UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MINNESOTA

SAMANTHA SOHMER and KATHY L. FELLGREN, Individually and on Behalf of All Others Similarly Situated, Plaintiffs, vs. UNITEDHEALTH GROUP INC., UNITED HEALTHCARE SERVICES, INC., UNITED HEALTHCARE INSURANCE COMPANY, OPTUM, INC., and OPTUMRX, INC., Defendants.	Case No. 18-cv-03191 (JNE/BRT) **DEFENDANTS' AMENDED ANSWER AND UNITED HEALTHCARE SERVICES, INC. AND UNITED HEALTHCARE INSURANCE COMPANY'S COUNTERCLAIM**

Defendants UnitedHealth Group Incorporated, United HealthCare Services, Inc., United Healthcare Insurance Company, Optum, Inc., and OptumRx, Inc. (collectively, "Defendants"), by and through counsel, submit the following Answer to Plaintiffs' Class Action Complaint. Except as otherwise stated herein, Defendants deny each and every allegation in the Complaint. Plaintiffs' Complaint contains numerous headings and sub-headings, which Defendants do not consider to be substantive allegations to which a response is required. However, to the extent that a response is nevertheless deemed to be required, Defendants deny any and all allegations within any such heading or sub-heading. In addition, the Complaint contains numerous footnotes, which Defendants have responded to as part of the answer to the corresponding paragraph for each footnote.

INTRODUCTION

1. Plaintiffs, who received prescription drug benefits through group health plans ("Plans")[1] administered and managed by Defendants—UnitedHealth Group, Inc. ("UnitedHealth"), United Healthcare Services, Inc. ("UHC Services"), United HealthCare Insurance Company ("UHC Insurance"), Optum, Inc., or OptumRx, Inc. (Optum, Inc. and OptumRx, Inc. are collectively referred to as "OptumRx")—allege that Defendants caused Plaintiffs to be overcharged for medically necessary prescription drugs in violation of their Plans.

RESPONSE: In response to Paragraph 1, Defendants admit that Plaintiff Sohmer is a former participant and Plaintiff Fellgren is a current participant in employer-sponsored health plans for which United HealthCare Services, Inc. serves as a claims administrator and that such plans offered certain benefits for outpatient prescription drugs. Defendants deny the remaining allegations contained in Paragraph 1.

2. Plaintiffs bring this action, on behalf of themselves and two Classes of similarly situated persons, to remedy Defendants' common scheme to artificially inflate prescription drug costs. Plaintiff Sohmer, on behalf of the ERISA Class (defined below), alleges violations of the Employee Retirement Income Security Act of 1974 ("ERISA") [codified at 29 U.S.C. § 1001 *et seq*.]. Plaintiff Fellgren, on behalf of the Non-ERISA Class (defined below), alleges state law claims for breach of contract, breach of implied covenant of good faith and fair dealing, violations of the Minnesota Uniform Deceptive Trade Practices Act ("UDTPA"), and unjust enrichment.

RESPONSE: In response to Paragraph 2, Defendants admit that Plaintiffs purport to bring the present action as a class action and raise claims under the Employee Retirement Income Security Act of 1974 ("ERISA"), state law claims for breach of contract, breach of implied covenant of good faith and fair dealing, violations of the Minnesota Uniform Deceptive Trade Practices Act ("UDTPA"), and unjust enrichment. Defendants state that Plaintiffs' breach of contract, breach of implied covenant of good

faith and fair dealing, unjust enrichment, and UDTPA claims have been dismissed by the Court (Dkt. 68). Defendants deny the remaining allegations contained in Paragraph 2.

3. About 90 percent 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[2] 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 (i.e., a "cost share") directly to the pharmacy in the form of a copayment (often a set dollar amount), coinsurance (often a percentage of the contracted rate), 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. Pharmacies 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 3 regarding unnamed individuals and such individuals' benefit plans, and on that basis, deny them. The fourth sentence of Paragraph 3 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 3.

4. Defendants administer health and pharmacy benefits provided to patients. Defendant OptumRx, a wholly owned subsidiary of UnitedHealth Group, serves as the prescription benefits manager ("PBM") to UnitedHealthcare members. PBM services include, *inter alia*: participating in managing a network of pharmacies that will serve as participating pharmacies at which Defendants' patients obtain prescriptions; working with the other Defendants 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 the first sentence of Paragraph 4, UnitedHealth Group Incorporated denies that it is in the business of insuring and administering health insurance plans and affirmatively states that UnitedHealth Group Incorporated is simply a holding company that does not issue or administer health insurance plans. Defendants admit that United HealthCare Services, Inc., United Healthcare Insurance Company, Optum, Inc. (through subsidiaries), and OptumRx, Inc. insure or administer health benefit plans and/or pharmacy benefit plans. In response to the second and third sentences of Paragraph 4, Defendants admit that OptumRx provides certain pharmacy benefits management services, including contracting with pharmacies to participate in networks offered to members of plans issued or administered by United HealthCare Services, Inc. and United Healthcare Insurance Company, and that OptumRx processes certain outpatient prescription drug claims on behalf of United HealthCare Services, Inc. and United Healthcare Insurance Company. Defendants deny the remaining allegations contained in Paragraph 4.

5. As set forth below, Defendants have engaged in a scheme to overcharge patients for the cost of medically necessary prescription drugs. Patients, including Plaintiffs and the members of the Classes ("Class Members"), paid excessive charges to participating pharmacies for prescription drugs. Under their Plans, Plaintiffs' and the Class Members' cost-sharing amounts were limited to the amount paid to the pharmacy for prescription drugs. Unbeknownst to Plaintiffs and the Class Members, Defendants forced the pharmacies to misrepresent the cost-sharing amounts for prescription drugs and charge Plaintiffs and Class Members excessive amounts and forced patients to pay excessive cost-sharing amounts. Plaintiffs paid copayments and coinsurance in excess of the cash price for their prescriptions. These excessive payments by patients were then collected by the pharmacies and "clawed back" from the pharmacies by Defendants. This is not a matter of mistaken or innocently erroneous calculations: it is a pervasive,

intentional scheme by Defendants to overcharge Plaintiffs and everyone similarly situated in connection with their prescription drug purchases.

RESPONSE: Defendants deny the allegations contained in Paragraph 5.

6. For example, as detailed below, the express language of the Plans promised that Plaintiffs and Class Members would not pay more for prescription drugs than Defendants agreed to pay the network pharmacy. In violation of this Plan provision, Defendants required network pharmacies to charge Plaintiffs and Class Members unauthorized and excessive cost-sharing amounts for prescription drugs that were not based on the amount paid to the pharmacies ("Overcharges").

RESPONSE: Defendants deny the allegations contained Paragraph 6.

7. Such Overcharges occurred in two ways. With respect to copayments or deductible payments, Defendants caused Plaintiffs and Class Members to pay cost shares that exceeded the amount that Defendants agreed to pay the pharmacy. With respect to coinsurance payments, Defendants caused Class Members to pay cost shares that exceeded the product of the applicable coinsurance percentage rate multiplied by the amount that Defendants agreed to pay the pharmacy.

RESPONSE: Defendants deny the allegations contained in Paragraph 7.

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

RESPONSE: Defendants deny the allegations contained in Paragraph 8.

9. For example, on October 24, 2016, Defendants unilaterally determined that Plaintiff Sohmer had to pay a $15 copayment to a pharmacy to purchase a prescription drug and required the pharmacy to collect this amount from Plaintiff Sohmer. Unknown to Plaintiff Sohmer, the $15 copayment Defendants required the pharmacy to collect from her was ***almost double the contracted fee*** the pharmacy was paid to fill the prescription. Specifically, on information and belief, Defendants' contract with the pharmacy provided that the pharmacy would be paid only $7.66 for the prescription. But, Defendants unilaterally directed and required the pharmacy to charge and collect the $15 copayment from Plaintiff Sohmer, thereby forcing Plaintiff Sohmer to pay not only the $7.66 contracted cost of the drug, but an additional $7.34. When, like in this example, the cost-

share ($15) exceeds the amount paid to the pharmacy ($7.66), the $7.34 difference is the "Spread."[3]

RESPONSE: In response to Paragraph 9, Defendants admit that on October 24, 2016, Plaintiff Sohmer had prescription drugs filled pursuant to an employer-sponsored plan and that the terms of her plan required Plaintiff Sohmer to make a copayment of $15 in connection with each of those prescription drugs. Defendants admit that on that date, Plaintiff had two prescriptions filled, one of which the pharmacy contractually agreed to accept $7.66 for that prescription drug. Defendants deny that they unilaterally determined the copayment amount and deny the remaining allegations contained in Paragraph 9.

10. Plaintiff Fellgren was also subject to Overcharges. For example, she purchased the same drug six times in 2016, paying only $1.61 (the amount Defendants agreed to pay the pharmacy) for each of the first four purchases. However, for her last two purchases in 2016—once she was no longer in the deductible phase of her prescription drug coverage—Plaintiff Fellgren began paying a $10 copayment per prescription for the exact same drug. This allowed Defendants to claw back $8.39 for each purchase, or ***over five times*** what appears to be the pharmacy's payment amount.

RESPONSE: In response to Paragraph 10, Defendants admit that Plaintiff Fellgren purchased the same prescription drug six times in 2016, that for four of those purchases Fellgren had not yet met her deductible for outpatient prescription drugs and paid $1.61 for each purchase, and that for the last two purchases Fellgren paid a copayment of $10 for each purchase. Defendants deny Fellgren was subject to Overcharges, deny that Defendants "clawed back" any amount, and deny the remaining allegations contained in Paragraph 10.

11. Upon information and belief, Defendants initially allowed pharmacies to keep Spread and other Overcharges. However, at some point during the Class Period,

Defendants began requiring the pharmacies to turn over (or credit) the Spread to Defendants, which payment from the pharmacy to the Defendants is known as a "Clawback." Regardless of whether there is a Clawback, Spread-pricing is unlawful under the Plans.

RESPONSE: In response to Paragraph 11, Defendants admit that, in some circumstances and at some period during the putative Class Period, and pursuant to the participant's plan terms, United HealthCare Services, Inc. and/or OptumRx 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. Defendants deny that such amounts are "Overcharges" and deny the remaining allegations contained in Paragraph 11.

12. These example transactions are not unusual. On information and belief, Defendants systematically instructed pharmacies to charge cost-sharing payments that exceeded the amounts that they have contractually agreed that pharmacies would be paid for drugs and then instructed the pharmacies to remit the Clawbacks to Defendants for their own accounts.

RESPONSE: In response to Paragraph 12, Defendants admit that, in some circumstances and at some period during the putative Class Period, and pursuant to the participant's plan terms, United HealthCare Services, Inc. and/or OptumRx 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. Defendants deny the remaining allegations contained in Paragraph 12.

13. Had Defendants lived up to their legal obligations under the Plans, Plaintiffs and Class Members would not have paid more than the amount the pharmacy agreed to be paid by Defendants for prescription drugs. Defendants should have and easily could have complied with the terms of the Plans and determined that the pharmacy should charge and collect only the amount that the pharmacy would receive for filling the prescription. Instead, Defendants imposed significant mark-ups—for example, $7.34

more than Plaintiff Sohmer's rightful $7.66 fee and $8.39 more than Plaintiff Fellgren's rightful $1.61 fee—and required the pharmacy to collect that excessive amount from Plaintiffs and Class Members.

RESPONSE: Defendants deny the allegations contained in Paragraph 13.

14. Defendants violated the Plan by secretly determining 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 14.

15. Defendants misrepresented to Plaintiffs and Class Members 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."

RESPONSE: Defendants deny the allegations contained in Paragraph 15.

16. In order to implement Defendants' Overcharge scheme, Defendants', including Optum, entered into contracts with participating pharmacies that required the pharmacies not to disclose the existence of the Overcharges or Clawbacks, or the fact that a patient could, in certain circumstances, pay less for a prescription drug than if the patient did not use a Defendant-administered Plan or 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 16.

17. Defendants' 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 and the express terms of the Plans. 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 17.

18. Indeed, the very purpose of obtaining or participating in a health plan that includes pharmacy benefits is to enable patients to benefit from the administrator's and

PBM's negotiating and buying power with prescription drug manufacturers and pharmacies. This should result in *reduced* costs for prescription drugs. Patients and Plans also pay substantial costs and fees, which should cover the other aspects of the prescription drug plans, including their administration. Moreover, PBMs and Plan providers such as Defendants are paid significant fees as compensation for their services that are entirely separate from the Clawbacks, making the Clawbacks excess, undisclosed profit in exchange for little to nothing. Accordingly, Plaintiffs and Class Members should not have been charged additional secret Overcharges and Clawbacks.

RESPONSE: Defendants deny the allegations contained in Paragraph 18.

19. As a result of Defendants' scheme to collect Overcharges, Defendants overcharged Plaintiffs and Class Members for prescription drugs during the Class Period (defined below). Defendants' misconduct has caused Plaintiffs and Class Members to suffer significant damages.

RESPONSE: Defendants deny the allegations contained in Paragraph 19.

20. As further alleged below, Plaintiffs seek to represent two Classes of Plan participants and beneficiaries whose health Plans are issued or administered by Defendants: (1) the ERISA Class; and (2) the Non-ERISA Class.

RESPONSE: In response to Paragraph 20, Defendants admit that Plaintiffs purport to bring the present action as a putative class action and that Plaintiffs purport to define the classes as alleged. Defendants deny that class certification is appropriate in this action.

21. Plaintiffs seek relief on behalf of themselves and the members of these two Classes by bringing the following claims:

(a) Count I: Plaintiff Sohmer brings a claim, on behalf of the ERISA Class, under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B),[4] to recover benefits due to her under the terms of the Plans, to enforce her rights and the rights of ERISA Class Members under the terms of the Plans, or to clarify her rights and the rights of ERISA Class Members to future benefits under the terms of the Plan.

(b) Count II: Plaintiff Fellgren brings a claim, on behalf of the Non-ERISA Class, alleging that Defendant UHC Services has breached its contracts with her and the Non-ERISA Class Members in

requiring them to pay fees for prescriptions drugs in excess of the fees authorized in the Plans, including Overcharges and Spread.

(c) Count III: Plaintiff Fellgren brings a claim, on behalf of the Non-ERISA Class, alleging that Defendant UHC Services has breached its implied covenant of good faith and fair dealing in requiring Plaintiff Fellgren and the Non-ERISA Class Members to pay Overcharges. Defendant UHC Services' actions were performed in bad faith, with the intent of maximizing its own revenue at participants' expense, in contravention of the reasonable expectations of Plaintiff Fellgren and the Non-ERISA Class Members.

(d) Count IV: Plaintiff Fellgren further brings a claim, on behalf of the Non-ERISA Class, alleging that Defendants' conduct violated the Minnesota Uniform Deceptive Trade Practices Act, and seeking an order enjoining Defendants from continuing to conduct business through their fraudulent conduct, requiring Defendants to conduct a corrective advertising campaign, and awarding Plaintiff Fellgren and the Non¬ERISA Class costs, including reasonable attorney's fees.

(e) Count V: Plaintiff Fellgren further alleges, on behalf of the Non-ERISA Class, that Defendants were unjustly enriched as a result of the conduct alleged herein and that they must make restitution and restore to her and the Non-ERISA Class the amount of the Overcharges.

RESPONSE: In response to Paragraph 21, Defendants admit that Plaintiffs purport to raise claims on behalf of themselves and the Classes as alleged. Defendants state that Counts III through V have been dismissed by the Court (Dkt. 68). Defendants deny that class certification is appropriate in this action, and deny the remaining allegations contained in Paragraph 21.

JURISDICTION

22. **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; (b) 29 U.S.C. § 1132(e)(1) providing for federal jurisdiction of actions brought under Title I of ERISA; and (c) 28 U.S.C. § 1332(a) and (d), which provides for federal jurisdiction over

cases involving parties who have diverse citizenship and the amount in controversy exceeds $75,000 or $5 million, respectively.

RESPONSE: In response to Paragraph 22, Defendants admit that Plaintiffs purport to assert claims against them under ERISA and that claims arising under ERISA are subject to the jurisdiction of the district courts of the United States. Defendants deny the remaining allegations contained in Paragraph 22.

23. **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. This Court also has personal jurisdiction over 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 Minnesota. Defendants may be found in this District and conduct substantial business herein: Defendants are authorized to do business in the State of Minnesota; Defendants conduct business in the State of Minnesota; Defendants have sufficient minimum contacts with the State of Minnesota; Defendants administer health plans from the State Minnesota; and/or Defendants otherwise intentionally avail themselves of the markets in the State of Minnesota through the marketing and sale of health care related 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. Moreover, Defendants' acts, practices and policies pertaining to the Overcharges or Clawbacks were established in and emanated from Minnesota. Further, Defendants' wrongful conduct, as described herein, foreseeably affects consumers in Minnesota and throughout the United States.

RESPONSE: Paragraph 23 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 23.

24. **Venue**. Venue is proper in this Court pursuant to 28 U.S.C. § 1391 because a substantial part of the events giving rise to the claims herein occurred within 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.

RESPONSE: Paragraph 24 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 24.

THE PARTIES

25. Plaintiff Samantha Sohmer is a citizen of New Jersey. Plaintiff Sohmer received prescription drug coverage under a "Choice Plus Plan A" group Plan purchased through her employer for her benefit. This Plan is a welfare benefit plan subject to ERISA. The Plan was serviced and administered by Defendant UHC Services. Under the Plan, Plaintiff Sohmer was obligated to pay copayments of $15-$175 for prescription drugs. On numerous occasions detailed below, Plaintiff Sohmer was charged a copay in an amount that exceeded the amount the Defendants agreed to pay the pharmacy (*i.e.*, the "Negotiated Price," defined below). As a result of Defendants' scheme, Plaintiff Sohmer has been injured by paying inflated amounts for medically necessary, covered prescription drugs.

RESPONSE: In response to Paragraph 25, Defendants state that they lack knowledge or information sufficient to form a belief as to the truth of the allegations regarding Sohmer's residence. Defendants admit that Plaintiff Sohmer was a participant in a health plan provided through her employer for which United HealthCare Services, Inc. was the claims administrator and admit that pursuant to the terms of the plan, Sohmer was responsible for paying certain copayments, but deny the allegations contained in Paragraph 25 to the extent they mischaracterize the plan or are inconsistent or incomplete thereto. Defendants deny the remaining allegations contained in Paragraph 25.

26. Plaintiff Kathy L. Fellgren is a Florida citizen and was a participant in the School District of Escambia County, Florida Choice HRA Base Plan with Medical and Pharmacy coverage. The Plan was administered by Defendant UHC Services. Under her

Plan, Plaintiff Fellgren was obligated to pay copayments of $10, $30, or $70. On numerous occasions detailed below, Plaintiff Fellgren was charged a copay in an amount that exceeded the amount the pharmacy agreed to pay. As a result of Defendants' scheme, Plaintiff Fellgren has been injured by paying inflated copays for medically necessary, covered prescription drugs.

RESPONSE: In response to Paragraph 26, Defendants state that they lack knowledge or information sufficient to form a belief as to the truth of the allegations regarding Fellgren's residence. Defendants admit that Plaintiff Fellgren is a participant in a health plan provided through her employer for which United HealthCare Services, Inc. is the claims administrator and admit that pursuant to the terms of the plan, Fellgren was responsible for paying certain copayments, but deny the allegations contained in Paragraph 26 to the extent they mischaracterize the plan or are inconsistent or incomplete thereto. Defendants deny the remaining allegations contained in Paragraph 26.

27. Defendant UnitedHealth is a Delaware corporation with its principal place of business in Minnetonka, Minnesota. UnitedHealth is a diversified managed healthcare company. In 2017, UnitedHealth reported revenue in excess of $201 billion, and the company is currently ranked sixth on the Fortune 500 list. The company claims that in 2017, through its UnitedHealthcare entities and its wholly-owned subsidiary OptumRx, it processed nearly three-quarters of a trillion dollars in gross billed charges and managed nearly $250 billion in aggregate health care spending on behalf of the customers and consumers it serves. UnitedHealth offers a spectrum of products and services including health insurance plans through its wholly owned subsidiaries and prescription drugs through its PBM, OptumRx.

RESPONSE: In response to Paragraph 27, Defendants admit that UnitedHealth Group, Incorporated is a Delaware corporation with its principal place of business in Minnetonka, Minnesota. Defendants further admit that UnitedHealth Group Incorporated offers a spectrum of products and services including health insurance plans through its wholly owned subsidiaries and admit that OptumRx is a pharmacy benefit manager.

UnitedHealth Group states that its size is irrelevant to Plaintiffs' claims and denies the remaining allegations in Paragraph 27.

28. Defendant UHC Services is a Minnesota corporation. UHC Services provides health insurance plans for employers, individuals, and families throughout the United States, and manages and administers both ERISA Plans and Non-ERISA Plans, including Medicare Advantage Plans. UHC Services administered Plaintiffs Sohmer and Fellgren's Plans.

RESPONSE: In response to Paragraph 28, Defendants admit that United HealthCare Services, Inc. is a Minnesota corporation, and that United HealthCare Services, Inc. served as the claims administrator for both Plaintiff Sohmer's and Plaintiff Fellgren's plans during the putative Class Period. Defendants further admit that United HealthCare Services, Inc. and its affiliates offer health insurance plans for employers and individuals in the United States and that it offers administrative services to both ERIS plans and non-ERISA plans. Defendants state that Medicare Advantage Plans are irrelevant to Plaintiffs' claims and deny the remaining allegations in Paragraph 28.

29. Defendant UHC Insurance operates as a subsidiary of UHIC Holdings, Inc., which is a subsidiary of UHC Services. UHC Insurance is a corporation organized under the laws of Connecticut with a principal place of business in Hartford, Connecticut. UHC Insurance contracts on behalf of itself and its affiliates for the payment of healthcare services provided to a participating provider's patients. UHC Insurance is the primary underwriter of insurance policies provided and administered by UHC Services and its state-level subsidiaries and affiliates.

RESPONSE: Defendants admit the first two sentences in Paragraph 29 and that United Healthcare Insurance Company is an underwriter of insurance policies. Defendants deny the remaining allegations contained in Paragraph 29.

30. Defendant Optum, Inc. is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota. Optum, Inc. is a subsidiary of United HealthCare

Services and manages the subsidiaries that administer UnitedHealth's pharmacy benefits, including OptumRx, Inc.

RESPONSE: In response to Paragraph 30, Defendants admit that Optum, Inc. is a Delaware corporation with is principal place of business in Eden Prairie, that Optum, Inc. is a subsidiary of United HealthCare Services, Inc., that OptumRx is ultimately a subsidiary of Optum, Inc., and that OptumRx is a pharmacy benefit manager. Defendants deny the remaining allegations contained in Paragraph 30.

31. Defendant OptumRx, Inc. is a California corporation with its principal place of business in Irvine, California. OptumRx, Inc. provides pharmacy care services to more than 65 million people in the United States through its network of more than 67,000 retail pharmacies, multiple home delivery and specialty pharmacies and through the provision of home infusion services. In 2017, OptumRx, Inc. managed approximately $85 billion in pharmaceutical spending, including $35 billion in specialty pharmaceutical spending.

RESPONSE: Defendants admit the allegations in Paragraph 31, but state that OptumRx, Inc.'s size is irrelevant to Plaintiffs' claims.

SUBSTANTIVE ALLEGATIONS

Health Insurance in the United States

32. Over 90 percent 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 32, and on that basis, deny them.

33. Health insurance is paid for by a premium paid for medical and prescription drug benefits for a defined period, 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 33, 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 33.

34. 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— to the extent they apply to prescription drug benefits—are the dollar amounts a 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 payments made by a patient toward the cost of a prescription drug and often are either set dollar amounts (*e.g.,* $10 or $15) or the actual pharmacy charge for the drug.

RESPONSE: In response to Paragraph 34, Defendants 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 terms of which speak for themselves. Defendants deny the remaining allegations in Paragraph 34.

The Pharmaceutical Benefits Industry and Pharmacy Benefits Managers

35. The pharmacy 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 35, 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 benefits industry," and on that basis, deny them.

36. 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 PBMs may operate mail-order pharmacy businesses.

RESPONSE: Defendants lack knowledge or information sufficient to form a belief as to the truth of the allegations contained in Paragraph 36, which are not specific to Defendants or any given pharmacy, and on that basis, deny them.

37. 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 insurer/administrator hired to participate in administering the prescription drug component of a health plan. For example, Optum acted as the United Defendants' delegee in participating in administering prescription drug plans during the Class Period.

RESPONSE: The third sentence of Paragraph 37 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 37. Defendants deny the remaining allegations contained in Paragraph 37.

38. PBMs like Optum reach contractual agreements with retail pharmacies regarding the total prices pharmacies will receive (the combined amounts paid by patients and their Plans) for drugs processed through the PBM, typically a percentage of an industry-standard pricing benchmark ("Negotiated Price").

RESPONSE: In response to Paragraph 38, Defendants deny that Optum, Inc., is a PBM, but admit that OptumRx enters into contractual agreements with retail pharmacies. Defendants further state that the referenced contracts speak for themselves and therefore

do not require a response, and deny the remaining allegations contained in Paragraph 38 to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

39. 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 including terms related to the amount of cost-sharing payments a patient must pay in exchange for the prescription benefit, 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 39, which are not specific to Defendants or any given pharmacy, and on that basis, deny them.

40. The PBM is supposed to pay the pharmacy any amounts owed to the pharmacy above and beyond the cost sharing payment (whether a copayment, coinsurance or deductible amount paid by the patient), to total the Negotiated Price. These amounts are aggregated and supposed to be 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 40, which are not specific to Defendants or any given pharmacy, and on that basis, deny them.

41. Under Defendants' scheme, 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: In response to the allegations in Paragraph 41, Defendants admit that, in some circumstances and at some period during the putative Class Period, and pursuant to each participant's plan terms, United HealthCare Services, Inc. and/or OptumRx 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. Defendants deny any allegations regarding a "scheme."

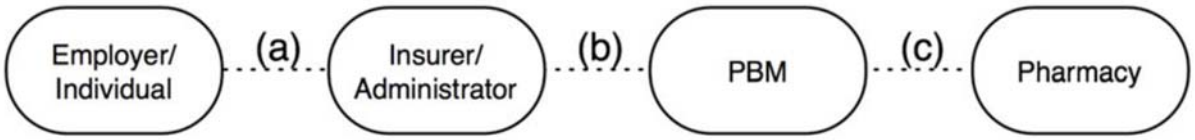
The Relevant Contractual Relationships

42. Contractual relationships exist at three relevant levels: (1) between the employer (or, in the case of non-employer sponsored Plans, the individual) and the 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 hire PBMs to manage the prescription drug benefits offered pursuant to their policies and administrative services only ("ASO") contracts. PBMs like Optum then have relationships with retail pharmacies, which govern, among other things, the Negotiated Prices that the pharmacies will be paid in exchange for drug purchases processed through the PBMs. Some pharmacies may be "in-network" and others may be "out of network."

RESPONSE: In response to Paragraph 42, 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 contained in Paragraph 42 to

the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

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



RESPONSE: In response to Paragraph 43, 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 contained in Paragraph 43 to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

44. **Employer/Individual–Insurer/Administrator 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 the Class Members are intended beneficiaries of such agreements and they are participants and beneficiaries in the Plans.

RESPONSE: In response to Paragraph 44, 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 contained in Paragraph 44 to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

45. **Insurer–PBM Agreements**. Health insurance/administration companies, such as the United Defendants, contract with and/or own PBMs such as Optum, which act

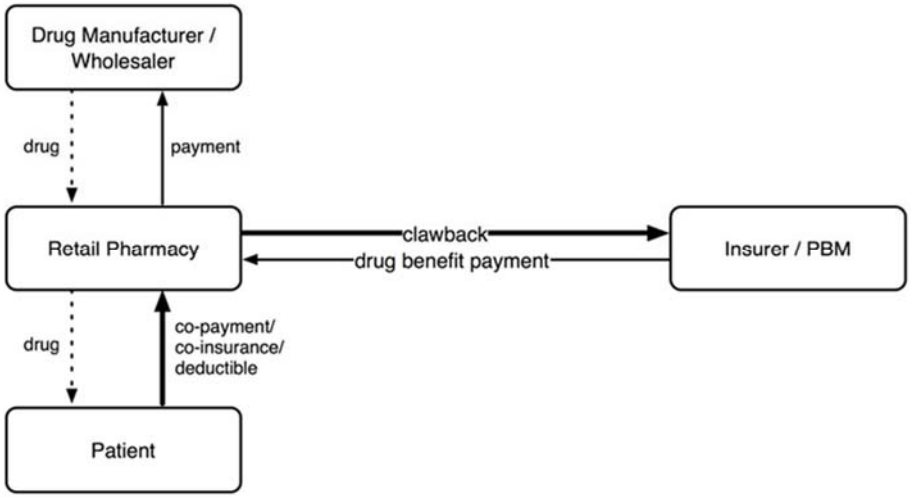
as their agents in administering the prescription drug benefits purchased through the health plans that the insurers issue or administer.

RESPONSE: In response to Paragraph 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 contained in Paragraph 45 to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

46. **PBM–Pharmacy Agreements**. For "in-network" benefits at issue in this case, PBMs like Defendant Optum 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 (the Negotiated Prices). Pursuant to these agreements, the pharmacy submits a claim to Optum on behalf of the patient. In response to this claim, pursuant to these agreements, Defendants 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 Defendants.

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 contained in Paragraph 46 to the extent they mischaracterize the contracts or are inconsistent or incomplete with respect thereto.

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



RESPONSE: Defendants deny the allegations contained in Paragraph 47.

48. 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 and administrators must ensure that PBMs do not overcharge patients for their prescription drug benefits.

RESPONSE: Paragraph 48 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 48.

49. On the contrary, PBMs, like Defendant Optum, acting as agents and/or in concert with the United 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 Plaintiffs' Plans and the Classes by charging Overcharges.

RESPONSE: Defendants deny the allegations contained in Paragraph 49.

The Plans

50. Defendant UHC Services was the "Claims Administrator" for Plaintiff Sohmer's 2012-2015 and 2016 Plans. It had the responsibility "to handle the day-to-day administration of the Plan's coverage as directed by the Plan's Administrator, through an administrative agreement" between the Plan sponsor and UHC Services.

RESPONSE: In response to Paragraph 50, Defendants admit that, United Healthcare Insurance Company and/or United HealthCare Services, Inc. and certain of their affiliates provided certain claims administrative services pursuant to an Administrative Services Agreement between them and Sohmer's employer. Defendants state that the Administrative Services Agreement speaks for itself. Defendants deny the allegations contained in Paragraph 50 to the extent they mischaracterize or are inconsistent or incomplete with respect to the terms of the Administrative Services Agreement.

51. Defendant UHC Services was the "Claims Administrator" for Plaintiff Fellgren's self-funded employee health benefit plan in effect as of 2013. UHC Services "provide[d] certain claim administration services for the Plan," including prescription drug benefit claims.

RESPONSE: In response to Paragraph 51, Defendants admit that United Healthcare Insurance Company and/or United HealthCare Services, Inc. and certain of their affiliates provided certain claims administrative services pursuant to an Administrative Services Agreement between them and Fellgren's employer. Defendants state that the Administrative Services Agreement speaks for itself. Defendants deny the allegations contained in Paragraph 51 to the extent they mischaracterize or are inconsistent or incomplete with respect to the terms of the Administrative Services Agreement.

52. As Plan administrators, the United Defendants and their PBM designee, Defendant Optum, had a number of responsibilities. In particular, they arranged for healthcare providers, including pharmacies, to participate in their network. Network pharmacies contracted with Defendants, or their designees and affiliates, to provide "Prescription Drugs Products" to Plaintiffs.

RESPONSE: In response to Paragraph 52, Defendants deny that they were "Plan administrators" for Plaintiffs' plans. Defendants further state that OptumRx served as the pharmacy benefit manager for certain plans administered by United HealthCare Services, Inc. or United Healthcare Insurance Company. Defendants admit that OptumRx entered into agreement with certain retail network pharmacies to dispense prescription drugs to certain plan participants and that the terms of its contracts with retail network pharmacies speak for themselves. Defendants deny the remaining allegations in Paragraph 52.

53. According to the Plans, the United Defendants had the option to retain and utilize their affiliates to provide claims administration services. Affiliates "are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries."

RESPONSE: Defendants admit that the quoted language appears in the summary plan descriptions for Plaintiffs Fellgren and Sohmer to describe the applicable claims administrator's affiliates. Defendants deny the remaining allegations in Paragraph 53.

54. UnitedHealth and UHC Services designated Defendant OptumRx to participate in providing prescription drug products to Plaintiffs under their Plans, including arranging for and managing the prescription drug network and managing and processing prescription drug claims on the United Defendants' behalf.

RESPONSE: In response to allegations in Paragraph 54, Defendants admit that OptumRx provided United HealthCare Services, Inc. with certain pharmacy benefit management services in support of certain commercial pharmacy benefit plans pursuant

to a Prescription Drug Benefit Administration Agreement, the terms of which speak for themselves. Defendants deny the allegations contained in Paragraph 54 to the extent they mischaracterize or are inconsistent or incomplete with respect to the terms of the referenced agreement. Defendants deny the allegations in Paragraph 54 as to UnitedHealth Group Incorporated.

55. Plaintiffs' Plans utilized a "lower of three" formula for determining the amount Plaintiffs pay for prescription drugs. Under these Plans, Plaintiffs were responsible for paying the lower of (1) the applicable copayment, (2) the network pharmacy's usual and customary charge, *i.e.*, the amount charged to a patient without insurance, or (3) the "Prescription Drug Charge," defined as the rate that Defendants agreed to pay the network pharmacy, including any applicable dispensing fee and taxes ("the Negotiated Price"). Under the "lowest of three" Plans, Plaintiffs should never pay more than the Negotiated Price.

RESPONSE: Defendants deny the allegations contained in Paragraph 55.

56. Coinsurance plans define "coinsurance" as "the percentage of Eligible Expenses [participants] are required to pay for certain covered health services" and define "Eligible Expenses" as "charges for Covered Health Services that are provided while the Plan is in effect and determined by the Claim's Administrator." With respect to network providers, "Eligible Expenses" are based on the "contracted rates with the provider." Accordingly, the cost-share of a participant in a coinsurance plan for prescription drugs should not exceed the product of the coinsurance rate (*i.e.,* 20 percent) and the amount that Defendants agreed to pay the network pharmacy.

RESPONSE: In response to Paragraph 56, Defendants state that neither Plaintiff had a plan that provided for coinsurance payments for prescription drug benefits. Furthermore, Paragraph 56 purports to quote and characterize unidentified plans, 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 contained in Paragraph 56 to the extent they mischaracterize the unidentified plans or are

inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 56.

Defendants' Plans Have Standard Terms

57. Defendants use 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 and managed by Defendants—do not differ materially across Plans. Accordingly, upon information and belief, the rights relevant to the claims alleged herein are shared by all Class Members, regardless of the funding arrangement underpinning the health plan benefits that Defendants offer and administer.

RESPONSE: In response to Paragraph 57, Defendants state that Plaintiffs' plans speak for themselves, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 57 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 57. Defendants further deny that class certification is appropriate in this action.

Plaintiffs' Purchases

58. During the time that Plaintiff Sohmer was covered by the Plans, she purchased prescription drugs for which she was required to make copayments in excess of the amounts provided for by her Plans, including, for example, the following specific purchases:

Filled Date	Amount UnitedHealth agreed to pay pharmacy	Amount Sohmer paid	Overcharge
01/16/16	$7.66	$15.00	$7.34

01/20/16	$8.45	$15.00	$6.55
01/20/16	$8.45	$15.00	$6.55
02/10/16	$8.35	$15.00	$6.65
02/10/16	$8.35	$15.00	$6.65
02/14/16	$7.66	$15.00	$7.34
03/23/16	$7.66	$15.00	$7.34
04/24/16	$7.66	$15.00	$7.34
05/05/16	$2.49	$5.09	$2.60
05/23/16	$7.66	$15.00	$7.34
06/20/16	$7.66	$15.00	$7.34
07/15/16	$7.57	$15.00	$7.43
07/17/16	$7.66	$15.00	$7.34
08/22/16	$7.66	$15.00	$7.34
08/22/16	$7.57	$15.00	$7.43
09/20/16	$7.66	$15.00	$7.34
10/11/16	$7.57	$15.00	$7.43
10/24/16	$7.66	$15.00	$7.34
10/24/16	$10.64	$15.00	$4.36
11/16/16	$7.66	$15.00	$7.34
12/21/16	$7.66	$15.00	$7.34

RESPONSE: In response to Paragraph 58, Defendants state that the terms of her respective plans required Plaintiff Sohmer to make copayments in connection with having those prescriptions filled. Defendants admit that, according to records maintained by OptumRx, Plaintiff Sohmer had prescription drugs filled on the above dates, among others and paid the amount indicated in the table. Defendants deny the remaining allegations contained in Paragraph 58.

59. Plaintiff Sohmer was illegally charged Overcharges for these prescription drugs in excess of the Negotiated Price. During this timeframe, Defendants then "clawed back" these Overcharges from Plaintiff Sohmer's pharmacy for their benefit.

RESPONSE: Defendants deny the allegations contained in Paragraph 59.

60. Plaintiff Fellgren was also subject to multiple Overcharges. For example, in 2016, she purchased the same prescription drug six times, and was Overcharged for the drug on her last two purchases.

RESPONSE: Defendants deny the allegations contained in Paragraph 60.

61. Under Plaintiff Fellgren's Plan, there was a $200 annual prescription drug deductible. During the deductible phase, patients paid "Eligible Expenses," defined as the "contracted rates with th[e] provider." In other words, during the deductible phase, Plaintiff Fellgren was obligated to pay the Negotiated Price until she reached $200 in out-of-pocket expenses. At that point, she was eligible for benefits under her "lowest of three" formula, and she should still have paid no more than the Negotiated Price for a prescription drug.

RESPONSE: Defendants admit that Plaintiff Fellgren had an annual prescription drug deductible. Defendants deny the remaining allegations contained in Paragraph 61.

62. That did not happen, however. During the deductible phase, Plaintiff Fellgren paid $1.61 per prescription for this particular prescription drug. In September of 2016, Plaintiff Fellgren met her $200 prescription drug deductible. Then, in October and December of 2016, she paid a $10 copayment per prescription — over ***five times*** the Negotiated Price:

Filled Date	Approved Ingredient Cost	Approved Dispensing Fee	Amount UnitedHealth agreed to pay pharmacy	Amount Fellgren paid
02/17/16	$0.61	$1.00	$1.61	$1.61
06/08/16	$0.61	$1.00	$1.61	$1.61
07/07/16	$0.61	$1.00	$1.61	$1.61
09/06/16	$0.61	$1.00	$1.61	$1.61
10/07/16	$9.00	$1.00	$10.00	$10.00
12/23/16	$9.00	$1.00	$10.00	$10.00

RESPONSE: In response to Paragraph 62, Defendants state that the terms of her respective plans required Plaintiff Fellgren to make copayments and/or deductible payments in connection with having those prescriptions filled. Defendants admit that,

according to records maintained by OptumRx, Plaintiff Fellgren had prescription drugs filled on the above dates, among others and paid the amount indicated in the table. Defendants deny the remaining allegations contained in Paragraph 62.

63. Plaintiff Fellgren's Plan entitled her to pay the *lowest* of (A) the applicable copayment ($10), (B) the usual and customary charge, or (C) the Prescription Drug Charge ($1.61). In violation of the Plan, Defendants required the pharmacy to collect a $10 copayment from her.

RESPONSE: Defendants deny the allegations contained in Paragraph 63.

Administrative Exhaustion Confirms Overcharges

64. On January 16, 2018, Plaintiffs' counsel sent Defendants a letter requesting administrative review of their Overcharge claims including claims of former-plaintiff Stephen Hawks. On March 7, 2018, Defendants issued an initial decision denying Plaintiffs' claims. Notably, the March 7 letter makes clear that Defendants patently misread Plaintiff Fellgren's Plan, calling it a "lessor [sic] of two" plan, when it was actually a "lowest of three" plan. Similarly, Plaintiff Sohmer's 2016 Plan—also a "lowest of three" plan—was ignored and treated as a "lessor [sic] of two" plan.

RESPONSE: Paragraph 64 purports to quote and characterize written documents, the content of each which speaks for itself, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 64 to the extent they mischaracterize the documents or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 64.

65. On March 12, 2018, Plaintiffs requested a first level appeal, maintaining their position that they paid Overcharges in violation of their Plans. The March 12 letter made clear that Plaintiffs sought to appeal Defendants' initial determination for multiple

years of claims, regardless of whether Defendants chose to provide claims data to Plaintiffs for all relevant transactions.

RESPONSE: In response to Paragraph 65, Defendants admit that Plaintiffs requested a first-level appeal on March 12, 2018. Defendants state that the second sentence of Paragraph 65 purports to characterize a letter, 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 the allegations contained in Paragraph 65 to the extent they mischaracterize the letter or are inconsistent or incomplete with respect thereto.

66. Defendants denied Plaintiff Sohmer's first level appeal, stating that she was not entitled to reversal of her transactions because she had a "lower of two" Plan. Again, Defendants did not acknowledge that Plaintiff Sohmer's 2016 Plan was a "lowest of three" Plan. Defendants informed Plaintiff Sohmer that she could request a second level review if she was not satisfied with the outcome of her first level appeal.

RESPONSE: In response to Paragraph 66, Defendants admit that the claims administrator United HealthCare Services, Inc. denied Plaintiff Sohmer's first-level appeal. Defendants state that the remaining allegations in Paragraph 66 purport to characterize a document, 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 the allegations contained in Paragraph 66 to the extent they mischaracterize the document or are inconsistent or incomplete with respect thereto.

67. Defendants denied Plaintiff Fellgren's first level appeal, again erroneously stating that she was not entitled to reversal of her transactions because she had a "lower of two" Plan. In fact, as discussed above, Plaintiff Fellgren's Plan was a "lowest of

three" Plan. Defendants informed Plaintiff Fellgren that she could request a second level review if she was not satisfied with the outcome of her first level appeal.

RESPONSE: In response to Paragraph 67, Defendants admit that the claims administrator United Healthcare Insurance Company denied Plaintiff Fellgren's first-level appeal. Defendants state that the remaining allegations in Paragraph 67 purport to characterize a document, 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 the allegations contained in Paragraph 67 to the extent they mischaracterize the document or are inconsistent or incomplete with respect thereto.

68. In contrast, Defendants partially granted former-plaintiff Hawks's first level appeal. Defendants determined that Plaintiff Hawks *had been overcharged* with respect to seven of his 2015 transactions, when he had a "lowest of three" Plan, stating: "Hawks actually paid the relevant member responsibility amount, which was more than the contract price negotiated with the individual pharmacy." Defendants thus admitted that they had engaged in improper Overcharges and Clawbacks as to at least some of Hawks's transactions, as evidenced by the check they issued to reimburse him for the Overcharges.

RESPONSE: In response to the first sentence of Paragraph 68, Defendants admit that the claims administrator partially granted former-plaintiff Hawk's first-level appeal. Defendants state that the second sentence of Paragraph 68 purports to characterize a document, 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 the allegations contained in Paragraph 68 to the extent they mischaracterize the document or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in the third sentence of Paragraph 68.

69. On April 24, 2018, Plaintiffs requested a second level appeal of their administrative claims.

RESPONSE: Defendants admit the allegations contained in Paragraph 69.

70. Plaintiff Sohmer's second level appeal was denied by letter on May 24, 2018, with Defendants affirming their previous determination that she was not entitled to reversal of any of her transactions and notifying her that she has the right to pursue a claim under ERISA § 502(a)(1)(B).

RESPONSE: In response to Paragraph 70, Defendants admit that claims administrator United Healthcare Services, Inc. denied Plaintiff Sohmer's second-level appeal. Defendants state that the remaining allegations in Paragraph 70 purport to characterize a letter, 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 the allegations contained in Paragraph 70 to the extent they mischaracterize the letter or are inconsistent or incomplete with respect thereto.

71. Plaintiff Fellgren's second level appeal likewise was denied by letter on May 24, 2018, with Defendants once again erroneously stating that she had a "lessor [sic] of two" plan and thus was not entitled to reversal of her transactions. She was informed of a right to sue if not satisfied with the result.[5]

RESPONSE: In response to Paragraph 71, Defendants admit that claims administrator United Healthcare Insurance Company denied Plaintiff Fellgren's second-level appeal. Defendants state that the remaining allegations in Paragraph 71 purport to characterize a letter, 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 the allegations contained in Paragraph 71 to the extent they mischaracterize the letter or are inconsistent or incomplete with respect thereto.

72. Although Defendants admitted wrongdoing in reversing former-plaintiff Hawks's Overcharges, they have not done so uniformly, even as to the named Plaintiffs. First, despite the fact that Hawks has the *same Plan language* as Plaintiffs Sohmer and Fellgren, and despite the fact that the transaction data for Plaintiffs Sohmer and Fellgren shows that they too paid more than the Negotiated Price on multiple occasions, Defendants denied Plaintiff Sohmer's and Plaintiff Fellgren's administrative appeals in their entireties.

RESPONSE: Defendants admit that they denied Plaintiffs' administrative appeals, but deny the remaining allegations in Paragraph 72.

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

73. Defendants have engaged in a scheme to charge Plaintiffs 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 73.

74. Defendants utilize technology and service platforms, retail network contracting and claims processing services to carry out this Overcharge and Clawback Scheme, including those of Defendant OptumRx.

RESPONSE: Defendants deny the allegations contained in Paragraph 74.

75. Defendant OptumRx's Provider Manual[6] explains the mechanism by which Defendants conducted the scheme:

(a) The Provider Manual "includes the policies and procedures" applicable to all pharmacies participating in OptumRx's pharmacy network and "is incorporated into and is a part of" the pharmacies' agreements with Defendants (through OptumRx).[7]

(b) The Provider Manual provides that OptumRx "shall communicate to [pharmacies] (via the POS System) the Cost-Sharing Amounts (*e.g.*, Co-payment and Deductible) applicable to Covered Prescription Services."[8] OptumRx directs that pharmacies "shall collect the full Cost-Sharing Amounts" from Plaintiffs and the Class Members purchasing medically necessary prescription drugs.[9] OptumRx directs that pharmacies "must charge . . . the Cost-Sharing Amount indicated in [Defendants'] online response and only this amount."[10] OptumRx dictates that waiving the Cost-Sharing Amount by

pharmacies is "strictly prohibited . . . and is considered a material breach of the Agreement."[11]

(c) The Provider Manual provides that "reimbursement pricing information, as well as prices paid to [pharmacies] . . . are "confidential and proprietary. . . ."[12]

(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."[13] Pharmacies are "subject to penalties or sanctions" if OptumRx determines that the pharmacies "disclosed confidential information. . . ."[14] These penalties include "at a minimum . . . $5,000 per incident," and pharmacies "may be subject to additional actions" by OptumRx, "up to termination from participation" in OptumRx's pharmacy network.[15] Pharmacies terminated from participation in the 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."[16]

RESPONSE: Paragraph 75 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 nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 75 to the extent they mischaracterize the Provider Manual or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 75.

76. Defendants used the OptumRx platforms to create and implement their unlawful Overcharge Scheme. Defendants programmed and manipulated the OptumRx technology and service platforms to violate the Plans' terms and charge greater Cost-Sharing Amounts than the Plans permitted, and they inputted 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 76.

77. Defendants further manipulated the 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 Plaintiffs and other patients when they filled their prescriptions. For example, Defendants made these

misrepresentations to Plaintiffs each time they filled a prescription and were advised of and required to pay an excessive copayment and Spread as alleged above.

RESPONSE: Defendants deny the allegations contained in Paragraph 77.

78. Defendants further directed that pharmacies "shall collect the full [inflated and unlawful] Cost-Sharing Amounts" from patients.[17] Defendants required that pharmacies "must charge . . . the Cost-Sharing Amount indicated in [Optum's] online response and only this amount,"[18] which included the excessive and unlawful Overcharges in violation of the Plans that Defendants improperly inputted into the system.

RESPONSE: Paragraph 78 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 nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 78 to the extent they mischaracterize the Provider Manual or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 78.

79. Where the patient pays a deductible and/or coinsurance (as opposed to 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 79.

80. 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 "copayments" 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 coinsurance 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 80.

81. On information and belief, some pharmacists were willing participants in the foregoing scheme while they were allowed to retain the Overcharges. However, once Defendants began "clawing back" the Overcharges (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 allegations contained in Paragraph 81.

82. For example, according to Doug Hoey ("Hoey") of the National Community Pharmacists Association ("NCPA"), a pharmacist sent him a letter received from OptumRx. Hoey stated that the letter from OptumRx "scolded the pharmacist," stating that OptumRx had '"recently discovered that pharmacy advised members that utilizing a cash price for their prescription is a better deal than using their insurance benefits."'[19] OptumRx further stated in the letter that "telling customers a cheaper price exists is a 'violation of the agreement,' [with] Optum," that OptumRx '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 82, Defendants state that Plaintiffs fail 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 82 to the extent they mischaracterize the referenced letter 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. 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.[20] 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 insurance companies and 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 preceding month.[21]

RESPONSE: In response to Paragraph 83, 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 83 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

84. 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."[22]

RESPONSE: In response to Paragraph 84, 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 84 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

85. 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 price for these drugs.

RESPONSE: Defendants deny the allegations contained in Paragraph 85.

86. 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."[23]

RESPONSE: In response to Paragraph 86, 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 86 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

87. Lawmakers, customers, and pharmacists have all raised concerns that there is a dangerous lack of transparency, rendering it difficult to assess whether a plan is being administered in compliance with plan or contract terms.[24]

RESPONSE: In response to Paragraph 87, 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 87 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

88. 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 88 contains legal conclusions to which no response is required. To the extent a response is nevertheless deemed to be required, Defendants lack knowledge or information sufficient to form a belief as to the truth of whatever

factual allegations may be contained Paragraph 88. Additionally, to the extent that Paragraph 88 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

89. 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.[25]

RESPONSE: In response to Paragraph 89, 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 89 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

The Fox 8 Investigation

90. 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 90, Defendants admit that a New Orleans television station, Fox 8, published a story regarding what it identified as "clawbacks,"

and that the reporter makes a number of allegations regarding that practice. Defendants deny the remaining allegations contained in Paragraph 90. 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 published a number of screenshots from a pharmacist's computer system showing, with respect to particular drugs, the amount of the payment that certain insurer/administrators (including Defendants) required pharmacists to collect from customers and the amount the pharmacists were required to pay to the health insurer/administrators as a "Clawback."

RESPONSE: In response to Paragraph 91, Defendants admit that a New Orleans television station, Fox 8, published a story, but lack knowledge or information as to the source or veracity of information provided therein, and on that basis, deny the allegations. 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 part of its investigation, Mr. Zurik requested comment from Defendants. Notwithstanding the specific provisions in the contract Defendants imposed on pharmacies that barred pharmacists from disclosing the existence of the Overcharges to customers (as detailed above), Defendants' 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 92 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 92.

93. An OptumRx representative further stated to Mr. Zurik, falsely, that OptumRx 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" Defendants' 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 93 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 93.

94. The OptumRx representative also claimed that the Clawback "does not accrue to [OptumRx'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 94 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 94.

95. 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.'"

RESPONSE: In response to Paragraph 95, 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. To the extent that Paragraph 95 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

96. 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 96, Defendants admit that a New Orleans television station, Fox 8, published a story regarding what it identified as "clawbacks," and that Mr. Johnson is purportedly quoted therein, but deny the allegations to the extent they mischaracterize the purported quotation or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 96.

To the extent that Paragraph 96 contains allegations that infer the existence of facts to support a claim for relief against Defendants, they are denied.

97. 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 97 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 97.

Overcharges Are Most Common With Widely Used Drugs

98. 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 (or not based on) 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 98.

CLASS ACTION ALLEGATIONS

99. Plaintiffs bring 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 following Classes:

> **ERISA Class**. All participants or beneficiaries who are or were enrolled in a health benefit plan issued and/or administered by Defendants or their affiliates or insured under Defendants' or their affiliates' health insurance policies and subject to ERISA, who purchased one or more prescription drugs pursuant to such plan and paid a cost-sharing amount for such drug(s) that exceeded the applicable Negotiated Price.
>
> **Non-ERISA Class**. All participants or beneficiaries who are or were enrolled in a health benefit plan issued and/or administered by Defendants or their affiliates or insured under Defendants or their affiliates' health insurance policies and not subject to ERISA, who purchased one or more prescription drugs pursuant to such plan and paid a cost-sharing amount for such drug(s) that exceeded the applicable Negotiated Price.

RESPONSE: In response to Paragraph 99, Defendants admit that Plaintiffs purport to bring the present action as a putative class action and that Plaintiffs purport to define the two classes as alleged. Defendants deny that class certification is appropriate in this action.

100. Excluded from the Classes 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 100, Defendants admit that Plaintiffs purport to bring the present action as a putative class action and that Plaintiffs purport to define the two classes as alleged. Defendants deny that class certification is appropriate in this action.

101. Plaintiffs reserve the right to redefine the Classes prior to certification.

RESPONSE: Defendants state that no response is required to Plaintiffs' reservation of rights in Paragraph 101. Defendants deny that class certification is appropriate in this action.

102. **Class Period**. Plaintiffs will seek to certify Classes and to recover benefits due to the Class Members and enforce their rights under the terms of the Plans during the longest period permissible under law, including applicable fraud or concealment tolling provisions, and the doctrine of equitable tolling. Further, Plaintiffs reserve the right to refine the Class Period after they have learned the extent of Defendants' scheme, the length of its concealment, and the time period during which Overcharges took place.

RESPONSE: In response to Paragraph 102, Defendants deny that they engaged in any fraud or other violations of law and state that no response is required as to the allegations contained in Paragraph 102 that relate to Plaintiffs' intent in seeking relief in this action.

103. 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 103 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.

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

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 that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 104.

105. Plaintiffs' claims are typical of the claims of the Class Members because Plaintiffs' claims, and the Class Members' claims, arise out of the same conduct, policies, and practices of Defendants as alleged herein, and all Class Members are similarly affected by Defendants' wrongful conduct.

RESPONSE: Paragraph 105 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 105.

106. There are questions of law and fact common to the Classes and these questions predominate over questions affecting only individual Class Members. Common legal and factual questions include, but are not limited to:

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

(b) Whether the members of the Class 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;

(c) Whether benefits are due to the Class Members under the terms of their Plans;

(d) Whether Class Members' rights under the terms of their Plans were violated;

(e) Whether Defendants have violated the state laws invoked here; and

(f) Whether the Class Members are entitled to declaratory and/or injunctive relief.

RESPONSE: Paragraph 106 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 106 and each of its subparts.

107. Plaintiffs will fairly and adequately represent the Classes and have retained counsel experienced and competent in the prosecution of class action litigation. Plaintiffs have no interests antagonistic to those of other Class Members. Plaintiffs are committed to the vigorous prosecution of this action and anticipate no difficulty in the management of this litigation as a class action.

RESPONSE: Paragraph 107 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 107.

108. 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 Members may be relatively small, the expense and burden of individual litigation make it impossible for Class Members 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 108 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 108.

109. Class action status in this action is warranted under Rule 23(b)(1)(B) because prosecution of separate actions by the Class Members would create a risk of adjudications with respect to individual Class Members 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 109 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 109.

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

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 that class certification is appropriate in this action and deny the remaining allegations contained in Paragraph 110.

111. 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 Class Members, thereby making appropriate final injunctive, declaratory, or other appropriate equitable relief with respect to each Class as a whole.

RESPONSE: Paragraph 111 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 111.

112. Class action status in this action is warranted under Rule 23(b)(3) because questions of law or fact common to Class Members 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 Class Members is impracticable.

RESPONSE: Paragraph 112 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 112.

113. Plaintiffs reserve the right to invoke any provision of Rule 23 appropriate at the time Plaintiffs move to certify the Classes or otherwise address class certification issues.

RESPONSE: Defendants state that no response is required to Plaintiffs' reservation of rights in Paragraph 113. Defendants deny that class certification is appropriate in this action.

PLAINTIFFS AND THE CLASS ARE ENTITLED TO TOLLING DUE TO FRAUD OR CONCEALMENT

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

RESPONSE: Defendants deny the allegations contained in Paragraph 114.

115. Neither Plaintiffs nor the Class Members knew of the Overcharge and Clawback Scheme, nor could they have reasonably discovered the existence of the Overcharge and Clawback Scheme, until recently.

RESPONSE: In response to Paragraph 115, Defendants state that they lack knowledge or information sufficient to form a belief as to the truth of the allegations regarding Plaintiffs' actual knowledge and therefore deny the same, and deny the remaining allegations contained in Paragraph 115.

116. Until recent news broke about Defendants' Overcharge and Clawback Scheme, their unlawful conduct was hidden from Plaintiffs and Class Members.

RESPONSE: Defendants deny the allegations contained in Paragraph 116.

117. Even today, the gag clauses in place between Defendants and providers continue to hide Defendants' unlawful conduct from Class Members. Even after the media began reporting about the scheme, as set forth above, Defendants and OptumRx made false and misleading statements about the scheme in order to continue its concealment.

RESPONSE: Defendants deny the allegations contained in Paragraph 117.

118. To the extent that any of the causes of action alleged herein are subject to a specific statute of limitations or repose, 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 118.

119. The Overcharge and Clawback Scheme—by its nature a secret endeavor by Defendants—remains hidden from most Class Members. Moreover, during the Class Period, as defined above, Defendants actively and effectively concealed their participation in the Overcharge and Clawback Scheme from Plaintiffs and other Class Members through "gag clauses," secrecy policies, material omissions, and false and misleading public statements. There is no question that Plaintiffs' claims are timely.

RESPONSE: Defendants deny the allegations contained in Paragraph 119.

COUNT I

For Violations of ERISA § 502(a)(1)(B)29 U.S.C. § 1132(a)(1)(B) by Plaintiff Sohmer on behalf of the ERISA Class

120. Plaintiff Sohmer 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 1-119 as if fully set forth herein.

121. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) provides that a participant or beneficiary may bring an action to recover benefits due under the terms of

the Plan, 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 121 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 121.

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

RESPONSE: Defendants deny the allegations contained in Paragraph 122.

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

RESPONSE: Defendants deny the allegations contained in Paragraph 123.

124. Plaintiff Sohmer and the ERISA Class 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 payment of all amounts due to them in accordance with their rights under the ERISA Plans;

(e) For a calculation and disgorgement of Defendants' profits from the Overcharge scheme; 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 124 and each of its subparts.

COUNT II

Breach of Contract
by Plaintiff Fellgren on behalf of the Non-ERISA Class

125. Plaintiff Fellgren 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 1-124 as if fully set forth herein.

126. Defendants offered, sold, and administered health insurance plans and ASO services in all 50 states during the Class Period alleged herein. Certain of these Plans are not subject to ERISA, including Plans that are not sponsored by employers and employer-sponsored Plans that fall within exemptions from ERISA, such as the exemption for governmental plans provided by ERISA § 4(b)(1), 29 U.S.C. § 1003(b)(1).

RESPONSE: In response to the allegations in Paragraph 126, Defendants admit that Defendants United HealthCare Services, Inc., United Healthcare Insurance Company, and OptumRx either insure or administer health benefit plans, some of which are employer-sponsored and governed by ERISA and some of which are not. Defendants deny the remaining allegations contained in Paragraph 126, except for the legal conclusions to which no response is required.

127. These Plans constitute contracts under the laws of each of the states in which they were sold and administered, and in all material respects for this action, these Plans are uniform contracts.

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 the allegations contained in Paragraph 127.

128. The definitions of the terms used in the Non-ERISA Class Members' Plans are materially the same, including, but not limited to, the definitions of the policy terms such as: "Allowed Amount," "Deductible," "Benefits," "Co-payment," "Co-insurance," "Covered Health Services," "Eligible Expenses," "Pharmaceutical Product(s)," "Premium," "Prescription Drug Charge," "Prescription Drug Product," and "Usual and Customary Charge."

RESPONSE: Paragraph 128 purports to quote and characterize unidentified plans, the terms of which speaks for themselves, and thus no response is required. To the extent a response is nevertheless deemed to be required, Defendants deny the allegations contained in Paragraph 128 to the extent they mischaracterize the unidentified plans or are inconsistent or incomplete with respect thereto. Defendants deny the remaining allegations contained in Paragraph 128.

129. Plaintiff Fellgren and the Non-ERISA Class Members are participants in the Plans that Defendants offered and administered and are either parties to or third-party beneficiaries of such Plans.

RESPONSE: In response to Paragraph 129, Defendants admit that Fellgren was a participant in an employer-sponsored plan for which United HealthCare Services, Inc. provided certain claims administration services. Defendants deny the remaining allegations in paragraph 129 except for the legal conclusion to which no response is required.

130. Defendants breached the Plans in each of the fifty states by requiring participants and beneficiaries to pay fees for prescription drugs in excess of the fees authorized in the Plans, including Overcharges and Spread, as alleged herein, and in taking Clawbacks.

RESPONSE: Defendants deny the allegations contained in Paragraph 130.

131. Plaintiff Fellgren and the Non-ERISA Class Members have suffered damages as result of Defendants' breaches.

RESPONSE: Defendants deny the allegations contained in Paragraph 131.

132. Plaintiff Fellgren and the Non-ERISA Class Members are entitled to recover damages and other appropriate relief, as alleged below.

RESPONSE: Defendants deny the allegations contained in Paragraph 132.

COUNT III

Breach of Covenant of Good Faith and Fair Dealing by Plaintiff Fellgren on behalf of the Non-ERISA Class

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

RESPONSE: The Court dismissed Count III of the Complaint (Dkt. 68), and thus no response to Paragraph 133 is required.

134. All contracts contain an implied covenant of good faith and fair dealing, including Plaintiff Fellgren's and the Non-ERISA Class Members' contracts with Defendants.

RESPONSE: The Court dismissed Count III of the Complaint (Dkt. 68), and thus no response to Paragraph 134 is required.

135. Plaintiff Fellgren and the Non-ERISA Class s members purchased the benefits under the Plans that Defendants offered and administered, and they are either parties to, or third-party beneficiaries of, such health benefit plans.

RESPONSE: The Court dismissed Count III of the Complaint (Dkt. 68), and thus no response to Paragraph 135 is required.

136. Defendants performance under the Plans deprived Plaintiff Fellgren and the Non-ERISA Class Members of the prescription drug prices that a reasonable consumer would expect to receive under the Plans.

RESPONSE: The Court dismissed Count III of the Complaint (Dkt. 68), and thus no response to Paragraph 136 is required.

137. On information and belief, Defendants' actions, as alleged herein, were performed in bad faith, in that the purpose behind the practices and policies alleged herein was to maximize Defendants' and/or its agents' revenue at the expense of Plaintiff Fellgren and the Non-ERISA Class Members in contravention of the reasonable expectations of Plaintiff Fellgren and the Non-ERISA Class Members.

RESPONSE: The Court dismissed Count III of the Complaint (Dkt. 68), and thus no response to Paragraph 137 is required.

138. Defendants have breached the covenant of good faith and fair dealing in the Plans as alleged herein.

RESPONSE: The Court dismissed Count III of the Complaint (Dkt. 68), and thus no response to Paragraph 138 is required.

139. Plaintiff Fellgren and the Non-ERISA Class Members have sustained damages as a result of Defendants' breaches as alleged herein.

RESPONSE: The Court dismissed Count III of the Complaint (Dkt. 68), and thus no response to Paragraph 139 is required.

COUNT IV

Minnesota's Uniform Deceptive Trade Practices Act, Minn. Stat. §325D.43, et seq., by Plaintiff Fellgren on behalf of the Non-ERISA Class

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

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 140 is required.

141. Plaintiff Fellgren brings this claim individually and on behalf of members of the Non-ERISA Class under Minnesota law.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 141 is required.

142. Plaintiff Fellgren purchased health insurance and paid copayments for prescription drugs for her own personal use.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 142 is required.

143. The acts and practices of Defendants as described above deceived Plaintiff Fellgren and members of the Non-ERISA Class as described herein, and have resulted, and will result in, damages to Plaintiff Fellgren and the Non-ERISA Class.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 143 is required.

144. MUDTPA provides that "[a] person engages in a deceptive trade practice when, in the course of business, vocation, or occupation, the person: [. . .] advertises goods or services with intent not to sell them as advertised" and "engages in any other conduct which similarly creates a likelihood of confusion or of misunderstanding." Minn. Stat. § 325D.44, subd.1(9), (13).

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 144 is required.

145. By committing the acts alleged above, Defendants have violated the MUDTPA.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 145 is required.

146. Plaintiff and the Non-ERISA Class Members suffered injuries caused by Defendants' misrepresentations by misrepresenting the true cost of prescription drugs and misrepresenting the true amount of a patient's copayment or coinsurance obligation.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 146 is required.

147. Defendants intentionally and knowingly misrepresented material facts regarding the cost of Plaintiff Fellgren's and Non-ERISA Class Members' prescription medications, fees charged to Plaintiff Fellgren and the Non-ERISA Class Members as a component of their copayment or coinsurance obligation, and the true amount of a patient's copayment or coinsurance obligation with intent to mislead Plaintiff Fellgren and the Non-ERISA Class.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 147 is required.

148. Defendants knew or should have known that their conduct violated the MUDTPA.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 148 is required.

149. Defendants owed Plaintiff Fellgren and the Non-ERISA Class a duty to disclose, truthfully, all the facts concerning the true cost of their prescription medications, the true amount of their copay, and any fees charged to Plaintiff Fellgren and the Non-ERISA Class.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 149 is required.

150. Defendants' misrepresentations were material to Plaintiff Fellgren and members of the Non-ERISA Class. Specifically, Defendants misrepresented to Plaintiff Fellgren and members of the Non-ERISA Class that they would pay the lesser of the price of a prescription drug, or the applicable copay when, in fact, they were, in many

cases, charged a copay that was greater than the full price of the price of drug as a result of a hidden Clawback fee.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 150 is required.

151. Defendants' unfair or deceptive acts or practices were likely to and did in fact deceive and reasonable consumers, including Plaintiff Fellgren and Non-ERISA Class Members, regarding the cost of Plaintiff Fellgren and Non-ERISA Class Members' prescription medications, fees charged to them as a component of their copayment or coinsurance obligation, and the true amount of a patient's copayment or coinsurance obligation with intent to mislead Plaintiff Fellgren and the Non-ERISA Class.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 151 is required.

152. In accordance with Minn. Stat. § 325D.45, Plaintiff seeks an order: (1) enjoining Defendants from continuing to conduct business through their fraudulent conduct; (2) requiring Defendants to conduct a corrective advertising campaign; and (3) awarding Plaintiff Fellgren and the Non-ERISA Class costs, including reasonable attorney's fees.

RESPONSE: The Court dismissed Count IV of the Complaint (Dkt. 68), and thus no response to Paragraph 152 is required.

COUNT V

Unjust Enrichment
by Plaintiff Fellgren on behalf of the Non-ERISA Class

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

RESPONSE: The Court dismissed Count V of the Complaint (Dkt. 68), and thus no response to Paragraph 153 is required.

154. To the detriment of Plaintiff Fellgren and the Non-ERISA Class Members, Defendants have been, and continue to be, unjustly enriched by requiring their insureds to

pay fees for prescription drugs in excess of the fees authorized in the policies, as alleged herein.

RESPONSE: The Court dismissed Count V of the Complaint (Dkt. 68), and thus no response to Paragraph 154 is required.

155. Defendants have unjustly benefited through the unlawful and/or wrongful collection of deductibles, copayments, and/or coinsurance payments that are based on fees that exceed the actual fees that Defendants or their agents paid to pharmacies for prescription drugs.

RESPONSE: The Court dismissed Count V of the Complaint (Dkt. 68), and thus no response to Paragraph 155 is required.

156. The amount of unjust enrichment is the difference between the fees paid for prescription drugs by the insured and fees actually paid by Defendants or their agents to the pharmacy for the prescription drugs.

RESPONSE: The Court dismissed Count V of the Complaint (Dkt. 68), and thus no response to Paragraph 156 is required.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, individually and on behalf of the Classes, pray for relief as follows as applicable for the particular claim:

A. Certifying this action as a class action and appointing Plaintiffs and the counsel listed below to represent the Classes;

B. Finding that Defendants violated the Plan terms;

C. Finding that Defendants withheld benefits from Plaintiffs and Class Members or violated Plaintiffs' and the Class Members' rights under the Plans;

D. Enjoining Defendants from further such violations;

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

F. Awarding Plaintiffs and the Classes damages, surcharge, and/or other monetary compensation as deemed appropriate by the Court;

G. Ordering Defendants to restore all losses to Plaintiff Sohmer and the ERISA Class and disgorge unjust profits and/or other assets of the ERISA Plans;

H. Awarding Plaintiffs and the Classes equitable relief to the extent permitted by the above claims;

I. Awarding Plaintiffs' 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;

J. Awarding Plaintiffs and the Classes their reasonable costs and expenses incurred in this action, including counsel fees and expert fees;

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

L. 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 Plaintiffs' Prayer for Relief.

JURY TRIAL DEMANDED

Defendants admit that Plaintiffs purport to seek a jury trial. Defendants deny that Plaintiffs are entitled to a jury trial on any or all of their claims.

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 as against Defendants.

3. Plaintiffs' 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.

4. Plaintiffs' claims are in the nature of benefit claims and the claims administrator's interpretation of the plan (and related, ancillary) documents was reasonable and correct.

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

6. Some or all of Plaintiffs' claims, and the claims of other purported class members, may be barred because Plaintiffs have failed to raise claims within the time period required by the applicable 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.

7. To the extent that Plaintiffs' claims, and the claims of other purported class members, raise issues related to plan language that does not accurately reflect the intent of plan sponsor, Defendants are entitled to reformation of such plan language to reflect that intent.

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

9. 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.

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

11. Plaintiffs' claims are barred because they lack constitutional standing to raise them, insofar as the Defendants do not have the ability to redress their injuries.

12. Plaintiffs cannot obtain an award of damages against the Defendants, but rather are limited to an order requiring Defendants to reprocess their claims, only to the extent that this is within the Defendants' power to offer this relief.

13. Plaintiffs have failed to join indispensable parties, including their benefit plans and the plan administrators for their individual plans.

14. The Defendants are not the proper defendants to these ERISA or state law claims.

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.

COUNTERCLAIM

To the extent necessary to preserve their defense that they are entitled to reformation of plan language to reflect the intent of plan sponsors, Counterclaim Plaintiffs United HealthCare Services, Inc. and United Healthcare Insurance Company

(collectively, "United" or "Counterclaim Plaintiffs"), by way of a counterclaim against Plaintiffs Sohmer and Fellgren, state and allege as follows:

1. Counterclaim Plaintiffs incorporate by reference their responses as stated in their Amended Answer above.

2. Because the counterclaim raised against Sohmer arises under federal law, this Court has jurisdiction under 28 U.S.C. § 1131 and 29 U.S.C. § 1132(e)(1). Further, because the counterclaim arises out of the same transactions or occurrences that are the subject matter of Plaintiffs' Complaint, this Court has jurisdiction over the claims set forth in the counterclaim pursuant to Fed. R. Civ. P. 13 and 28 U.S.C. § 1367.

3. Venue is appropriate in this Court.

COUNT I
(Reformation-Scrivener's Error/Mistake)

4. Counterclaim Plaintiffs reallege and reincorporate by reference their responses to Counterclaim Paragraphs 1-3 as if fully set forth herein.

5. Both Plaintiffs are or were participants in self-funded health benefit plans for which United served as the claims administrator pursuant to administrative services agreements. Specifically, United HealthCare Services, Inc. served as the claims administrator for the Huntington Learning Corporation Choice Plus Plan A group health plan (the "Huntington Plan") , while United HealthCare Insurance Company served as the claims administrator for the School District of Escambia County, Florida Choice HRA Base group health plan (the "Escambia Plan"). These United entities had the final

discretionary authority to resolve all claims for benefits presented under the terms of the respective Plans.

6. As a part of the administrative services United provides to its self-funded plan customers, United will offer customers the option of using its template Summary Plan Descriptions ("SPDs") to describe benefits available under the customer's plan. These customers have the opportunity to review, and potentially use, these SPDs. If a customer is interested in using a United template SPD, a United employee will create a draft template SPD. The template allows those drafting the SPD to include, delete, or modify certain terms, depending on the benefit selections made by plan sponsors. The plan sponsors are ultimately responsible for the content of the SPD and may make changes once the draft template SPD is provided to them.

7. For health benefit plans that include benefits for outpatient prescription drug benefits, the template SPD will include provisions relating to such benefits, including, where applicable, information regarding any deductible, copayment, or coinsurance that plan members must pay when filling prescriptions at retail network pharmacies.

8. Historically, the self-funded plans administered by United had different options available to the plan sponsor for calculating a covered member's out-of-pocket costs for prescription drugs. Under one method (known as the "lesser-of-two" logic) the plan provides that a member is responsible for paying the lower of (1) the "Usual and Customary Rate" charged by the pharmacy (defined as the usual fee that a pharmacy

charges individuals without reference to reimbursement to the pharmacy by third parties); or (2) the applicable copay or coinsurance (which is further defined in the SPD).

9. In another method (known as the "lesser-of-three" logic), a self-funded plan provides that the member pays the lower of (1) the Usual and Customary Rate; (2) the applicable copay or coinsurance; or (3) a negotiated rate.

10. The template SPD used by United during a portion of the class period should have presumptively included the following standard language:

> For Prescription Drugs at a retail Network Pharmacy, you are responsible for paying the lower of:
>
> - The applicable [copay and/or coinsurance]; or
> - The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.

11. The drafter of the SPD should have had the ability to modify this provision by selecting additional template language that could be added to the SPD. If selected, this template language would add a third bullet point if the plan sponsor had chosen a "lesser-of-three" plan logic.

12. The third bullet point discussed in Counterclaim Paragraph 11 above should have appeared in the SPD only if the drafter specifically elected to include it. Due to a coding error, (the "scrivener's error"), however, that third bullet point was automatically included in the template SPD used during portions of the class period—even if the plan sponsor did not intend for the SPD to include "lesser-of-three" logic and did not pay for such benefits.

13. The Plan sponsors for the Huntington Plan and the Escambia Plan both intended that their plans be set up as "lesser-of-two" plans, and both agreed to payment terms reflecting that intent. The error described above, however, resulted in certain template draft SPDs delivered to the sponsors for the Escambia Plan and the Huntington Plan erroneously stating:

> For Prescription Drugs at a retail Network Pharmacy, you are responsible for paying the lower of:
>
> - The applicable Copay; or
> - The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
> - The Prescription Drug Cost that UnitedHealthcare agreed to pay the Network Pharmacy.

United did not discover this error until recently. Upon information and belief, the Plan sponsors for the Huntington Plan and the Escambia Plans used the template draft SPDs with the above language as either the entire Plan document, or the portion of the Plan document that described the Plaintiffs' health benefits, including prescription drug benefits.

14. The scrivener's error was unintentional and did not reflect the intent of the plan sponsors or United.

15. Upon information and belief, neither Plaintiffs nor any other plan participant actually relied on the scrivener's error, nor was this language in any way inconsistent with any reasonable expectation that the Plaintiffs (or participants in the

Huntington or Escambia Plans) had regarding their benefits. To the contrary, upon information and belief, this mistake was mutual on the part of both parties.

16. The evidence of the scrivener's error is clear, precise, persuasive, and objective.

17. To preclude reformation here would produce a harsh and inequitable result and a windfall recovery for the alleged putative Class, their plans, and plan sponsors. Among other things, the fees that the Plan sponsors and participants in the Huntington and Escambia Plans paid for United's services were lower because the Plan sponsor had chosen the "lesser-of-two" logic. Allowing participants in the Huntington and Escambia Plans to pay those lower administrative costs while also obtaining the additional discounts reserved for "lesser-of-three" plans would result in a windfall for the members of the Huntington and Escambia Plans.

18. No sound reason, legal or equitable, prohibits reformation of the SPDs to correct the scrivener's error therein.

19. Accordingly, United is entitled to reformation under ERISA § 502(a)(3) and state law of Sohmer's and Fellgren's respective SPDs to state the following to reflect their intended terms:

> For Prescription Drugs at a retail Network Pharmacy, you are responsible for paying the lower of:
>
> - The applicable Copay; or
> - The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.

20. In the alternative, United is entitled to declaratory relief pursuant to ERISA 502(a)(3) and 28 U.S.C. § 2201, *et seq.*, declaring the portions of the SPDs upon which Plaintiffs rely to have been drafted in error and not to be the proper terms of the Plans.

21. In the event that the Court certifies the putative class described in the operative complaint in this matter or some revised class upon future motion by Plaintiffs (which Counterclaim Plaintiffs deny is appropriate for class certification), then Counterclaim Plaintiffs expect to amend this pleading to allege a counterclaim against the now-putative class members (or, if necessary, the participants in the Huntington Learning Corporation Choice Plus Plan A group health plan and the participants in the School District of Escambia County, Florida Choice HRA Base group health plan) whose SPDs are similarly subject to the scriveners' error described above.

WHEREFORE, Defendants and Counterclaim Plaintiffs pray for the following relief:

1. That the Court dismiss Plaintiffs' claims with prejudice.

2. That the Court enter judgment against Plaintiffs on the counterclaim and reform the Summary Plan Descriptions as requested.

3. That the Court award Defendants and Counterclaim Plaintiffs such further relief as the Court may deem just and equitable.

Dated: May 24, 2019

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