Oxybutynin, Oxycodone/APAP, Pantoprazole, Paroxetine, Penicillin, Percocet, Pramipexole, Pravastatin, Prednisone, Prednisolone, Promethazine/Codeine, Ramipril, Ranitidine, Restasis, Sertraline, Simvastatin, Singulair, SMZ/TMP, Sodium Chloride (1 gm), Sotalol HCL, Spironolactone, Sprintec, Sulfameth/Trimeth, Sumatriptan, Suprep, Synthroid, Tamiflu, Tamsulosin, Temazepam, Terazosin, Terbinafine, Tizanidine, Tobramycin/Sus Dexameth, Topiramate, Tramadol, Tranex, Trazodone, Tretinoin, Triamcinolone, Triamterene and Hydrochlorothiazide, Vagifem, Valacyclovir, Valsartan/hydrochlorothiazide, Valsartan, Vaniqa, Venlafaxine, Ventolin, Viagra, Vigamox, Vitamin D, Vyvanse, Warfarin, Xopenex, Zaleplon, and Zolpidem.

RESPONSE: Defendants deny the allegations contained in Paragraph 93.

Defendants Are Fiduciaries and Parties In Interest

94. Plaintiff and the members of the ERISA Subclass (as defined below) are participants in employee welfare benefit plans as that term is defined in 29 U.S.C. § 1002(1)(A),

insured or administered by Defendants to provide participants with medical care and prescription medications ("ERISA Plans").

<u>RESPONSE</u>: Defendants admit that Plaintiff was a participant in an employer-sponsored health plan administered by OHI. The remaining allegations contained in Paragraph 94 state legal conclusions, to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 94.

95. ERISA requires every plan to provide for one or more named fiduciaries who will have "authority to control and manage the operation and administration of the plan." ERISA § 402(a)(1), 29 U.S.C. § 1102(a)(1).

<u>RESPONSE</u>: Paragraph 95 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 95.

96. ERISA treats as fiduciaries not only persons explicitly named as fiduciaries under § 402(a)(1), 29 U.S.C. § 1102(a)(1), but also any other persons who in fact perform fiduciary functions. Thus, a person is a fiduciary to the extent "(i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan." ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A). This is a functional test. Neither "named fiduciary" status nor formal delegation is required for a finding of fiduciary status, and contractual agreements cannot override finding fiduciary status when the statutory test is met.

<u>RESPONSE</u>: Paragraph 96 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 96.

97. In addition, a fiduciary that appoints another person to fulfill all or part of its duties, by formal or informal hiring, subcontracting, or delegation, assumes the duty to monitor that appointee to protect the interests of the ERISA Plans and their participants. The power to appoint, retain, and remove plan fiduciaries or service providers confers fiduciary status upon the person holding such power. An appointing fiduciary must take prudent and reasonable action to determine whether the appointees are fulfilling their own separate fiduciary obligations.

RESPONSE: Paragraph 97 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 97.

98. Defendants are fiduciaries of all of the ERISA Plans to which they provided prescription drug benefits or for which they administered prescription drug benefits in that they exercised discretionary authority or control respecting the plan and plan asset management activities, ERISA § 3(21)(A)(i), 29 U.S.C. § 1002(21)(A)(i), and in that they had discretionary authority or discretionary responsibility in the administration of the ERISA Plans of participants and beneficiaries in the ERISA Subclass, ERISA § 3(21)(A)(iii), 29 U.S.C. § 1002(21)(A)(iii).

RESPONSE: Paragraph 98 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 98.

99. Defendants *had* fiduciary authority over benefit administration under the ERISA Plans in that they operated and controlled the prescription drug benefits under the ERISA Plans as alleged herein. For example, Plaintiff Mohr-Lercara's 2011-2013 Plans state:

> **Prudent Actions by Plan Fiduciaries**
>
> ➔ In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

RESPONSE: In response to Paragraph 99, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 99 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 99.

100. Defendants are also fiduciaries because they *exercised* fiduciary authority over plan management, in addition to *having* fiduciary authority over plan administration. By way of example, they:

(a) exercised discretion to violate the Plans to calculate and set the amount of and charge patients Overcharges;

(b) had and exercised discretion to set up a computer system to process prescription drug claims and exercised discretion to program and input data into that system which they used to intentionally set the amount of Overcharges in violation of the Plans (i.e., these were not unintentional miscalculations);

(c) had and exercised discretion to dictate the amount of and require pharmacies to charge and collect the Overcharges;

(d) exercised discretion to require the pharmacies to remit some or all of the Overcharges to Defendants as Clawbacks;

(e) exercised discretion to set their own compensation for services performed as fiduciaries by dictating Spread and Clawbacks;

(f) exercised discretion to unilaterally collect their own compensation for services performed by collecting Clawbacks;

(g) exercised discretion concerning whether to disclose Clawbacks;

(h) exercised discretion to require pharmacies to misrepresent to patients the proper cost-sharing amounts and prevent pharmacies from disclosing to patients the proper cost-sharing amounts and the manner in which they charged for prescription drugs as alleged above;

(i) exercised discretion to prohibit pharmacies from disclosing to patients the existence or amount of the Overcharges; and

(j) exercised discretion to prohibit pharmacies from disclosing to patients that they could purchase drugs at a price lower than the amount set by Defendants by not using their insurance or prescription benefits.

RESPONSE: The Court dismissed Plaintiff's claims based on allegations contained in (d), (h), (i), and (j) above (Dkt. 63), and thus no response is required to those allegations. Defendants deny the remaining allegations contained in Paragraph 100.

101. In addition to their fiduciary status under the foregoing provisions, Defendants are fiduciaries in that they *exercised* authority or control respecting management or disposition of plan assets. The insurance and ASO contracts underpinning the Plans are "plan assets" within the meaning of ERISA plan assets, ERISA § 3(21)(A)(i), 29 U.S.C. § 1002(21)(A)(i). Additionally, under coinsurance plans, the payments by the Plan and employers (and related trusts) for prescription drugs are plan assets. Defendants used their authority and control over these Plan assets and cost-sharing amounts to implement their Overcharge and Clawback scheme.

RESPONSE: Paragraph 101 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 101.

102. Defendants exercised control over the amounts paid by both employers/trusts and participants/beneficiaries by dictating that pharmacies charge Overcharges, as alleged above. Defendants exercised control and authority over the insurance policies, ASO contracts, and PBM agreements in that they used these contracts — from which they derived discretion and control over plan prescription drug management and pricing — to implement the Overcharge scheme, as alleged above.

RESPONSE: Defendants deny the allegations contained in Paragraph 102.

103. In addition, OHI was a fiduciary by exercising discretion over the Plans to retain and delegate to Optum some of OHI's fiduciary duty to provide prescription drug services for the benefit of the ERISA Subclass. When OHI endowed Optum with authority and discretion to control cost-sharing amounts to be paid by the ERISA Subclass, OHI assumed the duty to monitor Optum's exercise of that discretionary authority. OHI further owed and owes the ERISA Subclass the duty to establish policies and procedures to monitor Optum's performance of its duties, to monitor its prescription medication pricing, to monitor the effect of the Overcharge and Clawback Scheme described herein on the amount paid by the ERISA Subclass, to protect the interests of the ERISA Subclass, to avoid the misuse of plan assets, and to provide complete and accurate information to the ERISA Subclass.

RESPONSE: Defendants deny the allegations contained in Paragraph 103.

104. Defendants are also parties in interest under ERISA because (a) they are fiduciaries, ERISA § 3(14)(A), 29 U.S.C. § 1002(14)(A); and/or (b) they provided insurance, plan administration, and/or pharmacy benefit management services to the ERISA Plans, ERISA § 3(14)(B), 29 U.S.C. § 1002(14)(B).

RESPONSE: Paragraph 104 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 104.

105. As parties in interest, Defendants received direct and indirect compensation for services, some of which was in the form of excess Clawback fees that were collected in exchange for few to no services. Defendants also received and used plan assets for the benefit of themselves and their affiliates to impose their Overcharge and Clawback Scheme on the ERISA Subclass.

RESPONSE: Defendants deny the allegations contained in Paragraph 105.

106. Finally, even if any Defendant is found not to be a fiduciary, that Defendant is alternatively subject to equitable relief under ERISA, because it had actual or constructive knowledge of the ERISA violations through its role in the Overcharge and Clawback Scheme.

RESPONSE: Defendants deny the allegations contained in Paragraph 106.

Defendants' ERISA Duties

107. **The Statutory Requirements**: ERISA imposes strict fiduciary duties upon plan fiduciaries. ERISA § 404(a), 29 U.S.C. § 1104(a), states, in relevant part, that:

> [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of providing benefit to participants and their beneficiaries; and defraying reasonable expenses of administering the plan; with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims; by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and Title IV.

RESPONSE: Paragraph 107 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 107.

108. **The Duty of Loyalty**. ERISA imposes on a plan fiduciary the duty of loyalty — that is, the duty to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . ." The duty of loyalty entails a duty to avoid conflicts of interest and to resolve them promptly when they occur. A fiduciary must always administer a plan with an "eye single" to the interests of the participants and beneficiaries, regardless of the interests of the fiduciaries themselves or the plan sponsor.

RESPONSE: Paragraph 108 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any

characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 108.

109. **The Duty of Prudence**. Section 404(a)(1)(B) also imposes on a plan fiduciary the duty of prudence — that is, the duty "to discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man, acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. . . ."

RESPONSE: Paragraph 109 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 109.

110. **The Duty to Inform**. The duties of loyalty and prudence include the duty to disclose and inform. These duties entail: (a) a negative duty not to misinform; (b) an affirmative duty to inform when the fiduciary knows or should know that silence might be harmful; and (c) a duty to convey complete and accurate information material to the circumstances of participants and beneficiaries.

RESPONSE: Paragraph 110 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 110.

111. **Prohibited Transactions**. ERISA's prohibited transaction rules bar fiduciaries from certain acts because they are self-interested or conflicted and therefore become per se violations of ERISA § 406(b) — or because they are improper "party in interest" transactions under ERISA § 406(a). As noted above, under ERISA, a "party in interest" includes a fiduciary, as well as entities providing any "services" to a plan, among others. See ERISA § 3(14), 29 U.S.C. § 1002(14). ERISA's prohibited transaction rules are closely related to ERISA's duties of loyalty, which are discussed above.

RESPONSE: Paragraph 111 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To

the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 111.

112. ERISA § 406(a) provides that transactions between a plan and a party in interest are prohibited transactions unless they are exempted under ERISA § 408:

> (a) Transactions between plan and party in interest
>
> Except as provided in section 1108 of this title:
>
> (1) A fiduciary with respect to a plan shall not cause the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect —
>
> (A) sale or exchange, or leasing, of any property between the plan and a party in interest;
>
> (B) lending of money or other extension of credit between the plan and a party in interest;
>
> (C) furnishing of goods, services, or facilities between the plan and a party in interest;
>
> (D) transfer to, or use by or for the benefit of a party in interest, of any assets of the plan; or
>
> (E) acquisition, on behalf of the plan, of any employer security or employer real property in violation of section 1107(a) of this title.

29 U.S.C. § 1106(a)

RESPONSE: Paragraph 112 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 112.

113. ERISA § 406(b), provides:

A fiduciary with respect to a plan shall not —

> (1) deal with the assets of the plan in his own interest or for his own account,
>
> (2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or
>
> (3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

29 U.S.C. § 1106(b).

RESPONSE: Paragraph 113 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 113.

114. **Co-Fiduciary Liability**. A fiduciary is liable not only for fiduciary breaches within the sphere of its own responsibility, but also as a co-fiduciary in certain circumstances. ERISA § 405(a), 29 U.S.C. § 1105(a), states, in relevant part, that:

> In addition to any liability which he may have under any other provision of this part, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances:
>
> (1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach; or
>
> (2) if, by his failure to comply with section 404(a)(1) in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or
>
> (3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

RESPONSE: Paragraph 114 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To

the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 114.

115. **The Duty to Monitor**. In addition, a fiduciary that appoints another person to fulfill all or part of its duties, by formal or informal hiring, subcontracting, or delegation, assumes the duty to monitor that appointee or delegatee to protect the interests of the ERISA participants and beneficiaries. As noted above, the power to appoint, retain, and remove plan fiduciaries or service providers confers fiduciary status upon the person holding such power.

RESPONSE: Paragraph 115 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 115.

116. **Non-Fiduciary Liability**. Under ERISA, non-fiduciaries — regardless of whether they are parties in interest — who knowingly participate in a fiduciary breach may themselves be liable for certain relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Accordingly, as to the ERISA claims, even if any Defendant is not found to have fiduciary or party-in-interest status themselves, they must nevertheless restore unjust profits or fees and are subject to other appropriate equitable relief with regard to the transactions at issue in this action, pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), and well established case law. To the extent that any Defendant is not deemed to be a fiduciary or a party-in-interest with regard to any transaction at issue in this action, they are nevertheless subject to equitable relief under ERISA based on their actual or constructive knowledge of the wrongdoing at issue.

RESPONSE: Paragraph 116 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 116.

117. **Rights of Action Under the Plans, for Fiduciary Breach, Prohibited Transactions, and Related Claims**. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), provides that a participant or beneficiary may bring an action to enforce rights under the terms of the plan or to clarify his rights to future benefits under the terms of the plan. Further, ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes individual participants and fiduciaries to bring suit "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." The remedies

available pursuant to § 502(a)(3) include remedies for breaches of the fiduciary duties set forth in ERISA § 404, 29 U.S.C. § 1104, and for violation of the prohibited transaction rules set forth in ERISA § 406, 29 U.S.C. § 1106. Further, ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), permits a plan participant, beneficiary, or fiduciary to bring a suit for relief under ERISA § 409. ERISA § 409, 29 U.S.C. § 1109, provides, *inter alia*, that any person who is a fiduciary with respect to a plan and who breaches any of the responsibilities, obligations, or duties imposed on fiduciaries by ERISA shall be personally liable to make good to the plan any losses to the plan resulting from each such breach and to restore to the plan any profits the fiduciary made through use of the plan's assets. ERISA § 409 further provides that such fiduciaries are subject to such other equitable or remedial relief as a court may deem appropriate. Plaintiffs bring their ERISA claims pursuant to ERISA § 502(a)(3) and (2), as well as § 502(a)(1)(B), as further set forth below, because not all the remedies Plaintiffs seek are available under all sections of ERISA and, alternatively, Plaintiffs are pleading their claims in the alternative.

RESPONSE: Paragraph 117 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 117.

Defendants Breached Their Fiduciary Duties

118. Defendants breached the terms of the ERISA Plans, committed breaches of fiduciary duty, engaged in prohibited transactions, and harmed Plaintiff and ERISA Subclass members in the following ways:

(a) Defendants wrongfully charged Plaintiff and ERISA Subclass members excessive and unlawful copayments and Spread;

(b) Defendants wrongfully charged Plaintiff and ERISA Subclass members excessive and unlawful coinsurance payments in that, rather than charging a percentage of the amounts paid to the pharmacies for the dispensed drugs, the coinsurance payments were based on substantially inflated amounts;

(c) Defendants wrongfully charged Plaintiff and ERISA Subclass members excessive and unlawful deductible payments in that rather than charging the lesser of the applicable per occurrence deductible fee or the amount paid to the pharmacy for the dispensed drug, Plaintiff and ERISA Subclass members were charged deductible fees that were higher;

(d) Defendants wrongfully used a computer system and data they input into that system to charge patients unlawful Overcharges and dictate the excessive amounts pharmacies charged patients for prescription drugs;

(e) Defendants wrongfully required pharmacies to charge patients unlawful Overcharges;

(f) Defendants wrongfully required pharmacies to collect the unlawful Overcharges and pay Overcharges back to Defendants as Clawbacks;

(g) Defendants wrongfully misrepresented to patients the proper cost-sharing amounts at the time patients filled their prescriptions and were charged by pharmacies;

(h) Defendants misrepresented their cost-sharing terms, practices and procedures in the Plan terms;

(i) Defendants willfully failed to disclose to patients the proper cost-sharing amounts and the manner in which they charged for prescription drugs;

(j) Defendants wrongfully prohibited pharmacies from disclosing to patients the existence or amount of the Overcharges, including Spread, and Clawbacks;

(k) Defendants wrongfully prohibited pharmacies from disclosing to patients that they could purchase drugs at a price lower than the amount set by Defendants;

(l) Defendants wrongfully determined the amount of and collected additional unlawful undisclosed Clawback compensation;

(m) Defendants wrongfully determined the amount of and collected additional unlawful undisclosed Clawback premium payment;

(n) Defendants set, changed, and collected their own compensation for services performed as fiduciaries by collecting Clawbacks;

(o) Defendants failed to stop injuries to plan participants caused by their co-fiduciaries and service providers; and

(p) Defendants failed to monitor their agents, appointees, formal delegatees, and informal designees in the performance of their fiduciary duties.

RESPONSE: Defendants deny the allegations contained in Paragraph 118 and each of its subparts.

119. Defendant OHI further breached its fiduciary duties under ERISA by retaining Optum to provide PBM services for the benefit of the ERISA Subclass, but failing to take reasonable and prudent action to determine whether and ensure that Optum was fulfilling its own separate fiduciary obligations. OHI breached its duty to establish policies and procedures to monitor Optum's performance of its duties, to monitor its prescription drug pricing, to monitor the effect of the Overcharges and Clawback Scheme described herein on the amount paid by the ERISA Subclass, to protect the interests of the ERISA Subclass, and to provide complete and accurate information to the ERISA Subclass.

RESPONSE: Defendants deny the allegations contained in Paragraph 119.

CLASS ACTION ALLEGATIONS

120. Plaintiff brings this action as a class action pursuant to Rule 23(b)(1), (2) and (b)(3) of the Federal Rules of Civil Procedure on behalf of themselves and the Class and the ERISA Subclass defined as follows:

> **The Class**. All individuals residing in the United States and its territories who are enrolled in a health benefit plan issued and/or administered by OHI or insured by OHI, who purchased one or more prescription drugs pursuant to such plan and paid an amount for such drug(s) that was higher than the payment amount provided by the plan.

RESPONSE: In response to Paragraph 120, Defendants admit that Plaintiff purports to bring the present action as a putative class action and that Plaintiff purports to define the class as alleged. Defendants deny that class certification is appropriate in this action.

121. Within the Class there is one subclass:

> **ERISA Subclass**. All participants or beneficiaries who are enrolled in a health benefit plan issued and/or administered by OHI or insured by OHI and subject to ERISA, who purchased one or more prescription drugs pursuant to such plan and paid an amount for such drug(s) that was higher than the payment amount provided by the plan.

RESPONSE: In response to Paragraph 121, Defendants admit that Plaintiff purports to bring the present action as a putative class action and that Plaintiff purports to define the sub-class as alleged. Defendants deny that class certification is appropriate in this action.

122. Excluded from the Class and ERISA Subclass are Defendants, any of their parent companies, subsidiaries, and/or affiliates, their officers, directors, legal representatives, and employees, any co-conspirators, all governmental entities, and any judge, justice, or judicial officer presiding over this matter.

RESPONSE: In response to Paragraph 122, Defendants admit that Plaintiff purports to bring the present action as a putative class action and that Plaintiff purports to define the class and sub-class as alleged. Defendants deny that class certification is appropriate in this action.

123. Plaintiff reserves the right to redefine the Class prior to certification.

RESPONSE: Defendants state that no response is required to Plaintiff's reservation of rights in Paragraph 123. Defendants deny that class certification is appropriate in this action.

124. **Class Period**. Plaintiff will seek class certification, losses, and other available relief for fiduciary breaches and prohibited transactions occurring within the entire period allowable under ERISA § 413, 29 U.S.C. § 1113, including its fraud or concealment tolling provisions, as well as under RICO, 18 U.S.C. 1961, et seq. and the doctrine of equitable tolling. Further, Plaintiff reserves the right to refine the Class Period after they have learned the extent of Defendants' fraud, the length of its concealment, and the time period during which "Clawbacks" were taking place.

RESPONSE: In response to Paragraph 124, Defendants deny that they engaged in any fraud or other violations of law and state that no response is required as to the allegations that relate to Plaintiff's intent in seeking relief in this action.

125. This action is brought, and may properly be maintained, as a Class action pursuant to Fed. R. Civ. P. 23. This action satisfies the numerosity, typicality, adequacy, predominance, and superiority requirements of those provisions.

RESPONSE: Paragraph 125 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class certification is appropriate in this action.

126. The Class and Subclass are so numerous that the individual joinder of all of its members is impracticable. Due to the nature of the trade and commerce involved, Plaintiff believes that the total number of Class and Subclass members is in the thousands and that the members of the Class and Subclass are geographically dispersed across the United States. While the exact number and identities of the Class and Subclass members are unknown at this time, such information can be ascertained through appropriate investigation and discovery.

RESPONSE: Paragraph 126 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class

certification is appropriate in this action and deny the remaining allegations contained in Paragraph 126.

127. Plaintiff's claims are typical of the claims of the members of the Class and Subclass because Plaintiff's claims, and the claims of all Class and SubClass members, arise out of the same conduct, policies and practices of Defendants as alleged herein, and all members of the Class and Subclass are similarly affected by Defendant's wrongful conduct.

RESPONSE: Paragraph 127 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 127.

128. There are questions of law and fact common to the Class and Subclass and these questions predominate over questions affecting only individual Class and SubClass members. Common legal and factual questions include, but are not limited to:

(a) Whether Defendants are fiduciaries under ERISA;

(b) Whether Defendants are parties in interest under ERISA;

(c) Whether Defendants breached their fiduciary duties in failing to comply with ERISA as set forth above;

(d) Whether Defendants' acts as alleged above breached ERISA's prohibited transaction rules;

(e) Whether Defendants knowingly participated in and/or knew or had constructive knowledge of violations of ERISA, including breaches of fiduciary duty;

(f) Whether Defendants conducted or participated in the conduct of the affairs of an enterprise through a pattern of racketeering activity;

(g) Whether Defendants conspired to conduct or participate in the conduct of the affairs of an enterprise through a pattern of racketeering activity;

(h) Whether such racketeering consisted of acts that are indictable pursuant to 18 U.S.C. §§ 1341 and 1343;

(i) Whether Defendants engaged in a scheme to defraud;

(j) Whether each Defendant was a knowing and active participant;

(k) Whether the mail, interstate carriers or wire transmissions were used in connection with such scheme to defraud;

(l) Whether Plaintiff and Class members were injured in their property or business as a direct and proximate result of Defendants' racketeering activities;

(m) Whether Defendants violated the Plans' terms by authorizing or permitting pharmacies to collect and then remit Overcharges, including Spread amounts to them and thereby overcharged subscribers for prescription drugs;

(n) Whether the members of the Class and/or Subclass have sustained losses and/or damages and/or Defendants have been unjustly enriched, and the proper measure of such losses, and/or damages, and/or unjust enrichment; and

(o) Whether the members of the Class and/or Subclass are entitled to declaratory and/or injunctive relief.

RESPONSE: Paragraph 128 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 128 and each of its subparts.

129. Plaintiff will fairly and adequately represent the Class and Subclass and has retained counsel experienced and competent in the prosecution of class action litigation. Plaintiff has no interests antagonistic to those of other members of the Class and Subclass. Plaintiff is committed to the vigorous prosecution of this action and anticipates no difficulty in the management of this litigation as a class action.

RESPONSE: Paragraph 129 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 129.

130. A class action is superior to all other available methods for the fair and efficient adjudication of this controversy since joinder of all members is impracticable. Furthermore, as the damages suffered by individual Class and/or Subclass members may be relatively small, the expense and burden of individual litigation make it impossible for members of the Class and/or

Subclass to individually redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

RESPONSE: Paragraph 130 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 130.

131. Class action status in this ERISA action is warranted under Rule 23(b)(1)(B) because prosecution of separate actions by the members of the Class would create a risk of adjudications with respect to individual members of the Class which would, as a practical matter, be dispositive of the interests of the other members not parties to the actions, or substantially impair or impede their ability to protect their interests.

RESPONSE: Paragraph 131 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 131.

132. Class action status is also warranted under Rule 23(b)(1)(A) because prosecution of separate actions by the members of the Class would create a risk of establishing incompatible standards of conduct for Defendants.

RESPONSE: Paragraph 132 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 132.

133. Class action status in this action is warranted under Rule 23(b)(2) because Defendants have acted or refused to act on grounds generally applicable to the Class and Subclass, thereby making appropriate final injunctive, declaratory, or other appropriate equitable relief with respect to each Class and Subclass as a whole.

RESPONSE: Paragraph 133 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class

certification is appropriate in this action and deny the remaining allegations contained in Paragraph 133.

134. Class action status in this action is warranted under Rule 23(b)(3) because questions of law or fact common to members of the Class and Subclass predominate over any questions affecting only individual members, and class action treatment is superior to the other available methods for the fair and efficient adjudication of this controversy. Joinder of all members of the Class is impracticable.

RESPONSE: Paragraph 134 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 134.

135. Plaintiff reserves the right to invoke any provision of Rule 23 appropriate at the time Plaintiff moves to certify the class or otherwise address class certification issues.

RESPONSE: Defendants state that no response is required to Plaintiff's reservation of rights in Paragraph 135. Defendants deny that class certification is appropriate in this action.

EXHAUSTION IS NOT REQUIRED

Administrative Remedies or Claims Procedures Are Deemed Exhausted, Do Not Apply and/or Would be Futile

136. The doctrine of exhaustion of administrative remedies could only apply to the claims alleged in Count I under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). No other claims in this case are even arguably subject to the exhaustion defense, particularly on a motion to dismiss. *See Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89-90 (2d Cir. 2001).

RESPONSE: Paragraph 136 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 136.

137. Exhaustion does not apply to Count I for three reasons. First, Defendants cannot meet their burden of proving that Plaintiff was required to pursue administrative remedies prior to bringing this case under the terms of the Plans.

RESPONSE: Defendants deny the allegations contained in Paragraph 137.

138. Second, Defendants cannot meet their burden of proving that they have met all of the preconditions to asserting the exhaustion defense and, in particular, cannot meet their burden of proving compliance with the Department of Labor Regulation governing reasonable claims procedures. To the contrary, since Defendants have not complied with the Regulation, Plaintiff's claims are deemed exhausted as a matter of law.

RESPONSE: Defendants deny the allegations contained in Paragraph 138.

139. Finally, exhaustion would be futile.

RESPONSE: Defendants deny the allegations contained in Paragraph 139.

Administrative Remedies Do Not Apply

140. The Plans' administrative remedies do not apply to the Overcharge claims asserted in this case. Once the pharmacy collected the cost-sharing payments and dispensed the drugs, the pharmacy had been paid in full. When that occurred, Plaintiff had received her prescriptions and had received her benefits in full. Accordingly, this case does not concern a denial of benefits. It concerns an unlawful Overcharge.

RESPONSE: Defendants deny the allegations contained in Paragraph 140.

141. Plaintiff's 2011-2013 Plans state that "the cost of Medically Necessary Prescription Drug Products will be Covered . . . ." "Cover" means the "Medically Necessary Services paid for or arranged for [Plaintiff] by [Defendants] under the terms and conditions of the [Plan]." Accordingly, the Plan benefit is the payment of prescription drug costs subject to the cost-sharing provisions of the Plan.

RESPONSE: In response to Paragraph 141, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 141 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

142. The 2014-2016 Plans similarly provide "[Defendants] Cover Medically Necessary Outpatient Prescription Drugs ...." The 2014-2016 Plans have the same definition of "cover" as the 2011-2013 Plans. Accordingly, the 2014-2016 Plan benefits are also payment of prescription drug costs.

RESPONSE: In response to Paragraph 142, Defendants state that Plaintiff's 2014-2016 plans speak for themselves, and thus no response is required. To the extent a response is

required, Defendants deny the allegations contained in Paragraph 142 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

143. The 2011-2013 Plans expressly state the procedure for obtaining prescription drug coverage benefits:

> **4. If You Receive a Bill From a Network Provider**
>
> The cost of Covered Services provided by Network Providers in accordance with the terms of this Certificate will be billed directly to Us. **No claim forms are necessary.**
>
> If you should receive a bill from a Network Provider for Covered Services, please contact the Customer Care Department immediately.

RESPONSE: In response to Paragraph 143, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 143 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

144. The 2014-2016 Plans contain a similar procedure for obtaining prescription drug coverage benefits.

> **Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider you will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

RESPONSE: In response to Paragraph 144, Defendants state that Plaintiff's 2014-2016 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 144 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

145. Plaintiff followed this procedure in obtaining her prescription drug benefits. Plaintiff submitted prescriptions to the in-network pharmacy. The pharmacy electronically transmitted the prescription benefit requests to Defendants. Defendants exercised their discretion to (1) make coverage decisions, (2) authorize the pharmacies to dispense the drugs, (3) instruct the pharmacies as to the amount of the cost-sharing payments, (4) instruct the pharmacies to represent the cost-sharing payments to Plaintiff, and (5) instruct the pharmacies to collect those payments from Plaintiff. The pharmacies then represented the cost-sharing amounts to Plaintiff and collected the payments and dispensed the drugs to the Plaintiff. At this point, the benefits process was complete as Plaintiff had received the drugs and the pharmacies had been paid in full. Plaintiff accordingly received the entirety of her prescription drug benefits. Therefore, her claim is to recover the Overcharge, not to recover benefits.

RESPONSE: Defendants deny the allegations contained in sentences 3, 5 and 6 of Paragraph 145. Defendants lack information or knowledge sufficient to form a belief as to the truth of the remaining allegations and therefore denies them.

146. Defendants cannot meet their burden of establishing as a matter of law that the Plans include a mandatory pre-suit exhaustion requirement for Overcharge claims like the claims alleged here. *Kirkendall v. Halliburton, Inc.*, 707 F.3d 173, 179 (2d Cir. 2013).

RESPONSE: Defendants deny the allegations contained in Paragraph 146.

147. Plaintiff's 2014-2016 Plans provide:

> 24. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 3 years from the date the claim was required to be filed.

RESPONSE: In response to Paragraph 147, Defendants state that Plaintiff's 2014-2016 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 147 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

148. Here, the claim was submitted in writing when the pharmacy electronically submitted the claim to Defendants, which was more than sixty days ago. Accordingly, the only pre-suit requirement was met concerning this Plan.

RESPONSE: Defendants deny the allegations contained in Paragraph 148.

149. Plaintiff's 2011-2013 Plans provide:

> 16. Legal Action. No action at law or in equity may be maintained against Us for any expense or bill unless brought within the statute of limitations for such cause of action.

Since the statute of limitations either has not expired or has been tolled, as alleged below, this provision does not provide for a mandatory pre-suit exhaustion requirement.

RESPONSE: Defendants deny the allegations contained in Paragraph 149.

150. Moreover, the Grievance and Appeal Procedure under the 2011-2013 Plans is limited solely to Adverse Determinations and does not apply to the Overcharge claims asserted here.

> The Grievance and Appeal procedure is a procedure to be used after you have received an initial Adverse Determination concerning a claim for benefits or an administrative issue. Benefit issues include, but are not limited to: denials based on benefit exclusions or limitations and claims payment disputes. Administrative issues concern other requirements of your health plan. Administrative issues would include issues such as access to providers, eligibility or enrollment issues.

RESPONSE: Defendants deny the allegations contained in Paragraph 150.

151. An Adverse Determination is:

> **Adverse Determination -** Our determination that an admission, extension of stay, or other Health Care Service, is not Medically Necessary based on a review of the information provided. Additionally, an Adverse Determination will be rendered if We do not receive a response to Our request for information necessary to review your case.

RESPONSE: In response to Paragraph 151, Defendants state that Plaintiff's 2011-2013 plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 151 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

152. Since this case does not concern whether healthcare is "Medically Necessary" or any "request for information," and does not concern an initial "Adverse Determination," the Grievance and Appeal Procedure does not apply.

RESPONSE: Defendants deny the allegations contained in Paragraph 152.

153. For each of these reasons, the Plans do not contain any mandatory pre-suit administrative procedures.

RESPONSE: Defendants deny the allegations contained in Paragraph 153.

Plaintiff's Claims Are Deemed Exhausted

154. In order to prevail on an exhaustion affirmative defense, Defendants must meet their burden of proving factually that they complied with the DOL Regulation governing claim procedures. This Regulation provides that every Plan must "establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations." C.F.R. § 2560-503-1 (b). To take advantage of an exhaustion defense, Defendants have the burden of proving full compliance with this Regulation. *Halo v. Yale Health Plan, Director of Benefits & Records Yale University*, 819 F.3d 42, 56-58 (2nd Cir. 2016). If Defendants fail to meet their burden of proof, Plaintiffs are "deemed to have exhausted the administrative remedies under the Plans and shall be entitled to pursue any available remedies under section 502 (a)" of ERISA. 29 C.F.R. § 2560-503-1 (l)(1).

RESPONSE: Paragraph 154 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 154.

155. Plaintiff's Plans define a pre-service claim as "a request that a service or treatment be approved before it has been received." Because the claim was submitted by the pharmacy and approved by Defendants before the pharmacy was paid and the drugs were dispensed, the transactions at issue concern pre-service claims for benefits.

RESPONSE: In response to the allegations contained in the first sentence of Paragraph 155, Defendants state that Plaintiff's plans speak for themselves, and thus no response is required. Defendants deny the remaining allegations contained in Paragraph 155.

156. Plaintiff's Plans provide that for pre-service claims for benefits, Defendants will decide and notify Plaintiff of any decision on any grievance within 15 days of receipt of the grievance.

RESPONSE: In response Paragraph 156, Defendants state that Plaintiff's plans speak for themselves, and thus no response is required. To the extent a response is required, Defendants deny the allegations contained in Paragraph 156 to the extent they mischaracterize the plans or are inconsistent or incomplete with respect thereto.

157. Plaintiff sent and Defendants received Plaintiff's grievance on April 26, 2018. Defendants did not respond within 15 days and have not responded as of this date. Accordingly, Defendants violated the administrative procedures in Plaintiff's Plans.

RESPONSE: Defendants admit that their counsel received a letter from Plaintiff's counsel on April 26, 2018. Defendants deny the remaining allegations contained in Paragraph 157.

158. In addition to failing to respond to Plaintiff's grievance as provided by the Plans, in response to the claim for prescription drug benefits filed by the pharmacy for the benefit of Plaintiff as required by the Plans, Defendants failed to provide any, much less detailed, notice that the Regulation requires, including that there was an Overcharge, the amount of the Overcharge, the specific reason for the Overcharge, reference to the plan provisions on which the determination was based, a description of the review procedures and the rules relied upon in making the determination. 29 C.F.R. § 2560-503-1 (g). To the contrary, the most Plaintiff received was a piece of paper stapled to a pharmacy bag that stated only the amount of the cost-share (but concealed the fact that there was an Overcharge). That "notice" does not meet any of the requirements of the Regulation and it renders the exhaustion defense invalid.

RESPONSE: In response to Paragraph 158, Defendants lack information or knowledge sufficient to form a belief as to the truth of the allegations regarding what Plaintiff received from her pharmacies. Defendants deny the remaining allegations.

159. Moreover, Defendants blocked the pharmacy from disclosing the Overcharges to Plaintiff. Although the pharmacy had the amount of the Overcharges on its computer screen at the time Plaintiff submitted her prescriptions to be filled, Defendants prohibited the pharmacy from disclosing this important information to Plaintiff. By blocking disclosure of the Overcharges, Defendants' procedures unduly inhibited and hampered the initiation of claims in violation of 29 C.F.R. § 2560-503-1 (b)(3) and are unreasonable as a matter of law.

RESPONSE: In response to Paragraph 159, Defendants state that they lack knowledge or information sufficient to form a belief as to the truth of the allegations regarding the vaguely-referenced pharmacy's "computer screen at the time Plaintiff submitted her prescriptions to be filled," and on that basis, deny them. Defendants deny the remaining allegations contained in Paragraph 159.

160. For these reasons, Defendants did not establish and maintain reasonable claims procedures. Plaintiff is "deemed to have exhausted the administrative remedies under the Plan

and shall be entitled to pursue any available remedies under section 502 (a)" of ERISA. 29 C.F.R. § 2560.503-1 (l)(1).

RESPONSE: Paragraph 160 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

Administrative Appeals Would Be Futile.

161. Defendants' pervasive fraudulent Overcharge and Clawback scheme is a long-standing policy, broadly and systematically applied to all patients, regardless of their personal circumstances or locations.

RESPONSE: Defendants deny the allegations contained in Paragraph 161.

162. Defendants deliberately attempted to conceal their Overcharge and Clawback scheme through the "gag clauses," ensuring it would be difficult if not impossible for Plaintiffs to be aware or quantify the overcharges, thereby effectively thwarting a potential claimant from pursuing an administrative claim.

RESPONSE: Defendants deny the allegations contained in Paragraph 162.

163. Moreover, the notion that Defendants would disclose their massive fraudulent Overcharge and Clawback scheme in response to an administrative claim by a single patient is not remotely credible. Indeed, as discussed above, when a reporter exposed the Overcharge and Clawback scheme, Defendants publicly "doubled down" and lied about its scheme: claiming falsely that they "ensure[] the customer pays the lowest amount possible within their plan" and that the Clawbacks "do[] not accrue to our bottom line."

RESPONSE: Defendants deny the allegations contained in the first sentence of Paragraph 163. The second sentence of Paragraph 163 quotes an email, the content of which speaks for itself such that no response is required, and Defendants deny the allegations to the extent they mischaracterize the referenced email or are inconsistent or incomplete with respect thereto.

164. And, assuming Defendants did disclose the scheme to those patients who complained, correcting the prices paid by patients on an individualized basis would inevitably result in unfair, disparate, and discriminatory treatment among Subclass members who, despite the barriers Defendants have put in place, are able to obtain reimbursement for the overcharges, and those who have not or cannot. A far more equitable, efficient and effective way to

adjudicate overpayments made by the Subclass is for Defendants to disgorge in full these amounts pursuant to their own records that can track such payments for everyone in the Subclass.

RESPONSE: Defendants deny the allegations contained in Paragraph 164.

PLAINTIFF AND THE CLASS ARE ENTITLED TO TOLLING OF ERISA'S STATUTE OF LIMITATIONS DUE TO FRAUD OR CONCEALMENT

165. By its nature, Defendants' Overcharge and Clawback Scheme has hidden Defendants' unlawful conduct from injured parties.

RESPONSE: Defendants deny the allegations contained in Paragraph 165.

166. Neither Plaintiff nor Class members knew of the Overcharge and Clawback Scheme, nor could they have reasonably discovered the existence of the Overcharge and Clawback Scheme, until shortly before filing this action.

RESPONSE: In response to Paragraph 166, Defendants state that they lack knowledge or information sufficient to form a belief as to the truth of the allegations regarding Plaintiff's actual knowledge and therefore deny the same, and deny the remaining allegations contained in Paragraph 166.

167. Until recent news broke about Defendants' Overcharge and Clawback Scheme, their unlawful conduct was hidden from Plaintiff and the Class.

RESPONSE: Defendants deny the allegations contained in Paragraph 167.

168. Even today, the gag clauses in place between Defendants and providers continue to hide Defendants' unlawful conduct from members of the Class.

RESPONSE: Defendants deny the allegations contained in Paragraph 168.

169. To the extent that any of the causes of action alleged infra are subject to a specific statute of limitations, Defendants' fraud or concealment alleged herein tolls those requirements, for a specific amount of time to be determined as the litigation progresses.

RESPONSE: Defendants deny the allegations contained in Paragraph 169.

170. Further, ERISA's statute of limitations for fiduciary breach claims, ERISA § 413, 29 U.S.C. § 1113, provides that "in the case of fraud or concealment, [an] action may be commenced not later than six years after the date of discovery of such breach or violation."

RESPONSE: Paragraph 170 states legal conclusions and purports to characterize and partially quote a statute, the terms of which speak for itself, and thus no response is required. To

the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 170.

171. While the RICO statute does not contain an express limitation period, the United States Supreme Court has held that civil RICO claims must be brought within four years from the discovery of an injury, which limitation is subject to equitable tolling due to defendants' fraudulent concealment of their unlawful conduct. *Rotella v. Wood*, 528 U.S. 549 (2000).

RESPONSE: Paragraph 171 states legal conclusions and purports to characterize a judicial opinion, the content of which speaks for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 171.

172. The Overcharge and Clawback Scheme — by its nature a secret endeavor by Defendants — remains hidden from most members of the Class. Moreover, during the Class Period, as defined above, each Defendant actively and effectively concealed its participation in the Overcharge and Clawback Scheme from Plaintiffs and other members of the Class and Subclass through "gag clauses" and secrecy policies. There is no question that Plaintiffs' claims are timely.

RESPONSE: Defendants deny the allegations contained in Paragraph 172.

COUNT I

For Violations of ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) Against All Defendants on Behalf of the ERISA Subclass

173. Plaintiff incorporates by reference each and every allegation above as if set forth fully herein.

RESPONSE: Defendants reallege and reincorporate by reference their responses to Paragraphs 1-172 as if fully set forth herein.

174. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) provides that a participant or beneficiary may bring an action to enforce rights under the terms of the plan or to clarify her rights to future benefits under the terms of the plan.

RESPONSE: Paragraph 174 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 174.

175. As set forth above, as a result of being overcharged for prescription drugs, Plaintiff and the ERISA Subclass have been and likely will continue to be denied their rights under the Plans to be charged a lower amount for their prescriptions.

RESPONSE: Defendants deny the allegations contained in Paragraph 175.

176. Plaintiff and the ERISA Subclass have been damaged in the amount of the Overcharges, including Spread. Plaintiff and the ERISA Subclass are entitled to recover the amounts they have been overcharged.

RESPONSE: Defendants deny the allegations contained in Paragraph 176.

177. Plaintiff and the ERISA Subclass are entitled to enforce their rights under the terms of the plans and seek clarification of their future rights and are entitled to an order providing, among other things:

(a) That they have been overcharged;

(b) For a declaration that they have a right under the ERISA Plans to pay no more for prescription drugs than the Plans specify;

(c) For a readjudication of claims;

(d) For an accounting and calculation of Defendants' profits from the Overcharge scheme;

(e) For payment of all amounts due to them in accordance with their rights under the ERISA Plans; and

(f) For an order enjoining future Overcharges and Clawbacks or any other additional amounts that conflict with their rights under the ERISA Plans.

RESPONSE: Defendants deny the allegations contained in Paragraph 177 and each of its subparts.

COUNT II

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)
for Violations of ERISA § 406(a)(1)(C) & (D), 29 U.S.C. § 1106(a)(1)(C) & (D)
Against All Defendants on Behalf of the ERISA Subclass

178. Plaintiff incorporates by reference each and every allegation above as if set forth fully herein.

RESPONSE: Defendants reallege and reincorporate by reference their responses to Paragraphs 1-177 as if fully set forth herein.

179. ERISA § 406(a)(1)(C), 29 U.S.C. § 1106(a)(1)(C), provides that a fiduciary shall not cause a plan to engage in a transaction if it knows or should know that the transaction constitutes the payment of direct or indirect compensation in the furnishing of services by a party in interest to a plan.

RESPONSE: Paragraph 179 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 179.

180. ERISA § 406(a)(1)(D), 29 U.S.C. § 1106(a)(1)(D), provides that a fiduciary shall not cause a plan to engage in a transaction if it knows or should know that the transaction constitutes the transfer to, or use by or for the benefit of a party in interest, of any assets of the plan.

RESPONSE: Paragraph 180 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 180.

181. As alleged above, Defendants are fiduciaries of the ERISA Plans of the participants and beneficiaries in the ERISA Subclass. Defendants are also parties in interest under ERISA in that they are fiduciaries and/or they provided prescription drug insurance and/or administrative "services" to ERISA SubClass members pursuant to the ERISA Plans. ERISA § 3(14)(A) & (B), 29 U.S.C. § 1002(14)(A) & (B). Thus they were engaged on one or both sides of these § 406(a) prohibited transactions.

RESPONSE: Paragraph 181 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

182. As fiduciaries, each Defendant caused the ERISA Plans to engage in prohibited transactions with the other as alleged herein. Specifically, OHI caused the ERISA Plans to engage in prohibited transactions with Optum, and Optum caused the ERISA Plans to engage in prohibited transactions with OHI.

RESPONSE: Defendants deny the allegations contained in Paragraph 182.

183. As parties in interest, Defendants received direct and indirect compensation in the form of undisclosed compensation, including Clawbacks, in exchange for the services they provided to Plaintiff and the ERISA Subclass pursuant to their prescription drug Plans. ERISA § 406(a)(1)(C), 29 U.S.C. § 1106(a)(1)(C).

RESPONSE: Defendants deny the allegations contained in Paragraph 183.

184. Such transactions are strictly prohibited unless three requirements are met: (1) the services are necessary for the operation of a plan, (2) the services are furnished under a contract or arrangement that is reasonable; and (3) the compensation was reasonable. ERISA § 408(b)(2), 29 U.S.C. § 1108(b)(2).

RESPONSE: Paragraph 184 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 184.

185. While the burden is on Defendants to invoke and establish this exception, the compensation paid to each Defendant pursuant to each prohibited transaction was not reasonable under ERISA § 408(b)(2), 29 U.S.C. § 1108(b)(2) in that the compensation was excessive and/or unreasonable in relation to the value of the services provided. Defendants' compensation was also unreasonable because it exceeded the premiums and other fees that were agreed upon for fully providing prescription drug benefits. Further, Defendants as fiduciaries of the ERISA Plans are entitled to receive at most reimbursement for their direct expenses. Moreover, the contract or arrangement was unreasonable because the Defendants failed to disclose Overcharge/Spread/Clawback compensation pursuant to DOL Rule 408b-2(c).

RESPONSE: Defendants deny the allegations contained in Paragraph 185.

186. Defendants also received transfers of plan assets in that they received Plan and employer payments under coinsurance Plans through Clawbacks. ERISA § 406(a)(1)(D), 29 U.S.C. § 1106(a)(1)(D).

RESPONSE: Defendants deny the allegations contained in Paragraph 186.

187. In addition, Defendants used — and misused — assets of the ERISA Plans by leveraging the contracts underpinning these ERISA Plans to gain access to patients who needed prescription drugs and would be required to pay copayments, coinsurance, or deductible payments which Defendants could appropriate in their Overcharge and Clawback Scheme. Further, Defendants used — and misused — for their own benefit and the benefit of other parties in interest additional assets of the ERISA Plans — the contracts underpinning the ERISA Plans of members of the ERISA Subclass — to effectuate their Overcharge and Clawback Scheme. ERISA § 406(a)(1)(D), 29 U.S.C. § 1106(a)(1)(D).

RESPONSE: Defendants deny the allegations contained in Paragraph 187.

188. Plaintiff and the ERISA Subclass have suffered losses and/or damages and/or Defendants have been unjustly enriched in the amount of the Overcharges and Clawbacks Defendants took for themselves.

RESPONSE: Defendants deny the allegations contained in Paragraph 188.

189. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action: "(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

RESPONSE: Paragraph 189 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 189.

190. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiff and the Class, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions and readjudication of claims;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) restitution;

(h) full disclosure of the foregoing acts and practices;

(i) an injunction against further violations; and/or

(j) any other remedy the Court deems proper.

RESPONSE: Defendants deny the allegations contained in Paragraph 190.

COUNT III

**ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)
for Violations of ERISA § 406(b), 29 U.S.C. § 1106(b)
Against All Defendants on Behalf of the ERISA Subclass**

191. Plaintiff incorporates by reference each and every allegation above as if set forth fully herein.

RESPONSE: Defendants reallege and reincorporate by reference their responses to Paragraphs 1-190 as if fully set forth herein.

192. ERISA § 406(b), 29 U.S.C. § 1106(b), provides that a fiduciary shall not (1) deal with plan assets in its own interest or for its own account, (2) act in any transaction involving the plan on behalf of a party whose interests are adverse to the interests of participants or beneficiaries, or (3) receive any consideration for its own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

RESPONSE: Paragraph 192 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 192.

193. As alleged above, Defendants are fiduciaries to the ERISA Plans. They violated all three subsections of ERISA § 406(b).

RESPONSE: Defendants deny the allegations contained in Paragraph 193.

194. As alleged above, (i) cost-sharing payments by Plans and employers or trusts under coinsurance Plans, (ii) the contracts underpinning the ERISA SubClass members' ERISA Plans, and (iii) Plan contributions are plan assets under ERISA.

RESPONSE: Defendants deny the allegations contained in Paragraph 194.

195. First, (1) by setting their own compensation from Plan and employer cost-sharing payments and taking their own compensation from that same source, and (2) by using Plan contracts in their own interest or for their own account to effectuate the Overcharge and Clawback scheme, Defendants violated ERISA § 406(b)(1). As to the latter, Defendants acted in their own self interest in using their authority over prescription drug benefit management and administration derived from the insurance policies, ASO contracts, and PBM agreements to design and implement the Overcharge and Clawback scheme for their own benefit.

RESPONSE: Defendants deny the allegations contained in Paragraph 195.

196. Second, by acting on behalf of each other, themselves, and their affiliates, to profit from Overcharges and Clawbacks at the expense of Plaintiff and members of the ERISA Subclass — and thus acting with parties with interests adverse to the affected participants and beneficiaries — each Defendant engaged in a conflicted transactions each time it took Clawbacks in violation of ERISA § 406(b)(2). Under this subsection of ERISA § 406(b), plan assets need not be involved — dealing with a plan is enough.

RESPONSE: Defendants deny the allegations contained in Paragraph 196.

197. Third, through their Overcharge and Clawback Scheme, Defendants violated ERISA § 406(b)(3) because they received consideration for their own personal accounts from other parties — including each other, pharmacies, Plans, employers, trusts, and the members of the ERISA Subclass — that were dealing with the ERISA Plans in connection with a transaction (a prescription drug transaction) involving the assets of the ERISA Plans.

RESPONSE: Defendants deny the allegations contained in Paragraph 197.

198. Plaintiff and the ERISA Subclass have been damaged and suffered losses in the amount of the Overcharges and Clawbacks Defendants took through these prohibited transactions.

RESPONSE: Defendants deny the allegations contained in Paragraph 198.

199. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action: "(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

RESPONSE: Paragraph 199 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 199.

200. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiff and the ERISA Subclass, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions and readjudication of claims;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) restitution;

(h) full disclosure of the foregoing acts and practices;

(i) an injunction against further violations; and/or

(j) any other remedy the Court deems proper.

RESPONSE: Defendants deny the allegations contained in Paragraph 200.

COUNT IV

ERISA § 502(a)(2) and (3), 29 U.S.C. § 1132(a)(2) and (3) for Violations of ERISA §§ 404 and 409, 29 U.S.C. § 1104 and 1109 Against All Defendants on Behalf of the ERISA Subclass

201. Plaintiff incorporates by reference each and every allegation above as if set forth fully herein.

RESPONSE: Defendants reallege and reincorporate by reference their responses to Paragraphs 1-200 as if fully set forth herein.

202. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), provides that a fiduciary shall discharge its duties with respect to a plan in accordance with the documents and instruments governing the plan.

RESPONSE: Paragraph 202 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a

response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 202.

203. Defendants failed to discharge their duties in accordance with the documents and instruments governing the ERISA Plans by requiring pharmacies to charge participants and beneficiaries cost-sharing payments that exceeded the limits imposed by the ERISA Plans, as alleged above.

RESPONSE: Defendants deny the allegations contained in Paragraph 203.

204. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), further provides that a fiduciary shall discharge its duties with respect to a plan (1) solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan ("loyalty") and (2) 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 in the conduct of an enterprise of a like character and with like aims ("prudence").

RESPONSE: Paragraph 204 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 204.

205. In setting the amount of and charging Overcharges and taking Clawbacks, Defendants have breached their fiduciary duties of loyalty and prudence and have violated the terms of the Plans.

RESPONSE: Defendants deny the allegations contained in Paragraph 205.

206. Specifically, Defendants acted in furtherance of their own interests and the interests of their affiliates, and thus failed to act solely in the interests of participants and beneficiaries of the ERISA Plans, by requiring pharmacies to charge Overcharges and to remit Clawbacks.

RESPONSE: Defendants deny the allegations contained in Paragraph 206.

207. Defendants failed to act with the exclusive purpose of defraying reasonable expenses of administering the ERISA Plans by using their fiduciary control and discretion to require pharmacies collect Overcharges from participants and beneficiaries.

RESPONSE: Defendants deny the allegations contained in Paragraph 207.

208. Defendants failed to act with the care, skill, prudence, and diligence that a prudent PBM, insurer, and/or plan administrator would have used in similar circumstances by operating their Overcharge and Clawback scheme.

RESPONSE: Defendants deny the allegations contained in Paragraph 208.

209. The duties of loyalty and prudence also entail: (a) a negative duty not to misinform; (b) an affirmative duty to inform when the fiduciary knows or should know that silence might be harmful; and (c) a duty to convey complete and accurate information material to the circumstances of participants and beneficiaries.

RESPONSE: Paragraph 209 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 209.

210. Defendants breached the duty to inform by (i) misrepresenting to participants and beneficiaries the proper cost-sharing amounts in both the Plan terms and when participants and beneficiaries filled their prescriptions and were charged by pharmacies; (ii) failing to disclose to participants and beneficiaries the proper cost-sharing amounts, the manner in which they charged for prescription drugs, and the fact that the actual practices of charging and collecting cost-sharing payments for prescription drugs differ from the Plan terms; and (iii) prohibiting pharmacies from disclosing to participants and beneficiaries the existence or amount of the Overcharges, Spread, and Clawbacks and the fact that participants and beneficiaries could purchase drugs at a price lower than the amount set by Defendants.

RESPONSE: Defendants deny the allegations contained in Paragraph 210.

211. In addition, a fiduciary that appoints another person to fulfill all or part of its duties, by formal or informal hiring, subcontracting, or delegation, assumes the duty to monitor that appointee to protect the interests of the ERISA participants and beneficiaries. As noted herein, the power to appoint, retain, and remove plan fiduciaries or service providers confers fiduciary status upon the person holding such power.

RESPONSE: Paragraph 211 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 211.

212. OHI failed to adequately monitor the activities of Optum, including *inter alia*, failing to monitor the prices charged by Optum for prescription medications provided to Plaintiff and the ERISA Subclass and permitting and/or participating in the Overcharge and Clawback Scheme described herein. As such, OHI failed to monitor its appointees, formal delegatees, and informal designees in the performance of its fiduciary duties.

RESPONSE: Defendants deny the allegations contained in Paragraph 212.

213. Finally, it is never prudent to require or allow excessive compensation in the context of an ERISA-covered plan. In so doing, Defendants violated their duty of prudence.

RESPONSE: The first sentence of Paragraph 213 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the same. Defendants deny the remaining allegations contained in Paragraph 213.

214. Plaintiff and the ERISA Subclass have been damaged and suffered losses in the amount of their cost-sharing payments that exceeded the limits under the ERISA Plans or otherwise were excessive and unreasonable, including the amount of Spread that was Clawed Back by Defendants.

RESPONSE: Defendants deny the allegations contained in Paragraph 214.

215. ERISA § 409, 29 U.S.C. § 1109, provides, *inter alia*, that any person who is a fiduciary with respect to a plan and who breaches any of the responsibilities, obligations, or duties imposed on fiduciaries by ERISA shall be personally liable to make good to the plan any losses to the plan resulting from each such breach and to restore to the plan any profits the fiduciary made through use of the plan's assets. ERISA § 409 further provides that such fiduciaries are subject to such other equitable or remedial relief as a court may deem appropriate.

RESPONSE: Paragraph 215 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 215.

216. ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), permits a plan participant, beneficiary, or fiduciary to bring a suit for relief under ERISA § 409.

RESPONSE: Paragraph 216 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 216.

217. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action: "(A) to enjoin any act or practice which violates any provision

of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

RESPONSE: Paragraph 217 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 217.

218. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiff and the ERISA Subclass, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions and readjudication of claims;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) restitution;

(h) full disclosure of the foregoing acts and practices;

(i) an injunction against further violations; and/or

(j) any other remedy the Court deems proper.

RESPONSE: Defendants deny the allegations contained in Paragraph 218.

COUNT V

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)
for Violations of ERISA § 405(a), 29 U.S.C. § 1105(a)
Against All Defendants on Behalf of the ERISA Subclass

219. Plaintiff incorporates by reference each and every allegation above as if set forth fully herein.

RESPONSE: Defendants reallege and reincorporate by reference their responses to Paragraphs 1-218 as if fully set forth herein.

220. As alleged above, Defendants were fiduciaries within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A). Thus, they were bound by the duties of loyalty, exclusive purpose, and prudence and they were prohibited from engaging in self-interested and conflicted transactions.

RESPONSE Paragraph 220 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

221. As alleged above, ERISA § 405(a), 29 U.S.C. § 1105(a), imposes liability on a fiduciary, in addition to any liability which it may have under any other provision, for a breach of fiduciary responsibility of another fiduciary with respect to the same plan if it knows of a breach and fails to remedy it, knowingly participates in a breach, or enables a breach. The Defendants breached all three provisions.

RESPONSE: Paragraph 221 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

222. **Knowledge of a Breach and Failure to Remedy**. ERISA § 405(a)(3), 29 U.S.C. § 1105(a)(3), imposes co-fiduciary liability on a fiduciary for a fiduciary breach by another fiduciary if it has knowledge of a breach by such other fiduciary, unless it makes reasonable efforts under the circumstances to remedy the breach. Upon information and belief, each Defendant knew of the breaches by the other fiduciaries and made no efforts, much less reasonable ones, to remedy those breaches.

RESPONSE: Paragraph 222 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

223. **Knowing Participation in a Breach**. ERISA § 405(a)(1), 29 U.S.C. § 1105(a)(1), imposes liability on a fiduciary for a breach of fiduciary responsibility of another fiduciary with respect to the same plan if it participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach. Upon information and belief, each Defendant participated in the breaches by the other fiduciaries.

RESPONSE: Paragraph 223 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

224. **Enabling a Breach**. ERISA § 405(a)(2), 29 U.S.C. § 1105(a)(2), imposes liability on a fiduciary if, by failing to comply with ERISA § 404(a)(1), 29 U.S.C. §1104(a)(1), in the administration of its specific responsibilities which give rise to its status as a fiduciary, it has enabled another fiduciary to commit a breach, even without knowledge of the breach. Upon information and belief, each Defendant enabled the breaches by the other fiduciaries.

RESPONSE: Paragraph 224 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

225. Plaintiff and the ERISA Subclass have been damaged in the amount of the Overcharges.

RESPONSE: Defendants deny the allegations contained in Paragraph 225.

226. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action: "(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

RESPONSE: Paragraph 226 states legal conclusions and purports to characterize a statute, the terms of which speak for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny any characterization contrary to the terms of the statute and deny the remaining allegations contained in Paragraph 226.

227. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiff and the ERISA Subclass, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions and readjudication of claims;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) restitution;

(h) full disclosure of the foregoing acts and practices;

(i) an injunction against further violations; and/or

(j) any other remedy the Court deems proper.

RESPONSE: Defendants deny the allegations contained in Paragraph 227.

COUNT VI

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) for Knowing Participation in Violations of ERISA In the Alternative, Against All Defendants on Behalf of the ERISA Subclass

228. Plaintiff incorporates by reference each and every allegation above as if set forth fully herein.

RESPONSE: Defendants reallege and reincorporate by reference their responses to Paragraphs 1-227 as if fully set forth herein.

229. As noted above, fiduciary status is not required for liability under ERISA where non-fiduciaries participate in and/or profit from a fiduciary's breach or prohibited transaction. Accordingly, Plaintiff makes claims against Defendants to the extent that one or more of them may be found not to have fiduciary status with respect to the ERISA Plans. As nonfiduciaries, they nevertheless must restore unjust profits or fees and are subject to other appropriate equitable relief, pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), and pursuant to *Harris Trust & Sav. Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238 (2000).

RESPONSE: Paragraph 229 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 229.

230. Defendants had actual or constructive knowledge of and participated in and/or profited from the prohibited transactions and fiduciary breaches alleged in Counts II-V by the Defendants who are found to be fiduciaries. Accordingly, Defendants, even if found to be nonfiduciaries, are liable to disgorge ill-gotten gains and/or plan assets and to provide other appropriate equitable relief, pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), and *Harris Trust*.

RESPONSE: Paragraph 230 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

231. As a direct and proximate result of the fiduciary breaches and prohibited transactions alleged in Counts II-IV, Plaintiff and the members of the ERISA Subclass lost the Overcharges that were improperly used to generate profits for the Defendants, their affiliates, and third parties. Defendants collected and/or paid these amounts to themselves, their affiliates, or third parties from plan assets or generated them through improper leveraging of plan assets. Defendants, even to the extent they are found not to be fiduciaries, received these excessive payments and retained them for their own accounts.

RESPONSE: Defendants deny the allegations contained in Paragraph 231.

232. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), the Court should order equitable relief to Plaintiff and the ERISA Subclass, including but not limited to:

(a) an accounting;

(b) a surcharge;

(c) correction of the transactions and readjudication of claims;

(d) disgorgement of profits;

(e) an equitable lien;

(f) a constructive trust;

(g) restitution;

(h) full disclosure of the foregoing acts and practices;

(i) an injunction against further violations; and/or

(j) any other remedy the Court deems proper.

RESPONSE: Defendants deny the allegations contained in Paragraph 232.

COUNT VII

For Violating RICO, 18 U.S.C. § 1962(c)
Against OHI on Behalf of the Class

233. Plaintiff incorporate by reference each and every allegation above as if set forth fully herein.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 233 is required.

234. At all relevant times, OHI was associated with an enterprise consisting of Optum ("Optum Enterprise").

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 234 is required.

235. Optum is a legal entity enterprise within the meaning of 18 U.S.C. §1961(4).

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 235 is required.

236. At all relevant times, Optum has been engaged in, and its activities affect, interstate commerce within the meaning of RICO, 18 U.S.C. § 1962(c).

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 236 is required.

237. OHI is legally and factually distinct and separate from Optum. OHI is a legal entity that operates a health insurance company. On the other hand, Optum is a separate legal entity with different rights and responsibilities and it operates a distinct line of business as a PBM.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 237 is required.

238. OHI and Optum are separate and distinct from the pattern of racketeering acts in which Optum engaged.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 238 is required.

239. OHI agreed to and did conduct affairs and participate in the conduct of the Optum Enterprise. OHI operated and managed the affairs of the Optum Enterprise through, among other ways, contracts, and agreements through which OHI was able to and did exert control over Optum, which served as PBM for OHI.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 239 is required.

240. Optum has contracts with the pharmacies in its network, and a "Provider Manual" that "is incorporated in and is a part of" a provider's "Agreement" with Optum. The contracts

and the Manual describe the manner in which claims for medically necessary prescription drugs, including claims by Plaintiff and Class members, are submitted and processed.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 240 is required.

241. OHI had the ability to and did in fact direct the Optum Enterprise to intentionally misrepresent — and to direct its providers to intentionally misrepresent — the cost-sharing Overcharges Plaintiff and the Class members were required to pay to receive medically necessary prescription drugs. OHI further directed Optum and its pharmacies to collect a specified Overcharge amount. This specified Overcharge exceeded the amount OHI had promised Plaintiffs and the Class members they would pay for medically necessary prescription drugs. After Plaintiffs and Class members overpaid for the medically necessary services and equipment, OHI directed Optum to return some or all of these funds to OHI as Clawbacks.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 241 is required.

242. As described herein, Optum is a separate legal entity, whose purpose is to provide Plaintiff and the Class medically necessary prescription drugs in accordance with the terms of their Plans. These legitimate and lawful activities are not being challenged in this Complaint, other than to the extent that they create a false appearance of legitimacy for the fraudulent scheme alleged herein.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 242 is required.

243. OHI, however, also directs the Optum Enterprise to serve an unlawful purpose; that is, to create a mechanism through which OHI could obtain additional monies beyond what Plaintiffs and Class members should have paid under their Plans for medically necessary prescription drugs. This fraudulent Overcharge Scheme, was not legitimate and OHI uses Optum as a separate and distinct legal entity to disguise and perpetuate the fraudulent scheme. OHI uses Optum as a tool to create an appearance of legitimacy as a PBM when, in fact, it is using Optum to enforce the fraudulent scheme, which is not a legitimate function of a PBM. Indeed, as alleged above, Defendants acted in concert in making intentionally misleading statements to the media to try to continue to disguise this Overcharge Scheme as it was being exposed. Optum falsely declared that, as a PBM, its "program ensures the customer [like an OHI participant] pays the lowest amount possible within their plan." In this way, OHI used Optum as a vehicle for its unlawful activity.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 243 is required.

244. OHI agreed to and did conduct and participate in the conduct of Optum's affairs through a pattern of racketeering activity and for the unlawful purpose of intentionally defrauding Plaintiffs and the Class members. OHI used Optum to facilitate its goal of overcharging for medically necessary prescription drugs, and was unjustly enriched by overcharging for medically necessary prescription drugs.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 244 is required.

245. As described herein, OHI directly and indirectly conducted and participated in the conduct of the Optum Enterprise through a pattern of racketeering and activity in violation of 18 U.S.C. § 1962(c) for the unlawful purpose of defrauding Plaintiffs and Class members.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 245 is required.

246. Pursuant to and in furtherance of its fraudulent billing scheme, OHI directed Optum to commit multiple related predicate acts of "racketeering activity," as defined in 18 U.S.C. § 1961(5), prior to, and during, the Class Period and continue to commit such predicate acts, in furtherance of their fraudulent billing scheme, including: (a) mail fraud, in violation of 18 U.S.C. § 1341; and (b) wire fraud, in violation of 18 U.S.C. § 1343.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 246 is required.

247. As alleged herein, OHI's conduct went far beyond compliance with "arms-length" contracts — it entailed the exercise of control to impose illegal Overcharges and Clawbacks on participants. Nor is this Overcharge Scheme a "garden variety" dispute over interpretation of plan terms — it is an intentional scheme to knowingly conceal and impose fraudulent charges in violation of the rights of Plaintiff and all Class members. OHI directed Optum to engage in a fraudulent billing scheme to defraud Plaintiff and Class members through Overcharges, including Spreads, and Clawbacks. Specifically, this Overcharge Scheme entails: (a) OHI misrepresenting to Plaintiff and Class members through form Plan language that they would pay a certain amount for medically necessary prescription drugs with a present intent to have Plaintiff pay a higher amount; (b) OHI entering into an agreement with Optum, under which it agreed to process claims submitted by Plaintiff and the Class members for medically necessary prescription drugs in accordance with the terms of a particular Plan with a present intent that the claims processing would violate the Plan terms; (c) OHI entering into an agreement with Optum, under which Optum's created or maintained a provider network by way of contracts and a Provider Manual, which require pharmacies participating in the network to charge Plaintiff and Class members for medically necessary prescription drugs in fraudulent amounts specified by OHI and/or Optum; (d) Optum intentionally misrepresenting with OHI's knowledge and/or direction the correct charge for medically necessary prescription drugs as specified in Plaintiff's and Class members' Plans, and directing providers participating in the provider networks to

collect those improper amounts; (e) OHI's and/or Optum's "clawing back" and retention, directly or indirectly, of a portion of the amounts improperly collected by Optum and/or its providers, with intent to violate the Plaintiff's and Class member's Plans with OHI; and (f) OHI imposing an agreement or directing Optum to impose an agreement (1) barring providers from advising Plaintiffs and Class members that they could pay less for medically necessary prescription drugs by purchasing them outside of their respective Plans and (2) barring providers from selling in a transaction that would avoid the Overcharge.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 247 is required.

248. In sum, OHI's Overcharge Scheme took money from Plaintiff and Class members through deceit and false pretenses. OHI intentionally devised such an Overcharge Scheme and was a knowing and active participant in the scheme to defraud Plaintiff and Class members. OHI intended at the time it issued its Plan and knew that it would overcharge for medically necessary prescription drugs and that they would retain such amounts. OHI specifically intended to commit fraud, and such intent can be inferred from the totality of the allegations herein.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 248 is required.

249. It was and is reasonably foreseeable to OHI that mail, interstate carriers and wire transmissions would be used — and mail, interstate carriers and wire transmissions were in fact used — in furtherance of the scheme, including but not limited to the following manner and means: (a) whenever a Plaintiff or Class member seeks to receive medically necessary prescription drugs, the providers participating in Optum's provider network enter information into a computer and transmit it via interstate mail or carrier and/or wire transmissions to Optum for processing, and Optum transmits back to the pharmacy the amount of the Overcharge; (b) OHI and/or Optum's collecting of the Overcharge money takes place via interstate mail or carrier or wire transmissions; (c) Plaintiff and Class members make payments to Optum using credit or debit cards, which require the use of interstate wire transmissions; (d) prescription drugs received by Plaintiff and Class members through OHI's fraudulent scheme were delivered by mail or interstate carrier and (e) OHI's and Optum's representatives communicated with each other by mail, interstate carrier, and/or wire transmissions in order to carry out the fraudulent scheme.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 249 is required.

250. Having devised its Overcharge Scheme and intending to defraud Plaintiff and Class members, on or about the dates set forth below, OHI intentionally and unlawfully transmitted and caused to be transmitted by means of wire communication in interstate commerce, writings, signs, signals, pictures, and sounds, for the purpose of executing such scheme.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 250 is required.

251. For example, when Plaintiff Mohr-Lercara purchased prescription drugs, Defendants caused to be transmitted mail, interstate deliveries and/or wire transmissions for the purpose of executing such scheme and artifice on at least the following dates along with the amounts charged and the Overcharges, as Spread, as described below:

Filled Date	Usual And Customary	Approved Ingredient Cost	Approved Dispensing Fee	Amount Paid to Pharmacy	Copay	Spread / Clawback
10/30/2015	$160.76	$3.19	$1.00	$4.19	$15.00	($10.81)
10/30/2015	$29.63	$3.74	$1.00	$4.74	$15.00	($10.26)
10/30/2015	$27.50	$3.74	$1.00	$4.74	$15.00	($10.26)
10/30/2015	$164.90	$5.15	$1.00	$6.15	$15.00	($8.85)
10/02/2015	$174.59	$5.15	$1.00	$6.15	$15.00	($8.85)
10/02/2015	$29.63	$5.76	$1.00	$6.76	$15.00	($8.24)
10/02/2015	$27.50	$5.76	$1.00	$6.76	$15.00	($8.24)
10/02/2015	$164.90	$5.76	$1.00	$6.76	$15.00	($8.24)
09/08/2015	$174.59	$0.69	$1.35	$2.04	$10.00	($7.96)
09/08/2015	$164.90	$6.27	$1.00	$7.27	$15.00	($7.73)
09/01/2015	$27.50	$6.27	$1.00	$7.27	$15.00	($7.73)
08/31/2016	$33.20	$6.27	$1.00	$7.27	$15.00	($7.73)
07/26/2016	$27.50	$6.27	$1.00	$7.27	$15.00	($7.73)
04/12/2016	$27.50	$6.38	$1.00	$7.38	$15.00	($7.62)
03/10/2016	$29.63	$6.38	$1.00	$7.38	$15.00	($7.62)
03/10/2016	$27.50	$6.38	$1.00	$7.38	$15.00	($7.62)

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 251 is required.

252. On or about the dates identified above, Optum sent and received U.S. Mail or interstate wire transmissions in connection with (a) determining whether Plaintiff and the prescription drugs were covered under her Plan and how much she should pay for drugs; (b) communicating to Plaintiff the amount of the Overcharge; (c) processing Plaintiff's payment for such drugs and Overcharges; and (d) processing OHI's payments to and/or Clawbacks from the provider.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 252 is required.

253. The acts set forth above constitute a pattern of racketeering activity pursuant to 18 U.S.C. § 1961(5).

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 253 is required.

254. Each such use of U.S. Mail and interstate wire facilities as alleged constitutes a separate and distinct predicate act.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 254 is required.

255. The predicate acts were each related to one another in that: (a) OHI directed Optum to undertake each predicate act with a similar purpose of effectuating its scheme to defraud Plaintiff and Class members; (b) each predicate act involved the same participants — (1) OHI, which directed Optum to make the fraudulent statements and overcharge Plaintiff and Class members, (2) pharmacies within Optum's provider network, which processed claims and provided drugs, and (3) Plaintiff and Class members, who received the fraudulent statements and relied on them in paying the fraudulent amounts for medically necessary prescription drugs; (c) each predicate act involved similar victims — Plaintiff and Class members who purchased medically necessary prescription drugs; and (d) each predicate act was committed the same way — in response to a request from Plaintiff or Class members to purchase medically necessary prescription drugs, the provider participating in Optum's provider network transmitted a request via U.S. Mail or interstate wire to Optum. Optum, using the U.S. Mail or interstate wire, responded directing the provider to execute Optum's scheme, and Optum later effectuated its Overcharge Scheme by using the U.S. Mail or interstate wire to overbill the Plaintiff or Class member; and (e) the predicate acts could not have been conducted, nor Optum's scheme effectuated, without the existence and use of Optum.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 255 is required.

256. On information and belief, OHI conducts such racketeering activity through Optum as an ongoing and regular way of doing business, and continues and will continue to engage in such racketeering activity.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 256 is required.

257. As a direct and proximate result of OHI's racketeering activities and violations of 18 U.S.C. § 1962(c), Plaintiff and Class members have been injured in their business and property. Plaintiff and Class members were injured by reason of OHI's RICO violations because they directly and immediately received through interstate wires or mail a fraudulent demand for payment, incurred a corresponding debt and paid fraudulent charges for medically necessary prescription drugs. Their injuries were proximately caused by OHI's violations of 18 U.S.C. § 1962(c) because these injuries were the foreseeable, direct, intended, and natural consequence of OHI's RICO violations (and commission of underlying predicate acts) and, but for OHI's RICO violations (and commission of underlying predicate acts), they would not have suffered these injuries.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 257 is required.

258. Pursuant to RICO, 18 U.S.C. § 1964(c), Plaintiff and the Class members are entitled to recover, threefold, their damages, costs, and attorneys' fees from OHI and other appropriate relief.

RESPONSE: The Court dismissed Count VII of the Complaint (Dkt. 63), and thus no response to Paragraph 258 is required.

COUNT VIII

For Violating RICO, 18 U.S.C. § 1962(c)
Against Optum on Behalf of the Class

259. Plaintiffs incorporate by reference each and every allegation above as if set forth fully herein.

RESPONSE: Defendants Optum, Inc. and OptumRx reallege and reincorporate by reference their response to Paragraphs 1-258 as if fully set forth herein.

260. Plaintiffs, Class members, and Optum are "persons" within the meaning of RICO, 18 U.S.C. §§ 1961(3), 1964(c).

RESPONSE: Paragraph 260 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants Optum, Inc. and OptumRx deny the allegations contained in Paragraph 260.

261. At all relevant times, Optum conducted or participated in the conduct of enterprises (the "Optum Pharmacy Enterprises") consisting of each provider in Optum's provider network as a separate legal entity enterprise.

RESPONSE: Paragraph 261 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants Optum, Inc. and OptumRx deny the allegations contained in Paragraph 261.

262. At all relevant times, the Optum Pharmacy Enterprises have been engaged in, and their activities affect, interstate commerce within the meaning of RICO, 18 U.S.C. § 1962(c).

RESPONSE: Paragraph 262 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants Optum, Inc. and OptumRx deny the allegations contained in Paragraph 262.

263. Optum is legally and factually distinct from the Optum Pharmacy Enterprises.

RESPONSE: Paragraph 263 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants Optum, Inc. and OptumRx deny the allegations contained in Paragraph 263.

264. Optum and the Optum Pharmacy Enterprises are separate and distinct from the pattern of racketeering acts in which they engaged.

RESPONSE: Paragraph 264 states legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants Optum, Inc. and OptumRx deny the allegations contained in Paragraph 264.

265. Optum agreed to and did conduct and participate in the conduct of the Optum Pharmacy Enterprises' affairs. Optum operated and managed the affairs of the Optum Pharmacy Enterprises through a series of uniform contracts, agreements, and Provider Manuals with providers through which Optum was able to and did exert control over the Optum Pharmacy Enterprises. While some of the provisions of contracts, agreements and manuals served legitimate purposes, Optum manipulated and abused certain provisions to effectuate the fraudulent scheme. This case does not involve routine enforcement of "arms-length" contract terms, it entails abuse of contractual provisions and exercise of control to conceal and effectuate a massive fraudulent scheme.

RESPONSE: Paragraph 265 states legal conclusions and purports to characterize documents, the terms of which speak for themselves, and thus no response is required. To the extent a response is nevertheless deemed to be required, Optum, Inc. and OptumRx deny any

characterization contrary to the terms of the documents and deny the remaining allegations contained in Paragraph 265.

266. For example, Optum issues a Provider Manual to providers that are the Optum Pharmacy Enterprises. The Provider Manual "is incorporated in and is a part of" a provider's "Agreement" with Optum. If the providers' agreements with Optum conflict with the Provider Manual, the Provider Manual "will supersede" the agreement. Optum "reserves the right to limit [pharmacies'] participation in a network in its sole discretion," and directs that providers "shall not be allowed to opt-out of any networks without the written consent" of Optum. By submitting a claim to Optum, the providers agree that they are acknowledging their participation with one another in Optum's network, and that they accept "all corresponding terms and conditions, including the rates and reimbursements of Claims, for such network."

RESPONSE: Paragraph 266 refers to a 2017 Provider Manual that is issued by OptumRx, the terms of which speak for itself, and thus no response is required. To the extent a response is required, Optum, Inc. and OptumRx deny any characterization contrary to the terms of the document and deny the remaining allegations contained in Paragraph 266.

267. Also pursuant to the Provider Manual, providers "must charge the Member the Cost-Sharing Amount indicated in the online response and only this amount." Waiving the amount associated with the Member Cost-Sharing is strictly prohibited, unless required by law (e.g., Qualified Medicare Beneficiary) and is considered a material breach of the Agreement." "[R]eimbursement pricing information, as well as prices paid to Network Pharmacy Provider for individual Claims under this Agreement are confidential and proprietary Administrator information and may not be disclosed on Member receipts or insurance profiles." Providers are further directed to "treat as confidential and proprietary," *inter alia*, Optum's "pricing, programs, services, business practices, databases, software, layouts, designs, formats, processes, applications, systems, [and] technology, files," as well as the terms of the Provider Manual itself.

RESPONSE: Paragraph 267 refers to a 2017 Provider Manual that is issued by OptumRx, the terms of which speak for itself, and thus no response is required. To the extent a response is required, Optum, Inc. and OptumRx deny any characterization contrary to the terms of the document and deny the remaining allegations contained in Paragraph 267.

268. Also under the terms of the Provider Manual, providers are prohibited from "[o]ffering a cash price, or a different cash prices than the U&C price, to the Member as an alternative to or in lieu of submitting a Claim for a Covered Prescription Service via the POS System."

RESPONSE: Paragraph 268 refers to a 2017 Provider Manual that is issued by OptumRx, the terms of which speak for itself, and thus no response is required. To the extent a response is required, Optum, Inc. and OptumRx deny any characterization contrary to the terms of the document and deny the remaining allegations contained in Paragraph 268.

269. The Provider Manual defines "[n]on-compliance" to include "the disclosure of confidential information or data" or "the collection of a patient pay amount that differs from the amount specified in the Claims response."

RESPONSE: Paragraph 269 refers to a 2017 Provider Manual that is issued by OptumRx, the terms of which speak for itself, and thus no response is required. To the extent a response is required, Optum, Inc. and OptumRx deny any characterization contrary to the terms of the document and deny the remaining allegations contained in Paragraph 269.

270. The Provider Manual explains that "[f]ailure to adhere to any of the provisions . . . which includes this [Provider Manual] . . . will be viewed as a breach of the Agreement." Pharmacies are "subject to penalties or sanctions" if Optum determines that the pharmacies "disclosed confidential information. . . ." These penalties include "at a minimum . . . $5,000 per incident," and pharmacies "may be subject to additional actions" by Optum, "up to termination from participation" in Optum's pharmacy network. Pharmacies terminated from participation in Optum's pharmacy network are banned from the pharmacy network for five years and, only after such a period, may apply for reinstatement at Optum's "sole discretion."

RESPONSE: Paragraph 270 refers to a 2017 Provider Manual that is issued by OptumRx, the terms of which speak for itself, and thus no response is required. To the extent a response is required, Optum, Inc. and OptumRx deny any characterization contrary to the terms of the document and deny the remaining allegations contained in Paragraph 270.

271. As alleged herein, Optum engaged in a fraudulent billing scheme to defraud Plaintiff and Class members through Overcharges, Spreads and Clawbacks. In operating and managing the affairs of the Optum Pharmacy Enterprises, Optum exploited and abused the uniform contracts and agreements it entered with providers to implement the fraudulent Overcharge Scheme, knowing that the Plans did not permit the Overcharge Scheme.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 271.

272. This Overcharge Scheme is not a "garden variety" dispute over interpretation of plan terms — it is an intentional scheme to knowingly conceal and impose fraudulent charges in violation of the rights of Plaintiff and all Class members. In particular, this Overcharge Scheme entails: (a) Optum's entering into agreements with OHI through which Optum agreed to process claims submitted on behalf of Plaintiff and the Class members for medically necessary prescription drugs in accordance with the terms of a particular Plan, with a present intent to violate the Plan terms and impose fraudulent charges; (b) Optum's creation of a provider network through which Plaintiff and Class members could receive medically necessary prescription drugs and entering into agreements requiring providers participating in the provider network to charge for prescription drugs in fraudulent amounts specified by Optum, and prohibiting providers participating in the provider network from discussing any other amount with Plaintiff or the Class members; (c) Optum's knowingly misrepresenting the correct charge for prescription drugs as specified in Plaintiff and Class members' Plans; and (d) Optum's retention directly or indirectly, of a portion of the amounts improperly collected, with intent to violate the Plaintiff and Class members' Plans, and enforcing its agreements with providers participating in the provider network to prevent them from disclosing or avoiding the unlawful and improper plan or scheme.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 272.

273. The scheme to defraud also includes various misrepresentations and omissions of material fact, including, but not limited to: (a) misrepresenting the charge for medically necessary prescription drugs as specified in the Plan language, which misrepresentations were false when made because of Optum's knowledge and intent at that time that Class members would be Overcharged; (b) misrepresenting that a material portion of the "co-payments" that Optum instructed providers to collect were payments for prescription drugs and were "co-" payments by the insureds rather than unlawful payments to Defendants; (c) intentionally misrepresenting that prescription drug payments that Optum instructed providers to collect under deductible portions of health insurance policies were based on prescription drug prices paid to the pharmacies; (d) the intentional failure to disclose that co-insurance payments that Optum instructed providers to collect were based on prescription drug prices that exceeded the contracted fee between the PBM and the providers; and (e) the intentional failure to disclose and agreement not to disclose that Class members could pay less for a drug by purchasing it outside of their respective insurance policies.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 273.

274. Pursuant to the Overcharge Scheme, Optum (a) entered into agreements with providers and knowingly instructed the providers to overcharge Plaintiff and Class members for prescription drugs beyond what was allowed under the Plans; (b) intentionally overcharged Plaintiff and Class members for prescription drugs; and (c) entered into agreements with providers prohibiting the disclosure of the unlawful scheme and/or the sale of prescription drugs to Plaintiff and Class members at prices other than the unlawful prices. As such, the plan was to

deprive Plaintiff and Class members of money by deceit and false pretenses, and it was characterized by a departure from community standards of fair play and candid dealings.

RESPONSE: Paragraph 274 asserts legal conclusions and purports to characterize documents, the terms of which speak for themselves, and thus no response is required. To the extent that a response is nevertheless deemed to be required, Optum, Inc. and OptumRx deny the allegations contained in Paragraph 274 to the extent they mischaracterize the documents or are inconsistent or incomplete with respect thereto. Optum, Inc. and OptumRx further deny the remaining allegations contained in Paragraph 274.

275. The scheme to defraud consists of Optum wrongly depriving Plaintiffs and Class members of their property rights by dishonest methods or schemes. Such scheme was willfully devised by Optum (along with OHI) at the time that OHI issued its Plans to Plaintiff and Class members. Optum was a knowing and active participant in the scheme to defraud. Optum specifically intended to commit fraud at the time that OHI issued its Plans to Class members, and such intent can be inferred from the totality of the allegations herein.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 275.

276. The purpose of the scheme was and is to cause Plaintiffs and Class members to overpay for medically necessary prescription drugs.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 276.

277. Optum agreed to and did conduct and participate in the conduct of the Optum Pharmacy Enterprises' affairs through a pattern of racketeering activity and for the unlawful purpose of intentionally defrauding Plaintiff and the Class members. Optum used the Optum Pharmacy Enterprises to facilitate its goal of overcharging for medically necessary prescription drugs.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 277.

278. As described herein, Optum directly and indirectly conducted and participated in the conduct of the Optum Pharmacy Enterprises affairs through a pattern of racketeering and activity in violation of 18 U.S.C. § 1962(c) for the unlawful purpose of defrauding Plaintiff and Class members.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 278.

279. Pursuant to and in furtherance of its fraudulent Overcharge Scheme, Optum has committed multiple related predicate acts of "racketeering activity," as defined in 18 U.S.C. § 1961(5), prior to, and during, the Class Period and continues to commit such predicate acts, in furtherance of its "Overcharge Scheme," including: (a) mail fraud, in violation of 18 U.S.C. §1341; and (b) wire fraud, in violation of 18 U.S.C. §1343.

RESPONSE: Paragraph 279 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations.

280. In sum, the Overcharge Scheme took money from Plaintiff and Class members through deceit and false pretenses. Optum intentionally devised and/or implemented the Overcharge Scheme and was a knowing and active participant in the Overcharge Scheme to defraud Plaintiff and Class members. Optum intended at the time that OHI issued its Plans to Plaintiff and Class members and knew that it would overcharge for the costs of medically necessary prescription drugs. Optum specifically intended to commit fraud, and such intent can be inferred from the totality of the allegations herein.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 280.

281. It was and is reasonably foreseeable to Optum that mail, interstate carriers and wire transmissions would be used — and mail, interstate carriers and wire transmissions were in fact used — in furtherance of the Overcharge Scheme, including but not limited to the following manner and means: (a) whenever a Plaintiff or Class member seeks to receive prescription drugs, the providers participating in Optum's provider network enter information into a computer and transmit it via interstate mail or carrier and/or wire transmissions to Optum for adjudication; (b) Optum's receipt of money takes place via interstate mail or carrier or wire transmissions; (c) Plaintiff and Class members make payments using credit or debit cards, which require the use of interstate wire transmissions; (d) prescription drugs purchased through Optum's fraudulent scheme were delivered by mail or interstate carrier and Optum's representatives and providers participating in Optum's provider network communicated with each other mail, interstate carrier and/or wire transmissions in order to carry out the fraudulent scheme.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 281.

282. Having devised and/or implemented the Overcharge Scheme, and intending to defraud Plaintiff and Class members, on or about the dates set forth below, Optum intentionally

and unlawfully transmitted and caused to be transmitted by means of wire communication in interstate commerce, writings, signs, signals, pictures, and sounds, for the purpose of executing such scheme.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 282.

283. For example, when Plaintiff Mohr-Lercara purchased prescription drugs, Defendants caused to be transmitted by mail, interstate deliveries and/or wire transmissions for the purpose of executing such scheme and artifice on the following dates along with the amounts charged and the Overcharges, as Spread, as described below:

Filled Date	Usual And Customary	Approved Ingredient Cost	Approved Dispensing Fee	Amount Paid to Pharmacy	Copay	Spread / Clawback
10/30/2015	$160.76	$3.19	$1.00	$4.19	$15.00	($10.81)
10/30/2015	$29.63	$3.74	$1.00	$4.74	$15.00	($10.26)
10/30/2015	$27.50	$3.74	$1.00	$4.74	$15.00	($10.26)
10/30/2015	$164.90	$5.15	$1.00	$6.15	$15.00	($8.85)
10/02/2015	$174.59	$5.15	$1.00	$6.15	$15.00	($8.85)
10/02/2015	$29.63	$5.76	$1.00	$6.76	$15.00	($8.24)
10/02/2015	$27.50	$5.76	$1.00	$6.76	$15.00	($8.24)
10/02/2015	$164.90	$5.76	$1.00	$6.76	$15.00	($8.24)
09/08/2015	$174.59	$0.69	$1.35	$2.04	$10.00	($7.96)
09/08/2015	$164.90	$6.27	$1.00	$7.27	$15.00	($7.73)
09/01/2015	$27.50	$6.27	$1.00	$7.27	$15.00	($7.73)
08/31/2016	$33.20	$6.27	$1.00	$7.27	$15.00	($7.73)
07/26/2016	$27.50	$6.27	$1.00	$7.27	$15.00	($7.73)
04/12/2016	$27.50	$6.38	$1.00	$7.38	$15.00	($7.62)
03/10/2016	$29.63	$6.38	$1.00	$7.38	$15.00	($7.62)
03/10/2016	$27.50	$6.38	$1.00	$7.38	$15.00	($7.62)

RESPONSE: Optum, Inc. and OptumRx admit that according to records maintained by OptumRx, Plaintiff had prescription drugs filled on the above dates. Optum, Inc. and OptumRx state that because the table excludes certain information, including individual claim numbers, Optum, Inc. and OptumRx lack knowledge to admit or deny the specific dollar amounts included

for each transaction. Optum, Inc. and OptumRx deny the remaining allegations contained in Paragraph 283.

284. On or about these dates, BJs Drugs (for Plaintiff Mohr-Lercara), an Optum Network provider located in Forest Hills, New York, sent and received mail, interstate messages or deliveries and/or wire transmissions in connection with (a) determining whether the Plaintiff and the prescription drugs were covered under her Plan and how much Plaintiff should pay for the drugs; (b) processing Plaintiff's payments for such prescription drugs; and (c) processing the Optum payments, including any Overcharges, and/or Clawbacks.

RESPONSE: Optum, Inc. and OptumRx admit that according to records maintained by OptumRx, Plaintiff had prescription drugs filled on the above dates at a Network Pharmacy located in Forest Hills, New York. Optum, Inc. and OptumRx admit that information was electronically transmitted between OptumRx and the pharmacy in order to process Plaintiff's prescription drug purchases. Optum, Inc. and OptumRx deny that any payments included Overcharges or were contrary to the terms of Plaintiff's plan terms.

285. These acts constitute a pattern of racketeering activity pursuant to 18 U.S.C. § 1961(5).

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 285.

286. Each such use of U.S. Mail and interstate wire facilities as alleged constitutes a separate and distinct predicate act.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 286.

287. The predicate acts were each related to one another in that: (a) Optum directed a provider through the U.S. mails or wire to provide Plaintiff with equipment or services and Optum then overbilled Plaintiff and Class members through the U.S. mail or wire; (b) each predicate act involved the same participants — Optum, which made the fraudulent statements and overcharged Plaintiff and Class members; network providers within Optum's provider network, which processed claims and provided drugs, and Plaintiff and Class members, who received the fraudulent statements and relied upon them in paying the fraudulent amounts for prescription drugs; (c) each predicate act involved similar victims — Plaintiff and Class members who purchased prescription drugs; and (d) each predicate act was committed the same way — in response to a request from Plaintiff or Class members to purchase prescription drugs,

the provider participating in the Optum provider network transmitted a request via U.S. Mail or interstate wire to Optum, who, using the U.S. Mail or interstate wire, responded directing the provider to execute Optum's scheme, and Optum later effectuated its Overcharge Scheme by using the U.S. Mail or interstate wire to overbill the Plaintiff or Class member; and (e) the predicate acts could not have been conducted, nor OHI's scheme effectuated, without the existence and use of Optum.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 287.

288. As a direct and proximate result of Optum's racketeering activities and violations of 18 U.S.C. § 1962(c), Plaintiff Mohr-Lercara and the Class members have been injured in their business and property. Plaintiff and the Class members were injured by reason of Optum's RICO violations because they directly and immediately received through interstate wires or mail a fraudulent demand for payment, incurred a corresponding debt and paid fraudulent charges for prescription drugs. Their injuries were proximately caused by Optum's violations of 18 U.S.C. § 1962(c) because these injuries were the foreseeable, direct, intended, and natural consequence of Optum's RICO violations (and commission of underlying predicate acts) and, but for Optum's RICO violations (and commission of underlying predicate acts), they would not have suffered these injuries.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 288.

289. Pursuant to RICO, 18 U.S.C. § 1964(c), Plaintiff and the Class members are entitled to recover, threefold, their damages, costs, and attorneys' fees from Optum and other appropriate relief.

RESPONSE: Optum, Inc. and OptumRx deny the allegations contained in Paragraph 289.

COUNT IX

Violation of RICO, 18 U.S.C. § 1962(d)
Against All Defendants on Behalf of the Nationwide Class

290. Plaintiff incorporates by reference each and every allegation above as if set forth fully herein.

RESPONSE: The Court dismissed Count IX of the Complaint as against OptumRx (Dkt. 63), and thus no response by OptumRx is required. The remaining Defendants reallege and reincorporate by reference their responses to Paragraphs 1-289 as if fully set forth herein.

291. During the Class Period, Defendants agreed and conspired to violate 18 U.S.C. §1962(c). Specifically, OHI and Optum conspired to engage in the "Overcharge Scheme." Defendants also conspired with themselves and/or with other unnamed PBMs and pharmacies to engage in the "Overcharge Scheme." Defendants conduct and participate, directly or indirectly, in the conduct of the affairs of the Optum Enterprise (described above) and the Optum Pharmacy Enterprises (described above) through a pattern of racketeering activity (described above) which resulted in Plaintiff and Class members overpaying for medically necessary prescription drugs. The conspiracy to violate 18 U.S.C. §1962(c) constitutes a violation of 18 U.S.C. §1962(d).

RESPONSE: The Court dismissed Count IX of the Complaint as against OptumRx (Dkt. 63), and thus no response by it is required. In any event, Paragraph 291 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, the remaining Defendants deny the allegations.

292. In furtherance of this conspiracy, OHI and Optum and their co-conspirators committed numerous overt acts, as alleged above, in the pattern of racketeering described above, including mail fraud, in violation of 18 U.S.C. §1341; and (b) wire fraud, in violation of 18 U.S.C. §1343. OHI and Optum agreed to and did engage in a fraudulent "Overcharge Scheme" to defraud Plaintiff and Class members (described above). OHI and/or Optum intended to defraud Plaintiff and Class members by overcharging for medically necessary prescription drugs (described above). OHI and/or Optum reasonably foresaw that the U.S. Mail and/or interstate wire would be used in furthering the "Overcharge Scheme." OHI and/or Optum used the U.S. Mail and/or interstate wire to effectuate the "Overcharge Scheme" by transmitting various misrepresentations and omissions of material fact resulting in overcharges for medically necessary prescription drugs (described above).

RESPONSE: The Court dismissed Count IX of the Complaint as against OptumRx (Dkt. 63), and thus no response by it is required. In any event, Paragraph 292 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, the remaining Defendants deny the allegations.

293. OHI and/or Optum knew that their predicate acts were part of a pattern of racketeering activity and agreed to commission of those acts to further the "Overcharge Scheme" (described above).

RESPONSE: The Court dismissed Count IX of the Complaint as against OptumRx (Dkt. 63), and thus no response by it is required. The remaining Defendants deny the allegations contained in Paragraph 293.

294. As a direct and proximate result, and by reason of the activities of OHI and/or Optum and their conduct in violation of 18 U.S.C. §1962(d), Plaintiff and the Class have been injured in their business and property within the meaning of 18 U.S.C. §1964(c) and are entitled to recover treble damages, together with the costs of this lawsuit, expenses, and reasonable attorneys' fees.

RESPONSE: The Court dismissed Count IX of the Complaint as against OptumRx (Dkt. 63), and thus no response by it is required. The remaining Defendants deny the allegations contained in Paragraph 294.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, individually and on behalf of the Class and Subclass, prays for relief as follows as applicable for the particular claim:

A. Certifying this action as a class action and appointing Plaintiff and the counsel listed below to represent the Class and Subclass;

B. Finding that Defendants are fiduciaries and/or parties in interest as defined by ERISA;

C. Finding that Defendants violated their fiduciary duties of loyalty and prudence to ERISA Subclass members and awarding Plaintiff and the ERISA Subclass such relief as the Court deems proper;

D. Finding that Defendants engaged in prohibited transactions and awarding Plaintiff and the ERISA Subclass such relief as the Court deems proper;

E. Finding that Defendants denied Plaintiff, the Class, and the Subclass benefits and their rights under the policies and awarding such relief as the Court deems proper;

F. Enjoining Defendants from further such violations;

G. Finding that Plaintiff and the ERISA Subclass are entitled to clarification of their rights under the ERISA Plans and awarding such relief as the Court deems proper;

H. Awarding Plaintiff, the Class, and the Subclass damages, surcharge, and/or other monetary compensation as deemed appropriate by the Court;

I. Ordering Defendants to restore all losses to Plaintiff and the ERISA Subclass and disgorge unjust profits and/or other assets of the ERISA Plans

J. Adopting the measure of losses and disgorgement of unjust profits most advantageous to Plaintiff and the ERISA Subclass to restore Plaintiff's losses, remedy Defendants' windfalls, and put Plaintiff in the position that she would

have been in if the fiduciaries of the ERISA Plans had not breached their duties or committed prohibited transactions;

K. Ordering other such remedial relief as may be appropriate under ERISA, including the permanent removal of Defendants from any positions of trust with respect to the ERISA Plans of the members of the ERISA Subclass and the appointment of independent fiduciaries to serve in the roles Defendants occupied with respect to the ERISA Plans of the ERISA Subclass, including as pharmacy benefit administrators and managers;

L. Awarding treble damages in favor of Plaintiff and the Class members against all Defendants for all damages sustained as a result of Defendants' violations of RICO, in an amount to be proven at trial, including interest thereon;

M. Awarding Plaintiff, the Class, and the Subclass equitable relief to the extent permitted by the above claims;

N. Finding that Defendants are jointly and severally liable as fiduciaries and/or co-fiduciaries and/or parties in interest;

O. Awarding Plaintiff's counsel attorneys' fees, litigation expenses, expert witness fees and other costs pursuant to ERISA § 502(g)(1), 29 U.S.C. 1132(g)(1), and/or the common fund doctrine;

P. Awarding Plaintiff's counsel attorneys' fees, litigation expenses, expert witness fees and other costs pursuant to RICO, 18. U.S.C. § 1964(c).

Q. Awarding Plaintiff, the Class, and the Subclass their reasonable costs and expenses incurred in this action, including counsel fees and expert fees;

R. Finding that Defendants are jointly and severally liable for all claims; and

S. Awarding such other and further relief as may be just and proper, including pre-judgment and post-judgment interest on the above amounts.

RESPONSE: In response to the PRAYER FOR RELIEF, Defendants deny that Plaintiffs or any putative class members are entitled to any type of remedy, relief, or damages whatsoever, including the relief requested in Plaintiff's Prayer for Relief. Defendants deny the remaining allegations contained in the PRAYER FOR RELIEF and each of its subparts.

GENERAL DENIAL

Defendants deny each and every allegation not specifically admitted herein.

AFFIRMATIVE DEFENSES

1. The Complaint fails to state a claim upon which relief can be granted.

2. The claims asserted in the Complaint are barred because they fail to state facts sufficient to constitute a cause of action against Defendants.

3. The ERISA claims asserted in the Complaint are barred by ERISA, in that Plaintiff has failed to comply with the requirements of ERISA and has failed to exhaust, in whole or in part, the administrative claims procedures pursuant to ERISA.

4. Plaintiff's claims, and the claims of each purported class member, are barred for failure to comply with the terms and conditions of the subject plans and policies.

5. Plaintiff's claims are in the nature of benefit claims and the Defendants' interpretation of the plan (and related, ancillary) documents was reasonable and correct.

6. Plaintiff's claims are barred, in whole or in part, because she did not rely upon any allegedly inaccurate statements of benefits available under the plans made by the Defendants.

7. Any loss or damage that Plaintiff alleges is due to the fault or responsibility of persons and entities over whom Defendants have no control.

8. Some or all of Plaintiff's ERISA claims may be barred because Plaintiff has failed to raise her claims within the time period required by ERISA's statute of limitations, or the limitations periods referenced in the various plan documents, or the limitations periods proscribed by Department of Labor regulations and rules.

9. To the extent that Plaintiff's claims, and the claims of other purported class members, raise issues related to plan language that does not accurately reflect the intent of plan sponsors or issuers of the insurance policies funding the plan, Defendants are entitled to reformation of such plan language to reflect that intent.

10. Plaintiff's claims, and the claims of other purported class members, are barred, in or whole or in part, by their lack of standing as neither Plaintiff nor any purported class member has suffered any injury from the alleged conduct.

11. The claims of Plaintiff, and the claims of other purported class members, are barred, in whole or in part, by their lack of statutory standing to bring claims on behalf of the plans under ERISA Section 502(a)(2), 29 U.S.C. Section 1132 (a)(3).

12. Plaintiff's claims, and the claims of each purported class member, are barred because the plans have not suffered any actual injury or damage.

13. The claims asserted in the Complaint are barred because this action may not be maintained as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure.

14. Plaintiff and each member of the putative class failed to mitigate any and all damages or losses claimed by them.

15. Defendants are informed and believe, and on such basis, allege that they may have additional defenses available to it, which are not now fully known and of which it is not now aware. Defendants reserve the right to raise and assert such additional defenses once such additional defenses have been ascertained.

WHEREFORE, Defendants respectfully request that judgment be entered in their favor and against Plaintiff, and that all claims asserted by Plaintiff be dismissed with prejudice, for an award of costs and attorneys' fees, and for such other further relief as this Court deems just and proper.

Dated: April 24, 2019

DORSEY & WHITNEY LLP

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