

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

SETH STERN, et al.

Plaintiffs,

v.

JPMORGAN CHASE & CO., et al.

Defendants.

Case No. 1:25-cv-02097

ORAL ARGUMENT REQUESTED

NOTICE OF MOTION FOR JUDGMENT ON THE PLEADINGS

PLEASE TAKE NOTICE that Defendants JPMorgan Chase & Co., JPMorgan Chase Bank N.A., JPMorgan Chase U.S. Benefits Executive, and JPMorgan Chase Compensation & Management Development Committee (“Defendants”), by their undersigned counsel, will move this Court, on a date and time to be determined by the Court, for an Order granting Defendants judgment on the pleadings pursuant to Fed. R. Civ. P. 12(c). In support of their Motion, Defendants rely on the accompanying Memorandum in Support of Defendants’ Motion for Judgment on the Pleadings and the concurrently filed Declaration of Jaime A. Santos in Support of Defendants’ Motion for Judgment on the Pleadings, and the exhibits attached thereto, as well as the previously filed Declaration of Dave Rosenberg in Support of Defendants’ Motion to Dismiss the Class Action Complaint, and the exhibits attached thereto (ECF No. 31).

Dated: June 3, 2026

Respectfully submitted,

/s/ James O. Fleckner

James O. Fleckner, *admitted pro hac vice*

Dave Rosenberg, *admitted pro hac vice*

GOODWIN PROCTER LLP

100 Northern Avenue

Boston, MA 02210

Tel.: (617) 570-1000

jfleckner@goodwinlaw.com
drosenberg@goodwinlaw.com

Gabrielle L. Gould
GOODWIN PROCTER LLP
The New York Times Building
620 Eighth Avenue
New York, New York 10018
Tel.: (212) 813-8800
ggould@goodwinlaw.com

Jaime A. Santos, *admitted pro hac vice*
GOODWIN PROCTER LLP
1900 N Street, N.W.
Washington, DC 20036
Tel: (202) 346-4000
jsantos@goodwinlaw.com

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

SETH STERN, et al.

Plaintiffs,

v.

JPMORGAN CHASE & CO., et al.

Defendants.

Case No. 1:25-cv-02097

**MEMORANDUM OF LAW IN SUPPORT OF DEFENDANTS’
MOTION FOR JUDGMENT ON THE PLEADINGS**

TABLE OF CONTENTS

	Page
INTRODUCTION	1
BACKGROUND	4
I. The Plan.....	4
II. Plaintiffs’ Complaint	5
III. The Court’s motion-to-dismiss order	7
IV. Plaintiffs’ Reply to Defendants’ Answer	9
LEGAL STANDARD.....	11
ARGUMENT	12
I. Plaintiffs fail to allege a plausible prohibited-transaction claim.	12
A. Plaintiffs misstate the “necessary services” prong and plead no facts overcoming that the services here are “necessary” for the operation of a health plan.	13
B. Plaintiffs have not pleaded specific facts that Defendants paid more than reasonable compensation for benefits-administration services.	15
II. Plaintiffs’ prohibited-transaction claims are barred by ERISA’s statute of repose.....	17
III. Plaintiffs lack standing to bring their prohibited-transaction claims.....	20
A. Plaintiffs’ alleged injury of excessive out-of-pocket costs is not fairly traceable to the purported prohibited transactions.	21
B. Plaintiffs do not plausibly allege injury-in-fact.....	25
CONCLUSION.....	28

TABLE OF AUTHORITIES

	Page(s)
Cases:	
<i>I-800 Contacts, Inc. v. JAND, Inc.</i> , 119 F.4th 234 (2d Cir. 2024)	11
<i>Acosta v. Chimes D.C., Inc.</i> , 2019 WL 931710 (D. Md. Feb. 26, 2019)	15
<i>Altman v. Bedford Cent. Sch. Dist.</i> , 245 F.3d 49 (2d Cir. 2001).....	24, 25
<i>Browe v. CTC Corp.</i> , 15 F.4th 175 (2d Cir. 2021)	17
<i>Bugielski v. AT&T Servs., Inc.</i> , 76 F.4th 894 (9th Cir. 2023)	14
<i>Cal. Pub. Emps.’ Ret. Sys. v. ANZ Sec., Inc.</i> , 582 U.S. 497 (2017).....	17
<i>Cassell v. Vanderbilt Univ.</i> , 285 F. Supp. 3d 1056 (M.D. Tenn. 2018).....	18
<i>Chao v. Graf</i> , 2002 WL 1611122 (D. Nev. Feb. 1, 2002).....	14
<i>Cunningham v. Cornell Univ.</i> , 604 U.S. 693 (2025).....	2, 8, 9, 10, 11, 12, 15, 16
<i>D.L. Markham DDS, MSD, Inc. 401(K) Plan v. Variable Annuity Life Ins. Co.</i> , 88 F.4th 602 (5th Cir. 2023)	18
<i>David v. Alphin</i> , 704 F.3d 327 (4th Cir. 2013)	18
<i>Davis v. FEC</i> , 554 U.S. 724 (2008).....	3, 20
<i>Doe I v. Express Scripts, Inc.</i> , 837 F. App’x 44 (2d Cir. 2020)	19
<i>In re Express Scripts/Anthem ERISA Litig.</i> , 285 F. Supp. 3d 655 (S.D.N.Y. 2018).....	19

Fisher v. Dallas Cnty.,
299 F.R.D. 527 (N.D. Tex. 2014)12, 15

Heidel v. Governor of New York State,
2023 WL 1115926 (2d Cir. Jan. 31, 2023)21

Johnson v. U.S. Off. of Pers. Mgmt.,
783 F.3d 655 (7th Cir. 2015)22

*Knight First Amend. Inst. at Columbia Univ. v. United States Citizenship &
Immigr. Servs.*,
30 F.4th 318 (2d Cir. 2022)14

Kraus v. Snow Teeth Whitening LLC,
2022 WL 4642170 (E.D.N.Y. Sept. 15, 2022)27

Loper Bright Enters. v. Raimondo,
603 U.S. 369 (2024).....14

Lugo v. City of Troy, New York,
114 F.4th 80 (2d Cir. 2024)25

Lujan v. Defs. of Wildlife,
504 U.S. 555 (1992).....20

Mahon v. Ticor Title Ins. Co.,
683 F.3d 59 (2d Cir. 2012).....21

N. Cypress Med. Ctr. Operating Co. v. Aetna Life Ins. Co.,
898 F.3d 461 (5th Cir. 2018)4

Navarro v. Wells Fargo & Co.,
2025 WL 897717 (D. Minn. Mar. 24, 2025)23, 24

Navarro v. Wells Fargo & Co.,
2026 WL 591454 (D. Minn. Mar. 3, 2026)23, 25

Ortiz v. Consol. Edison Co. of New York, Inc.,
801 F. Supp. 3d 260 (S.D.N.Y. 2025).....3, 20

P. Stolz Fam. P’ship L.P. v. Daum,
355 F.3d 92 (2d Cir. 2004).....20

Plutzer on behalf of Tharanco Grp., Inc. v. Bankers Tr. Co. of S. Dakota,
2022 WL 17086483 (2d Cir. Nov. 21, 2022).....26

Police & Fire Ret. Sys. of City of Detroit v. IndyMac MBS, Inc.,
721 F.3d 95 (2d Cir. 2013).....17

Shaulis v. Nordstrom, Inc.,
865 F.3d 1 (1st Cir. 2017).....27

Singh v. Deloitte LLP,
123 F.4th 88 (2d Cir. 2013)15, 16

Singh v. Deloitte LLP,
650 F. Supp. 3d 259 (S.D.N.Y. 2023).....26

SoundExchange, Inc. v. Sirius XM Radio Inc.,
796 F. Supp. 3d 1 (S.D.N.Y. 2025).....11

Taylor v. BDO USA, P.C.,
2025 WL 2420941 (D. Mass. Aug. 21, 2025)27

Thole v. U.S. Bank N.A.,
590 U.S. 538 (2020).....20, 22, 26

TransUnion LLC v. Ramirez,
594 U.S. 413 (2021).....21

United States v. Taylor,
596 U.S. 845 (2022).....14

White v. Chevron Corp.,
2017 WL 2352137 (N.D. Cal. May 31, 2017).....19

White v. Chevron Corp.,
752 F. App’x 453 (9th Cir. 2018).....18

Statutes:

29 U.S.C. §1002(14)13

29 U.S.C. §1106(a)12

29 U.S.C. §1106(a)(1)(A).....7

29 U.S.C. §1106(a)(1)(B)7

29 U.S.C. §1106(a)(1)(D).....7

29 U.S.C. §1108(b)(2)2, 9, 10, 12, 13, 15, 16

29 U.S.C. §1113(1).....2, 17, 18

Other Authorities:

29 C.F.R. §2550.408b-2(b).....14

42 Fed. Reg. 32389 (June 24, 1977)14

91 Fed. Reg. 4348 (Jan. 30, 2026)17

Axis Advisors, *Unravelling the Drug Pricing Blame Game* (Sept. 19, 2023),
<https://www.3axisadvisors.com/projects/2023/9/19/unravelling-the-drug-pricing-blame-game>24

PBGH, *Purchasing Standards for Plan Sponsors* (June 2023),
<https://www.pbgh.org/wp-content/uploads/2023/10/PBGH-PBM-Common-Purchasing-Standards.pdf>6

Neil Weinberg & Robert Langreth, *Drug Costs Too High? Fire the Middleman*,
Bloomberg (Mar. 3, 2017), <https://www.bloomberg.com/news/articles/2017-03-03/drug-costs-too-high-fire-the-middleman>5

INTRODUCTION

Following the Court’s dismissal of the core of Plaintiffs’ ERISA lawsuit, Plaintiffs are left with “prohibited transaction” claims that were an afterthought in their Complaint. Now that both parties have, as the Court directed, submitted additional pleadings, those prohibited-transaction claims fail as a matter of law. Plaintiffs have done no meaningful work to show how these prohibited-transaction claims fall outside ERISA’s statutory safe harbor for necessary services procured for reasonable compensation or are timely under the statute of repose. Further, with the focus now squarely on Plaintiffs’ prohibited-transaction claims, they have not articulated how their alleged Article III injury relates to those specific claims—if they suffered injury at all.

The prohibited-transaction claims that survived Defendants’ motion to dismiss were not Plaintiffs’ Plan A for this litigation. “The gravamen of Plaintiffs’ Complaint,” the Court held, challenged non-fiduciary conduct by focusing on the design and structure of JPMorgan Chase & Co.’s (“JPMC”) prescription-drug plan (the “Plan”). MTD Order 26. That non-fiduciary conduct included Defendants’ establishment of the Plan’s formulary, the cost-sharing terms, the selection of pricing models for prescription drugs, and the decision to allegedly use a “traditional” pharmacy-benefit manager (“PBM”) model, rather than a “pass-through” model. Though overseeing a PBM’s (Caremark) services in “resolving prescription-drug claims” and “processing prior authorizations” was fiduciary conduct, the non-fiduciary conduct was settlor in nature and thus could not be the basis of fiduciary claims under ERISA. *Id.* at 24 (brackets omitted). Accordingly, the Court dismissed the fiduciary claims challenging the settlor conduct that was the gravamen of the Complaint.

Plaintiffs’ threadbare prohibited-transaction claims, however, survived. As the Court correctly acknowledged, MTD Order 32-33, the Supreme Court recently held that the normal *Twombly/Iqbal* pleading standard governs prohibited-transaction claims, even when a statutory

exemption to a prohibited transaction might apply. But the Supreme Court also directed district courts to use “existing tools” to screen out prohibited-transaction claims “before discovery” where the challenged transaction is covered by a statutory exemption. *Cunningham v. Cornell Univ.*, 604 U.S. 693, 708 (2025). The Court followed that procedure here, requiring Plaintiffs to file a Reply to Defendants’ Answer “putting forward specific, nonconclusory factual allegations showing” that any prohibited-transaction exemption invoked by Defendants “does not apply” to the fiduciary transactions. *Id.* (brackets and quotation marks omitted); MTD Order 33 n.11. Plaintiffs have filed that Reply, but have not identified any “specific, non-conclusory factual allegations” saving their prohibited-transaction claims. Those claims are now subject to dismissal, for three reasons.

First, Plaintiffs’ prohibited-transaction claims fail on the merits. Defendants’ Answer invoked the prohibited-transaction exemption of 29 U.S.C. §1108(b)(2), which exempts from ERISA’s prohibited-transaction provisions contracting with a service provider for “services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.” Plaintiffs’ pleadings are devoid of any factual allegations plausibly suggesting that Caremark’s benefits-administration services are unnecessary, or that the Plan paid more than reasonable compensation for those services. Indeed, even as to Plaintiffs’ original, broader challenge to the prescription-drug structure and pricing, this Court already held that Plaintiffs failed to plausibly allege overpayments by the Plan. Plaintiffs offer even less to plausibly show that the Plan overpaid Caremark for benefits-administration services.

Second, Plaintiffs’ prohibited-transaction claims are time-barred by ERISA’s six-year statute of repose. 29 U.S.C. §1113(1). Plaintiffs’ claims challenge the retention of Caremark, which occurred more than six years before Plaintiffs filed their Complaint on March 13, 2025, and

courts have rejected continuing-violation theories of prohibited transactions that would circumvent ERISA's statute of repose.

Finally, Plaintiffs lack Article III standing to press the prohibited-transaction claims that remain in this case. Standing is not dispensed in gross but must instead be established "for each claim [a plaintiff] claims to press." *Davis v. FEC*, 554 U.S. 724, 734 (2008) (citation omitted). But Plaintiffs' alleged injury and Plaintiffs' prohibited-transaction claims are unrelated to each other. Plaintiffs' only theory of Article III injury that this Court previously considered viable was an "out-of-pocket" costs theory that Plaintiffs were overcharged for prescription drugs by pharmacies. MTD Order 15-19. Even if that alleged injury were sufficiently traceable to Plaintiffs' challenge to the Plan's structure and prescription-drug pricing to permit jurisdiction over those claims, Plaintiff's only claim left to press is that the fiduciaries' retention of Caremark for benefits-administration services was a prohibited transaction. Plaintiffs do not offer any facts plausibly suggesting that the out-of-pocket costs they paid *pharmacies* for four prescription drugs are fairly traceable to the Plan's fiduciary retention of *Caremark* for benefits-administration services. Nor, under Second Circuit precedent, do they plausibly allege that those costs constitute *overcharges* in the first place as required by Second Circuit precedent. Accordingly, the Court also can and should reconsider its earlier conclusion regarding Article III's injury-in-fact prong. *See Ortiz v. Consol. Edison Co. of New York, Inc.*, 801 F. Supp. 3d 260, 325 (S.D.N.Y. 2025) (Rochon, J.) (exercising discretion under "law of the case doctrine" to reconsider prior conclusion).

In all events, this Court should grant judgment on the pleadings and dismiss the remainder of Plaintiffs' Complaint.

BACKGROUND¹

I. The Plan

JPMC voluntarily makes available medical benefits, including prescription-drug coverage, to eligible JPMC employees, their spouses, and their dependents through the Plan. Compl. ¶17. Historically, benefits have been funded primarily by JPMC. Compl. ¶229. In total, JPMC contributed more than \$7 billion from 2019-2023—\$1.7 billion in 2023 alone—to fund these healthcare benefits.

The Plan’s medical component in which Plaintiffs participate is “self-funded,” meaning that JPMC bears direct financial responsibility for Plan benefits that are not paid by participants, including prescription-drug benefits and all costs paid to any of the Plan’s service providers. Compl. ¶224. In self-funded plans the “employer is responsible for paying claims and bearing the financial risk” of doing so. *N. Cypress Med. Ctr. Operating Co. v. Aetna Life Ins. Co.*, 898 F.3d 461, 468 (5th Cir. 2018). Accordingly, if claims, healthcare costs, or any other Plan expenses are higher than expected, JPMC is responsible for paying the difference.

The costs participants pay toward their healthcare varies based on a wide variety of factors specified in the Plan document.² Currently, preventive drugs are provided at no out-of-pocket expense to Plan participants, no deductible applies to prescription-drug benefits, and once Plan participants reach an annual out-of-pocket maximum the Plan pays 100% of the cost of covered

¹ Because this Court is already familiar with the factual background, *see* MTD Order 2-7, for the sake of brevity Defendants have avoided an extended discussion of the details of the Plan. A lengthy description was included at pages 3-7 of Defendants’ motion to dismiss (ECF No. 30). Unless otherwise noted, any exhibits referenced herein refer to the exhibits attached to the Rosenberg Declaration, which was filed contemporaneously with Defendants’ motion to dismiss. ECF No. 31. They are properly before this Court for the reasons explained in the Court’s opinion. MTD Order 9-10.

² Ex. B, SPD, at MTD-051-057, MTD-073.

prescription drugs.³ Plaintiffs do not allege that they personally paid expenses directly to Plan service providers, including Caremark, and the Plan itself expressly provides that administrative expenses are paid out of the Plan's Trust.⁴

Caremark has served as the Plan's PBM during the entirety of the Putative Class Period. Compl. ¶17. Caremark is widely used in the health-plan marketplace—it is one of three PBMs used by the vast majority of U.S. health plans. Compl. ¶¶90, 207. According to a source cited in the Complaint (¶208), the Big 3 PBMs “process about 70% of the nation's prescriptions.”⁵ As this Court has previously explained, PBMs can provide a variety of offerings to health plans and the employers that sponsor them. Those offerings include assistance with the design of the Plan's prescription-drug-benefit program (*e.g.*, determining the formulary, setting pricing benchmarks, deciding on the plan structure), as well as assistance administering the program as designed (*e.g.*, resolving prescription-drug claims, processing prior authorizations, and the like). MTD Order 23-24.

II. Plaintiffs' Complaint

The “gravamen of Plaintiffs' Complaint” was rooted in “Defendants' alleged failure to consider or implement alternative pricing structures for the Plan's prescription-drug component.” MTD Order 26. Put differently, Plaintiffs were “collectively focus[ed] less on [Plan] administration and more on Defendants' decisions regarding the design and structure of the Plan's pharmacy benefit arrangements.” *Id.* at 23.

³ *Id.* at MTD-043, MTD-073, MTD-111.

⁴ Ex. A, Plan Document, MTD-004

⁵ Neil Weinberg & Robert Langreth, *Drug Costs Too High? Fire the Middleman*, Bloomberg (Mar. 3, 2017), <https://www.bloomberg.com/news/articles/2017-03-03/drug-costs-too-high-fire-the-middleman>.

For example, Plaintiffs initially alleged that Defendants mismanaged the Plan’s prescription-drug program by failing to negotiate sufficiently favorable terms for the Plan’s formulary—the list of prescription drugs covered under the Plan—resulting in excessively priced prescription drugs. *See* MTD Order 26. In general, Plaintiffs complained that “pass-through” PBM arrangements are more favorable to plans and participants than “traditional” arrangements that use “spread” pricing and permit the PBM to retain prescription-drug rebates. Compl. ¶¶8, 53-74. And Plaintiffs assumed that because the Plan uses Caremark, a “traditional PBM,” it pays for services through “spread” compensation instead of a “pass-through” model, resulting in excessive prescription-drug costs (*e.g.*, Compl. ¶¶8, 53, 104, 174).

Plaintiffs also contended that the “specialty” drugs on the Plan’s formulary were, on average, several times higher than average pharmacy “acquisition” costs reported in the “NADAC” database. Compl. ¶¶109, 112-126; MTD Order 23. As Plaintiffs’ cited source explains, NADAC is a measure of some pharmacies’ average costs to *acquire* drugs, not the prices they *charge customers* for those drugs (prices that includes fees, as well as the pharmacies’ own profits). MTD Order 19-20 n.5.⁶ Plaintiffs also alleged that Defendants allowed Caremark to steer participants toward high-priced biosimilar drugs developed by a Caremark-affiliated company. Compl. ¶¶129-135; MTD Order 5.

Plaintiffs never alleged *they* were ever prescribed these specialty drugs or biosimilars. Instead, they alleged they collectively purchased 11 common generic drugs that they contend cost the Plan more than the pharmacy acquisition cost reported in NADAC. Compl. ¶127. For example, Plaintiffs pointed to one drug that was priced at \$4.73, but had a NADAC-reported

⁶ PBGH, *Purchasing Standards for Plan Sponsors* 11 (June 2023), <https://www.pbgh.org/wp-content/uploads/2023/10/PBGH-PBM-Common-Purchasing-Standards.pdf> (quoted in ¶¶138-141).

average acquisition cost of \$2.74. *Id.* Plaintiffs pointed to only four drugs on this list for which they paid out-of-pocket costs, the most expensive of which was \$30. Compl. ¶¶247-249.

Based on these allegations, Plaintiffs originally brought four claims under ERISA. Counts I and II alleged that Defendants breached their fiduciary duties of prudence and loyalty under 29 U.S.C. §1104(a)(1)(A)-(B). Compl. ¶¶264-267. Counts IV and V alleged that Defendants' dealings with Caremark constituted prohibited transactions under 29 U.S.C. §1106(a)(1)(A)-(B), (D). Compl. ¶¶278-293.⁷

III. The Court's motion-to-dismiss order

On March 9, 2026, the Court granted in part and denied in part Defendants' motion to dismiss. The Court first rejected that Plaintiffs had adequately pleaded their "higher premiums" theory of standing, but concluded that they had sufficiently alleged standing based on an "out-of-pocket overpayments" theory. MTD Order 11, 13-19. Under that latter theory, Plaintiffs asserted that "Defendants' alleged mismanagement" caused them to incur "higher out-of-pocket costs" for certain prescription drugs. *Id.* at 6.

After concluding that Plaintiffs had plausibly alleged their out-of-pocket costs theory, the Court dismissed Counts I and II, which alleged breaches of ERISA's fiduciary duties of prudence and loyalty. MTD Order 23-29. The Court reasoned that Defendants were not acting as fiduciaries when making decisions regarding "the design and structure of the Plan's pharmacy benefit arrangements" including "how the PBM was compensated, how drugs were categorized, what pricing benchmarks were used, and which alternatives were not adopted." *Id.* at 23-29. The Court also determined that, "even if the Complaint concerned fiduciary conduct," "Plaintiffs d[id] not

⁷ The Complaint contained no Count III.

plead actual overpayment” by the Plan for prescription drugs sufficient to plausibly support “an inference of breach.” *Id.* at 19-20 n.5.

The Court denied Defendants’ motion to dismiss only as to Counts IV and V, alleging prohibited transactions. MTD Order 29-34. As to those claims, the Court recognized that a viable prohibited-transaction claim would have to challenge *fiduciary*, not *settlor*, conduct. *Id.* at 30. The Court determined that Plaintiffs had adequately pleaded that Defendants acted as fiduciaries when “entering into and/or renewing a contract” with Caremark and when making “payments to Caremark thereunder.” *Id.* at 30 (quotation marks and brackets omitted). But, as limited by the Court’s ruling on Plaintiffs’ fiduciary-breach claims, this aspect of the Court’s order is necessarily limited to the only aspect of Defendants’ conduct that was fiduciary in nature: the retention of Caremark to assist in *administering* prescription-drug benefits by, for example, “resolving prescription-drug claims” and “processing prior authorizations.” *Id.* at 24 (quoting ECF No. 38, at 6). It does not encompass actions Defendants took as to Caremark’s role in helping JPMC set Plan benefits by establishing the formulary, determining the method of PBM compensation, deciding pricing benchmarks, and selecting a structure (pass-through or otherwise) for prescription-drug benefits. *Id.* at 23-24, 30. Those functions still do not concern fiduciary conduct, and thus are not the proper subject of a prohibited-transaction claim. *See id.* at 30.

Although the Court allowed the service-provider aspects of Plaintiffs’ prohibited-transaction claims to proceed, it ordered Plaintiffs to “file [a] reply pursuant to Federal Rule of Civil Procedure 7(a)(7) to address” any exemptions Defendants “invoked” in their Answer. MTD Order 34. The Court recognized that, as explained in *Cunningham*, “ERISA plaintiffs need only plausibly allege the elements of a prohibited-transaction claim,” and need not affirmatively plead around prohibited-transaction exemptions in the first instance. *Id.* at 32-33. Yet it also

acknowledged that “this ‘barebones’ pleading standard could result in claims ‘too easily get[ting] past the motion-to-dismiss stage.’” *Id.* at 33 (quoting *Cunningham*, 604 U.S. at 708). One way the Supreme Court suggested that district courts could thereafter “screen out [such] meritless claims” is to “insist that a plaintiff file a reply to an answer that raises one of the §1108 exemptions as an affirmative defense.” *Id.* at 33-34 & n.11. If the plaintiffs’ reply fails to allege “specific, nonconclusory factual allegations showing the exemption does not apply,” the Supreme Court explained, district courts “may then dismiss th[ose] suits” at the close of the pleadings. *Cunningham*, 604 U.S. at 708. This Court decided to make use of that mechanism here. MTD Order 33-34 & n.11.

IV. Plaintiffs’ Reply to Defendants’ Answer

Defendants’ Answer invokes as an affirmative defense 29 U.S.C. §1108(b)(2), which exempts from ERISA’s prohibited-transaction provisions contracting with a service provider for “services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefore.” *See* Answer p. 61 (Third Defense). Defendants’ Answer also alleged that processing claims and providing prior authorizations, among other things, are necessary services for the operation of a health plan, and that when the Plan conducted a request for proposal for PBM services, Caremark “was both the cheapest of all of the bidders on a total cost basis, including claims administration services and processing, and was graded by the benefits consulting firm retained by Defendants to be the most advantageous for the Plan qualitatively.” Answer ¶13. Defendants also specifically alleged that, under its contract with Caremark, “the amount Caremark has charged the Plan for prescription drugs has been the same as what Caremark reimbursed network pharmacies for retail, mail, and specialty drugs” and that “Caremark has not received spread-based compensation in connection with the Plan.” Answer ¶18.

Under this Court’s order, Defendants’ invocation of the §1108(b)(2) exemption triggered Plaintiffs’ obligation to file a Reply setting forth specific, nonconclusory factual allegations plausibly establishing that the exemption is not satisfied. *See* MTD Order 34; *Cunningham*, 604 U.S. at 708.

In their Reply, Plaintiffs first contest that the exemption’s necessary-services component is satisfied here. Reply ¶¶5-10. They do not claim that the types of benefits-administration services that Caremark provides to the Plan—*e.g.*, resolving prescription-drug claims and processing prior authorizations—are not “necessary for the establishment or operation of the plan,” as §1108(b)(2) provides. Rather, they contend that it was not necessary for JPMC to *outsource* those functions to “any third-party PBM,” or to Caremark in particular. Reply ¶¶6-10 (claiming that JPMC could have “administer[ed] its own prescription drug program,” “provid[ed] pharmacy benefits directly,” or retained a different PBM (such as a pass-through PBM), rather than Caremark).

Plaintiffs also contest that the compensation paid to Caremark was reasonable. Reply ¶¶11-38. They “deny that the terms of the Caremark Agreement are financially competitive,” but largely do not plead facts supporting that denial. Reply. ¶13. Rather, they dispute that Defendants’ robust processes for monitoring Caremark, including by performing market checks, requests for proposals, and considering alternative providers, support that Caremark’s compensation was reasonable (Reply ¶¶14-26), and they refer back to allegations in their Complaint regarding the structure and design of the Plan’s prescription-drug benefits, including:

- the alleged lack of carve-outs for specialty drugs (Reply ¶20);
- the alleged failure to contract with a PBM offering pass-through pricing (Reply ¶25);
- Defendants’ alleged adoption of a “spread pricing” model (Reply ¶29);

- alleged “pricing discrepancies” between the alleged prices that the Plan paid for prescription drugs and alleged pharmacy-acquisition costs or prices allegedly paid by other plans (Reply ¶32); and
- the alleged pricing benchmarks Defendants allegedly chose to use (*i.e.*, the alleged failure to use NADAC as the pricing benchmark) (Reply ¶34).

Plaintiffs also allege decreases in prices for 352 of the drugs covered by the Plan since they filed this lawsuit, which they claim “demonstrates that the prices charged beforehand was unreasonable” and “undercuts” the notion that Caremark was paid reasonable compensation. Reply ¶36.

LEGAL STANDARD

In deciding motions for judgment on the pleadings under Rule 12(c), this Court “applies the same standard it would on a motion to dismiss under Rule 12(b)(6).” *SoundExchange, Inc. v. Sirius XM Radio Inc.*, 796 F. Supp. 3d 1, 7 (S.D.N.Y. 2025). Thus, a Rule 12(c) motion should be granted unless the plaintiffs’ pleadings “contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face.” *Id.* (citation omitted). In deciding such motions, the Court may properly consider “(1) the non-movant’s pleadings; (2) the documents that are attached to, integral to, or incorporated by the pleadings; and (3) judicially noticeable extrinsic evidence.” *1-800 Contacts, Inc. v. JAND, Inc.*, 119 F.4th 234, 246 (2d Cir. 2024).

This same standard applies to that aspect of Defendants’ motion challenging Plaintiffs’ failure to plausibly allege that Defendants engaged in any nonexempt prohibited transactions. As explained in *Cunningham*, when a court orders ERISA plaintiffs to file a Rule 7(a)(7) reply addressing any prohibited-transaction exemption invoked by a defendant’s answer, the plaintiffs must put “forward specific, nonconclusory factual allegations showing the exemption does not

apply.” 604 U.S. at 708 (quoting *Crawford-El v. Britton*, 523 U.S. 574, 598, (1998)). If they cannot “plausibly” allege such “specific, nonconclusory factual allegations,” their prohibited-transaction claims are subject to dismissal. *Id.* As other courts have put it in other contexts in which Rule 7(a)(7) is employed, “[t]he case should not be allowed to proceed unless plaintiffs can assert specific facts that, if true, would overcome the defense.” *Fisher v. Dallas Cnty.*, 299 F.R.D. 527, 532 (N.D. Tex. 2014).

ARGUMENT

I. Plaintiffs fail to allege a plausible prohibited-transaction claim.

Plaintiffs’ prohibited-transaction claims, both brought under §1106(a), should be dismissed because the allegations in Plaintiffs’ Complaint and Reply do not plausibly demonstrate that the retention of Caremark to provide benefits-administration services falls outside of a statutory exemption.

Notwithstanding the general bar on prohibited transactions in §1106(a), §1108(b)(2) exempts “making reasonable arrangements with a party in interest for ... services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.” *Cunningham*, 604 U.S. at 695. As noted, in response to this exemption that was “invoked” by Defendants’ Answer, MTD Order 34, Plaintiffs were required to “put[] forward specific, nonconclusory factual allegations showing the exemption does not apply,” *Cunningham*, 604 U.S. at 708 (quotation marks omitted). In other words: to “assert specific facts that, if true, would overcome the defense.” *Fisher*, 299 F.R.D. at 532. Plaintiffs have failed to do so as to both the necessary-services and reasonable-compensation prongs of the §1108(b)(2) exemption. They instead distort what it means for services to be “necessary.” And they allege nothing about the quality or costs of the benefits-administration services that Caremark provides to the Plan as

compared to what other PBMs offer or that similar health plans receive for those services—allegations that are necessary in this context.

A. Plaintiffs misstate the “necessary services” prong and plead no facts overcoming that the services here are “necessary” for the operation of a health plan.

Plaintiffs suggest in their Reply that Defendants cannot rely on the §1108(b)(2) exemption because it was not “necessary” for Defendants to outsource prescription-drug-plan administrative services at all, or to Caremark in particular. Reply ¶¶5-10. But that is not how the exemption works. The exemption turns on whether *the services fiduciaries procured* were necessary to the operation of a plan (here, a health plan), not whether a plan’s fiduciaries had no option but to retain the *specific service provider* they ultimately selected. The latter interpretation of §1108(b)(2) could never be satisfied given the wide variety of service-provider options available in the market and the theoretically ever-present option of simply providing plan-administration services in-house. And Defendants are unaware of any case, regulation, or other authority that adopts Plaintiffs’ view, which is contrary to the statutory text, regulatory guidance, caselaw, and common sense.

On the text, the plain language of the statute asks whether the types of “services” outsourced are “necessary”—not, as Plaintiffs would have it, whether it was “necessary” to outsource performance of those services to a service provider. It provides an exemption for:

Contracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.

29 U.S.C. §1108(b)(2). While “party in interest” is defined to include “a person providing services to [a] plan,” 29 U.S.C. §1002(14), “necessary” modifies the word “services,” not the term “party in interest.” Thus, Plaintiffs’ interpretation would require the impermissible addition of an extra

“necessary” before the term “party in interest.” *Knight First Amend. Inst. at Columbia Univ. v. United States Citizenship & Immigr. Servs.*, 30 F.4th 318, 331 (2d Cir. 2022) (“It is not the province of the courts to add words to statutes that Congress has enacted.”). That “other services” follows particular types of services (“legal” and “accounting”), rather than particular types of service providers (“accountants” or “lawyers”) further underscores that “services necessary” does not mean “service providers necessary.” *United States v. Taylor*, 596 U.S. 845, 856 (2022) (“a law’s terms are best understood by ‘the company [they] kee[p]’”). By its plain terms, then, the statute provides that plans may contract with service providers so long as the types of “services” contracted for are “necessary”—even if plan sponsors could theoretically provide those services in-house, and even if providers other than the one selected are available.

Longstanding Department of Labor guidance points the same way. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 386 (2024) (noting “longstanding practice of the government ... can inform [a court’s] determination of what the law is”) (quotation marks omitted). Since 1977, a DOL regulation has spoken in terms of “necessary services”—not “necessary service providers.” 42 Fed. Reg. 32389, 32390 (June 24, 1977) (codified at 29 C.F.R. §2550.408b-2(b)). According to that regulation, a “*service* is necessary for the establishment or operation of a plan ... if the *service* is appropriate and helpful to the plan obtaining the *service* in carrying out the purposes for which the plan is established or maintained.” 29 C.F.R. §2550.408b-2(b) (emphases added).

Given the clear text and longstanding administrative interpretation of the provision, courts addressing the question also have spoken universally in terms of “necessary services” rather than “necessary service providers.” *See, e.g., Bugielski v. AT&T Servs., Inc.*, 76 F.4th 894, 901 (9th Cir. 2023) (noting the exemption covers “‘service transactions’ that keep plans running

smoothly”); *Acosta v. Chimes D.C., Inc.*, 2019 WL 931710, at *15 (D. Md. Feb. 26, 2019) (finding “services were necessary for the operation of the [p]lan”); *Chao v. Graf*, 2002 WL 1611122, at *13 (D. Nev. Feb. 1, 2002) (deeming marketing “services” necessary). Plaintiffs simply have no support for the notion that the exemption applies only if JPMC were unable to perform the outsourced services in-house, or only if the service provider selected was the only entity capable of providing those services.

Properly understood as focused on the necessity of the services themselves, Plaintiffs have failed to “assert specific facts that, if true, would overcome the defense.” *Fisher*, 299 F.R.D. at 532. Plaintiffs nowhere allege that a health plan does not need claims-administration or prior-authorization services—because such an assertion would be patently implausible on its face given the obvious necessity of benefits-administration services in a medical-benefit plan. Instead, their allegations rise and fall on their inaccurate interpretation of ERISA—they allege, for example, that Caremark’s services were not truly “necessary” for this Plan because JPMC considered managing pharmacy benefits in-house and because other PBMs were available. Reply ¶¶5-9. But as noted, those allegations speak to the wrong question and, accordingly, do not “overcome the defense” that Defendants’ Answer properly invoked. *Fisher*, 299 F.R.D. at 532.

B. Plaintiffs have not pleaded specific facts that Defendants paid more than reasonable compensation for benefits-administration services.

Plaintiffs also have not articulated “specific, nonconclusory factual allegations” demonstrating that Caremark received “more than reasonable” compensation for the benefits-administration services it provided. 29 U.S.C. §1108(b)(2); *Cunningham*, 604 U.S. at 708. The Second Circuit has squarely held that whether a service provider’s compensation is “excessive” must be viewed “relative ‘to the services rendered.’” *Singh v. Deloitte LLP*, 123 F.4th 88, 93 (2d Cir. 2013). Accordingly, what is necessary are facts regarding the compensation paid, and “the

nature and quality of the services provided.” *Id.* at 94. And where a plaintiff is attempting to plead excessive compensation by means of comparison, they “must state facts to show the funds or services being compared are, indeed, comparable.” *Id.* (citation omitted); *accord id.* (“[T]he way to plausibly plead a claim of this type is to identify similar plans [being provided] the same services for less.” (brackets in original) (quoting *Matousek v. MidAmerican Energy Co.*, 51 F.4th 274, 279 (8th Cir. 2022))).

Plaintiffs have failed to do so here. To begin, even if the services at issue were the plan-design services in setting drug pricing terms that this Court held do not implicate ERISA’s fiduciary obligations, this Court has already held—correctly—that Plaintiffs’ Complaint did not plausibly allege that *the Plan* paid excessive costs, because Plaintiffs’ comparators are not apples-to-apples. MTD Order 19-20 n.5. And Plaintiffs’ Reply added virtually nothing. Instead, Plaintiffs simply denied Defendants’ invocation of the §1108(b)(2) defense, denied that the robust processes described in Defendants’ Answer plausibly support that Caremark was paid reasonable compensation, and pointed back repeatedly to the allegations in Plaintiffs’ Complaint. Reply ¶¶11-38. Other than that, Plaintiffs asserted that *some* drug prices have dropped since Plaintiffs originally pulled pricing information from the Plan portal to include in the Complaint (which was two Plan years ago)—an allegation that Plaintiffs had already put before the Court in advance of the motion-to-dismiss hearing. Reply ¶¶11-38; ECF No. 44 (pre-hearing letter).⁸

⁸ Plaintiffs also repeatedly fault Defendants for failing to produce evidence in their Answer (*e.g.*, Reply ¶12 & n.1), but Plaintiffs ignore that under the Rule 7(a)(7) procedure that the Supreme Court encouraged and this Court invoked, Plaintiffs must affirmatively offer “specific, nonconclusory factual allegations showing the [§1108(b)(2)] exemption does not apply.” *Cunningham*, 604 U.S. at 708. Plaintiffs cannot do so simply by denying Defendants’ invocation of the exemption. While Plaintiffs want to skip over the pleadings stage to get right to discovery, the pleadings provide no basis to get to evidentiary stages of the case.

In any event, Plaintiffs’ challenge to the Plan’s prescription-drug pricing and structure is no longer at issue in this case; the Court already dismissed those claims because they challenge non-fiduciary conduct. And Plaintiffs’ pleadings taken together allege next to nothing about what is left in the case: the level of administrative services Caremark provides, or how the costs paid for them compare to those paid by similarly situated plans retaining similar services. *That* deficiency is particularly acute given how the Court has narrowed Plaintiffs’ claims—this Court dismissed Plaintiffs’ claims targeting Caremark’s Plan-design assistance (which does not implicate ERISA’s fiduciary obligations) and allowed Plaintiffs’ claims to go forward only on a narrow prohibited-transaction theory related to Caremark’s benefits-administration services, such as claims processing. MTD Order 24. Plaintiffs allege literally nothing about *those* services, Caremark’s compensation for them, or the quality (or cost) of similar services obtained by other health plans or offered by other PBMs.⁹

II. Plaintiffs’ prohibited-transaction claims are barred by ERISA’s statute of repose.

Plaintiffs’ prohibited-transaction claims also fail because they are untimely. ERISA bars plaintiffs from bringing suit more than six years after the last action constituting a part of the violation. 29 U.S.C. §1113(1). The six-year limitations period under §1113(1) “is a statute of repose that begins running ... irrespective of whether the injured party knows of the conduct or injury.” *Browe v. CTC Corp.*, 15 F.4th 175, 190 (2d Cir. 2021). “The purpose of a statute of repose is to create ‘an absolute bar on a defendant’s temporal liability.’” *Cal. Pub. Emps.’ Ret.*

⁹ Plaintiffs assert that reasonable compensation cannot be assessed “without addressing prescription drug pricing.” Reply ¶33. That disregards this Court’s motion-to-dismiss ruling, and in any event is based *entirely* on a *proposed* regulation that is not yet in effect that would newly bring drug pricing within the fiduciary-oversight umbrella. *See* Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure, 91 Fed. Reg. 4348, 4425 (Jan. 30, 2026). Whether or not that proposed regulation can withstand an APA challenge, it is not the law now and does not support Plaintiffs’ prohibited-transaction claims.

Sys. v. ANZ Sec., Inc., 582 U.S. 497, 507 (2017). “In light of [this] purpose ... the provision is in general not subject to tolling.” *Id.*; accord *Police & Fire Ret. Sys. of City of Detroit v. IndyMac MBS, Inc.*, 721 F.3d 95, 107 (2d Cir. 2013).

Here, the challenged “transactions” are the Plan’s engagement with Caremark to provide PBM services. Compl. ¶¶104, 280; MTD Order 30. Plaintiffs filed their Complaint on March 13, 2025, meaning they can only challenge transactions post-dating March 13, 2019. 29 U.S.C. §1113(1). Yet it is clear from the Forms 5500 that Caremark has served as the Plan’s PBM since well before that date.¹⁰ Indeed, Plaintiffs admit that Caremark has been the Plan’s PBM since 2006. Answer ¶1; Reply ¶2. Any challenge to Defendants’ initial contracting with Caremark is accordingly time-barred and should be dismissed. *See White v. Chevron Corp.*, 752 F. App’x 453, 455 (9th Cir. 2018) (affirming dismissal of prohibited-transaction claim as time-barred “because the transaction alleged to have violated the statute—hiring [a service provider]—[wa]s alleged to have occurred in 2002, and th[e] action was not commenced until 2016”).

Plaintiffs may try to base their prohibited-transaction claims on contractual renewals or payments made to Caremark on an ongoing basis. But in the context of a prohibited-transaction claim (as opposed to a cause of action for breach of ERISA’s fiduciary duties of prudence and loyalty, which include an ongoing duty to monitor), “the only action that can support an alleged prohibited transaction is the initial” action of selecting a particular service provider. *David v. Alphin*, 704 F.3d 327, 340 (4th Cir. 2013); accord *D.L. Markham DDS, MSD, Inc. 401(K) Plan v. Variable Annuity Life Ins. Co.*, 88 F.4th 602, 612 (5th Cir. 2023) (“‘transaction’ under §1106(a) does not include payments in accordance with a contract”). Plaintiffs therefore cannot defeat ERISA’s repose period by pointing to “continued transactions”—that is, renewals of the

¹⁰ Ex. I, 2017 Form 5500, at 46 (Santos Declaration).

relationship or individual payments thereunder—between a plan and a service provider that occur only as a result of that “initial” action. *See Cassell v. Vanderbilt Univ.*, 285 F. Supp. 3d 1056, 1068 (M.D. Tenn. 2018). “[T]here is no such thing as a ‘continuing’ prohibited transaction.” *White v. Chevron Corp.*, 2017 WL 2352137, at *22 (N.D. Cal. May 31, 2017), *aff’d*, 752 F. App’x 453 (9th Cir. 2018).¹¹

White is instructive. There, the plaintiffs asserted a prohibited-transaction claim premised on the defendants’ hiring of a recordkeeper fourteen years before the complaint was filed. 2017 WL 2352137, at *22. Seeking to avoid dismissal, the plaintiffs claimed that the initial hiring, although outside the repose period, resulted in the recordkeeper “receiving excessive compensation” within the repose period, making their claim timely as to those specific payments. *Id.* The district court disagreed. *Id.* The “continuing violation” doctrine on which the plaintiffs premised their argument, the court reasoned, is “inapplicable” to prohibited-transaction claims, since the “duty to monitor” on which the doctrine is based is “tethered” only to “[29 U.S.C.] §1104’s duty of prudence”—“not the ‘prohibited transactions’ element of §1106.” *Id.* It accordingly dismissed the claim as untimely. *Id.*; *accord Cassell*, 285 F. Supp. 3d at 1067-69.

The same result should follow here. Any transactions with Caremark postdating March 13, 2019, exist only as a result of the primary “transaction” of the first retention of Caremark’s

¹¹ One court in this district has determined that “[a] plaintiff may ... sue under ERISA for the renewal of a contract where the renewal took place within six years of the filing of the complaint.” *In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655, 674 (S.D.N.Y. 2018), *aff’d sub nom. Doe 1 v. Express Scripts, Inc.*, 837 F. App’x 44 (2d Cir. 2020). That holding is against the weight of the authority and, notably, the Second Circuit did not address that portion of the district court’s opinion on appeal. *See generally Doe 1 v. Express Scripts, Inc.*, 837 F. App’x 44 (2d Cir. 2020).

benefits-administration services. That retention occurred well before March 13, 2019, making challenges to that transaction time-barred. *Supra*, p. 18.¹²

III. Plaintiffs lack standing to bring their prohibited-transaction claims.¹³

This Court’s motion-to-dismiss decision and Plaintiffs’ Reply have crystallized an additional problem with Plaintiffs’ case: their failure to plead Article III standing to specifically challenge the retention of Caremark for benefits-administration services.

As the Supreme Court has emphasized, “[t]here is no ERISA exception to Article III.” *Thole v. U.S. Bank N.A.*, 590 U.S. 538, 547 (2020). Courts apply the “ordinary Article III standing analysis,” which at the pleading stage requires plaintiffs to “plausibly and clearly” allege (i) “an injury in fact” that is concrete, particularized, and actual or imminent, *id.* at 540, 544, 547, (ii) fairly traceable to the alleged fiduciary violations, and (iii) likely to be redressed by a favorable decision, *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560, 563 n.2 (1992). Plaintiffs fail to satisfy both Article III’s traceability requirement and its injury-in-fact component.

¹² That Ms. Schmitt did not become a Plan participant until 2022 does not change the analysis. *See* Compl. ¶15. “[A] repose period can run to completion even before injury has occurred to a potential plaintiff, extinguishing a cause of action before it even accrues.” *P. Stolz Fam. P’ship L.P. v. Daum*, 355 F.3d 92, 103 (2d Cir. 2004).

¹³ This Court previously concluded that Plaintiffs satisfied Article III based on their allegations of overpaying out-of-pocket for prescription drugs at the pharmacy. MTD Order 14-19. However, that was before this Court dismissed the “gravamen of Plaintiffs’ Complaint”—Defendants’ design of the Plan’s prescription-drug component, including the determination of the formulary, cost-sharing terms, drug pricing terms, etc.—because it involved *non-fiduciary* conduct that cannot be challenged under ERISA’s fiduciary provisions. *Id.* at 23-20. This Court did not specifically consider whether Plaintiffs’ out-of-pocket-costs theory could provide standing to challenge the narrow prohibited-transaction claims that the Court allowed to go forward. Because standing must be established for each claim, *Davis*, 554 U.S. at 734, Plaintiffs always bear the burden of establishing standing at every stage of the proceedings, and this Court always has the authority to revisit its prior decisions before final judgment, Defendants again challenge Plaintiffs’ standing here for Plaintiffs’ surviving claims. *See Ortiz*, 801 F. Supp. 3d at 325 (noting “discretion” under “law of the case doctrine” and reconsidering prior conclusion).

Again, the only aspect of Plaintiffs' case that this Court allowed to go forward are claims that fiduciaries engaged in a prohibited transaction by retaining Caremark to provide benefits-administration services to the Plan. But the injuries Plaintiffs point to are alleged out-of-pocket payments to pharmacies for prescription drugs. Even if those payments sufficed to establish standing to challenge Defendants' decisions regarding the structure, terms, and pricing of the Plan's prescription-drug component, Plaintiffs offer no allegations that those alleged overpayments are fairly traceable to the Plan's payments to Caremark for administering the Plan's prescription-drug benefits *as designed*. Nor, in any event, have Plaintiffs established that the out-of-pocket costs they paid for four generic prescription drugs represent "overpayments" necessary to amount to an Article III injury under Second Circuit precedent.

A. Plaintiffs' alleged injury of excessive out-of-pocket costs is not fairly traceable to the purported prohibited transactions.

Plaintiffs allege that they have standing as a result of the out-of-pocket costs they paid for four prescription drugs. Compl. ¶¶284, 292. But Plaintiffs have failed to plausibly allege that those costs are fairly traceable to the Plan's retention of Caremark to *administer* prescription-drug benefits by, *e.g.*, resolving prescription-drug claims and providing prior authorizations. The Complaint's allegations, in other words, "never connect the dots" between Plaintiffs' "alleged injuries" and the claimed prohibited transactions. *Heidel v. Governor of New York State*, 2023 WL 1115926, at *2 (2d Cir. Jan. 31, 2023).

"[S]tanding is not dispensed in gross." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 431 (2021). Instead, "a plaintiff must demonstrate standing for each claim [s]he seeks to press." *Mahon v. Ticor Title Ins. Co.*, 683 F.3d 59, 64 (2d Cir. 2012) (quoting *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 335 (2006)). This means that, "for each claim of wrongdoing alleged, a plaintiff must demonstrate ... that [s]he has suffered ... an injury that is traceable *to the wrongdoing*

alleged in that particular claim.” *Johnson v. U.S. Off. of Pers. Mgmt.*, 783 F.3d 655, 661 (7th Cir. 2015) (emphasis added). Put differently, “a plaintiff’s injury must match the legal problem [s]he alleges.” *Id.* at 663; *accord Malinowski v. Int’l Bus. Mach. Corp.*, 2025 WL 965812, at *4 (S.D.N.Y. Mar. 31, 2025) (plaintiffs must plead facts supporting that the “decried adverse actions could be reasonably construed as resulting from the” challenged conduct).

Here, the only “legal problem” remaining in the case is the purported prohibited transaction that Defendants, acting in their fiduciary capacity, caused between the Plan and Caremark, *i.e.*, the retention of Caremark to administer the prescription-drug plan as designed—by, for example, “resolving prescription-drug claims” and “processing prior authorizations,” but not helping JPMC “set[] the benefits promised by the Plan” by setting the formularies or determining drug pricing. MTD Order 24, 30. Thus, to have standing to assert their claims, Plaintiffs must “plausibly and clearly” plead facts demonstrating that their alleged injury (purportedly overpaying for prescription drugs out-of-pocket at the pharmacy), is traceable to the only fiduciary conduct that this Court held is at issue in this case (hiring and paying Caremark for its service-provider functions in helping Defendants administer the plan—not setting drug prices). *Thole*, 590 U.S. at 544. But they have not, and there is no nonspeculative reason to infer such a connection here.

First, Plaintiffs do not plead that the out-of-pocket drug costs they claim to have paid are at all connected to the compensation paid to Caremark for its benefits-administration functions. The Complaint instead alleges that those drug costs were informed by matters of Plan design, such as setting the formulary, setting the prescription-drug pricing structure, determining pricing benchmarks, and deciding or negotiating drug costs—all non-fiduciary functions that cannot form the basis of a prohibited-transaction claim. *See* MTD Order 23-26, 30; *e.g.*, Compl. ¶¶86, 156, 172, 173, 174. Plaintiffs nowhere allege that the retail-drug costs they paid were connected to

Caremark's role as a benefits administrator, *i.e.*, processing and resolving drug-reimbursement claims, or to any monetary transfers the Plan made to Caremark for those services. Indeed, Plaintiffs do not allege that the out-of-pocket drug costs they incurred were paid to Caremark or any other party in interest (they were paid to pharmacies), or that the benefits-administration services that Caremark provides to the Plan have any relationship to out-of-pocket drug pricing.

Nor would it be proper to simply infer such a causal relationship, for reasons similar to those explained in *Navarro v. Wells Fargo & Co.*, 2025 WL 897717 (D. Minn. Mar. 24, 2025). There, the plaintiffs claimed that the compensation paid to a PBM resulted in increased health premiums and out-of-pocket drug costs. *See id.* at *3. The court rejected that standing theory in part for lack of traceability. *Id.* at *9. Even with the plaintiffs' "attempts to establish a direct connection" between amounts paid to the PBM via the alleged prohibited transactions and Plaintiffs' contribution rates and prescription-drug costs, the court reasoned, it was too "speculative" that the former "had any effect at all" on the latter. *Id.* And in a subsequent decision (considering the plaintiffs' amended complaint), the court reiterated that there are "simply too many variables" contributing to these types of pricing decisions to infer that the alleged overcharges were traceable to the Plan's PBM arrangement. *Navarro v. Wells Fargo & Co.*, 2026 WL 591454, at *9 (D. Minn. Mar. 3, 2026) (addressing participant contribution amounts); *see also id.* at *10 (concluding that the plaintiffs' theory of standing based on out-of-pocket costs paid to pharmacies "fails for essentially the same reasons").

Here, similar to *Navarro*, all that Plaintiffs allege as to the connection between the drug costs they claim to have paid and Defendants' alleged prohibited transactions is that the latter "increased the amounts that [they] were required to pay in ... out-of-pocket costs." Compl. ¶284. But, like in *Navarro*, Plaintiffs do not explain how they get from point A to point B. Indeed, as

Defendants previously explained, prescription-drug pricing is exceedingly complicated—it is influenced by manufacturers’ pricing decisions, supply-chain issues, tariffs, and regulatory issues, in addition to deals negotiated by PBMs.¹⁴ Here, as in *Navarro*, it is those variables that, when considered alongside Plaintiffs’ failure to explain how the purported prohibited transactions figure into the analysis, render the link between the prescription-drug costs that Plaintiffs paid and the alleged prohibited transactions completely speculative. And that deficiency is particularly acute given how this case has been narrowed; unlike in *Navarro* (in which the court was evaluating standing to challenge the design and pricing terms of the sponsor’s prescription-drug plan), the challenged conduct is limited to Defendants’ retention of Caremark to provide benefits-administration services—conduct even further causally removed from the injury alleged than in *Navarro*. Any connection between payments to Caremark for the limited service-provider functions that are the subject of the remaining prohibited-transaction claims, and the out-of-pocket drug costs that Plaintiffs claim to have paid to *pharmacies*, is thus “tenuous at best.” *Navarro*, 2025 WL 897717, at *9.

The Court previously viewed *Navarro*’s traceability reasoning as inapt because Plaintiffs here have conducted NADAC price comparisons as to more drugs on the Plan’s formulary than in

¹⁴ See generally Axis Advisors, *Unravelling the Drug Pricing Blame Game* (Sept. 19, 2023), <https://www.3axisadvisors.com/projects/2023/9/19/unravelling-the-drug-pricing-blame-game>. The Court’s motion-to-dismiss order operated under the assumption that Defendants had not challenged the “causal element” of Article III standing. MTD Order 18. Respectfully, however, Defendants addressed traceability at length in their briefing (both their motion, ECF No. 30, at 12-13, and their reply, ECF No. 38, at 4), and at oral argument (Hrg. Tr. 12:16-13:4). In any event, standing is jurisdictional and can be raised or revisited at any time. See *Altman v. Bedford Cent. Sch. Dist.*, 245 F.3d 49, 69 (2d Cir. 2001). And here, Plaintiffs’ jurisdictional problems have become even more pronounced now that the only fiduciary conduct remaining is Caremark’s provision of services to *administer* the Plan as designed—and Plaintiffs nowhere allege that the Plan’s retention of Caremark for those services influenced the amounts they paid to the pharmacy out-of-pocket.

Navarro. MTD Order 18. But the *Navarro* court’s subsequent opinion (which was not before this Court at the time of its motion-to-dismiss ruling) did not even mention the quantity of the plaintiffs’ drug comparisons as a relevant factor in the standing analysis—even while expressly acknowledging that “the price comparisons alleged ... are staggering.” 2026 WL 591454, at *11. And nothing about a higher quantity of drug comparisons (260 in *Navarro* versus 404 here) could supply the missing causal link given the myriad factors that contribute to drug pricing at the pharmacy level, as noted above. That Plaintiffs here ran more price comparisons than in *Navarro* does not in any way account for those dynamics.

At bottom, Plaintiffs have offered no allegations plausibly supporting the bare assertion that the prescription-drug costs they paid were influenced by retaining and paying Caremark for the benefits-administration functions remaining in this case. Their “lower out-of-pocket costs” theory of standing accordingly fails for lack of traceability.

B. Plaintiffs do not plausibly allege injury-in-fact.

Separately from the lack of traceability between Plaintiffs’ purported out-of-pocket costs and the prohibited-transaction claims that remain, this Court also lacks jurisdiction for an independent reason: Under Second Circuit precedent, Plaintiffs’ allegations about the out-of-pocket prescription drug costs that they incurred do not plausibly plead a constitutionally-cognizable overcharge injury.¹⁵ While Plaintiffs allege that they *paid* for prescription drugs, they (sensibly) do not claim that simply *paying* for prescription drugs is an injury. Instead, they claim

¹⁵ This Court previously ruled that Plaintiffs alleged an Article III injury based on an overcharge theory. MTD Order 14-15. But this Court must assure itself of jurisdiction at every stage of the proceedings, *see Lugo v. City of Troy, New York*, 114 F.4th 80, 87 (2d Cir. 2024), and in any event is always empowered to reconsider its prior conclusions at any point before final judgment, *see Altman*, 245 F.3d at 69. Defendants therefore respectfully again challenge Plaintiffs’ failure to plausibly plead an injury in fact consistent with the Second Circuit’s overcharge precedents.

an injury from *overpaying* for prescription drugs. Compl. ¶¶127, 247-249. But they do not plausibly allege any *overpayment* at all for their medications.

This Court previously suggested that Plaintiffs' failure to plead the "over" part of overpayment to be a merits issue, rather than a standing issue. MTD Order 18. To be sure, standing and the merits are two distinct issues, and they require different allegations. But Plaintiffs bear the burden of pleading both. Here, to satisfy the merits and plead a plausible claim for breach of ERISA's fiduciary obligations based on price comparisons, Plaintiffs had to plead a meaningful benchmark plausibly demonstrating that *the Plan* so overpaid for the products or services it received that a court could infer that Plan fiduciaries lacked a prudent and loyal decisionmaking process. *See Singh v. Deloitte LLP*, 650 F. Supp. 3d 259, 266-67 (S.D.N.Y. 2023). The Court determined that Plaintiffs failed to meet that burden here. MTD Order 19-20 n.5. Separately, to satisfy Article III's requirements, Plaintiffs were *also* required to plead that *these three Plaintiffs* actually overpaid for *their four* prescription drugs. *Thole*, 590 U.S. at 540. To meet this standing burden, Plaintiffs needed to allege facts plausibly supporting that they were *overcharged* for the four prescriptions drugs for which they incurred out-of-pocket costs.

The Second Circuit has been clear on this point: "even if overpayment may constitute a sufficient injury in fact in the general case," a complaint must still "adequately allege that overpayment occurred." *Plutzer on behalf of Tharanco Grp., Inc. v. Bankers Tr. Co. of S. Dakota*, 2022 WL 17086483, at *2 (2d Cir. Nov. 21, 2022) (citing *John v. Whole Foods Market Group Inc.*, 858 F.3d 732, 736 (2d Cir. 2017)). In other words, it is not enough for plaintiffs to invoke the word "overpayment"; they must plead facts plausibly suggesting that, in fact, an *overpayment* occurred.

To sufficiently plead that an overpayment occurred, plaintiffs must first establish a plausible baseline from which their allegations of overpayment can be judged. *See Shaulis v. Nordstrom, Inc.*, 865 F.3d 1, 12 (1st Cir. 2017) (noting “claims of injury premised on ‘overpayment’ ... require an objective measure against which the plaintiff’s allegations may be evaluated”). One way to establish the necessary baseline is through benchmarking: pleading facts establishing what similarly situated individuals paid for similar products or services. *Compare Kraus v. Snow Teeth Whitening LLC*, 2022 WL 4642170, at *4 (E.D.N.Y. Sept. 15, 2022), *report and recommendation adopted*, 2022 WL 4662819 (E.D.N.Y. Sept. 30, 2022) (plaintiff pleaded overpayment injury by plausibly establishing “that he could have purchased similar ... products ... for a lower price”), *with Taylor v. BDO USA, P.C.*, 2025 WL 2420941, at *3 (D. Mass. Aug. 21, 2025) (dismissing for lack of standing where plaintiff did “not adequately allege any measure” by which to assess claimed overpayment).

Plaintiffs fail to plausibly allege an overpayment injury affecting them in a concrete and personalized way, since they have not established such a plausible baseline against which the prices they allege they paid can be judged. While the Complaint complains about prices paid for “specialty” (Compl. ¶¶112-126) and biosimilar drugs (Compl. ¶¶129-135), it does not allege that any of the Plaintiffs purchased those drugs at all, let alone paid for them out of pocket at an inflated price. Instead, all Plaintiffs do is identify four low-cost generic drugs they claim to have purchased and compare (a) their out-of-pocket costs at a retail pharmacy with (b) the NADAC cost, which is a measure of the average pharmacy *acquisition* costs for the drugs (before fees or the pharmacy’s own profits are figured in).¹⁶ Compl. ¶¶247-249. Plaintiffs do not allege what *Plaintiffs’*

¹⁶ As explained above, NADAC data simply report what a narrow slice of pharmacies responding to a survey procured particular drugs for *on average*, excluding fees much less the pharmacies’ profits. *Supra*, p. 6.

pharmacies paid for these drugs, what those pharmacies charged others, or what participants of *other plans* paid for the same drugs. At best, these allegations simply suggest that Plaintiffs purchased these four drugs for a higher price than the price at which *some pharmacies acquired* them. None of the allegations suggest Plaintiffs' (very low) prices were excessive, or that by paying the out-of-pocket prices that they did, Plaintiffs overpaid for these four drugs.

Plaintiffs' theory improperly relies on the unremarkable fact that retail prices exceed average wholesale costs. But that gap is not evidence of an overcharge; it is the ordinary structure of retail pricing. By Plaintiffs' logic, every restaurant overcharges every customer, because the meal always costs more than the ingredients. Defendants are unaware of a single case holding that *wholesale* costs are an appropriate benchmark for establishing excessive *retail* pricing. Because Plaintiffs' flour-to-bread comparison does not provide a plausible baseline against which to measure an alleged overcharge, they have not alleged a concrete and particularized injury.

CONCLUSION

For these reasons, this Court should grant judgment on the pleadings and dismiss the remainder of Plaintiffs' claims.

Dated: June 3, 2026

Respectfully submitted,

/s/ James O. Fleckner

James O. Fleckner, *admitted pro hac vice*

Dave Rosenberg, *admitted pro hac vice*

GOODWIN PROCTER LLP

100 Northern Avenue

Boston, MA 02210

Tel.: (617) 570-1000

jfleckner@goodwinlaw.com

drosenberg@goodwinlaw.com

Gabrielle L. Gould

GOODWIN PROCTER LLP

The New York Times Building

620 Eighth Avenue

New York, New York 10018
Tel.: (212) 813-8800
ggould@goodwinlaw.com

Jaime A. Santos, *admitted pro hac vice*
GOODWIN PROCTER LLP
1900 N Street, N.W.
Washington, DC 20036
Tel: (202) 346-4000
jsantos@goodwinlaw.com

CERTIFICATE OF COMPLIANCE

I, James O. Fleckner, hereby certify that the foregoing Memorandum of Law in Support of Defendants' Motion for Judgment on the Pleadings contains 8,548 words, as reported by Microsoft Word, not including those portions of the document that do not count against the word limit.

/s/ James O. Fleckner
James O. Fleckner

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

SETH STERN, et al.

Plaintiffs,

v.

JPMORGAN CHASE & CO., et al.

Defendants.

Case No. 1:25-cv-02097

**DECLARATION OF JAIME A. SANTOS IN SUPPORT OF DEFENDANTS’
MOTION FOR JUDGMENT ON THE PLEADINGS**

I, Jaime A. Santos, hereby state and affirm as follows:

1. I am a counsel with the law firm of Goodwin Procter LLP and a member in good standing with the Bars of the District of Columbia, Commonwealth of Massachusetts, and State of California. I am admitted *pro hac vice* to the United States District Court for the Southern District of New York and am an attorney of record for the Defendants in the above-captioned case.

2. I make this declaration in support of Defendants’ Motion for Judgment on the Pleadings. This declaration is based on personal knowledge and my review of documents and files in the possession of Goodwin Procter LLP.

3. Attached hereto as Exhibit I¹ is a true and correct copy of the 2017 Form 5500 for the Plan, dated October 4, 2018 and filed with the United States Department of Labor. The Plan’s Forms 5500 are expressly referenced in Plaintiffs’ Complaint (at ¶¶17, 21, 227), and therefore this

¹ Exhibits A-H, attached to the Rosenberg Declaration (ECF No. 31), accompanied Defendants’ earlier Motion to Dismiss. Defendants cite some of those exhibits in their current Motion for Judgment on the Pleadings. Thus, to avoid confusion, Defendants continue the sequential ordering and use Exhibit I to refer to the 2017 Form 5500 attached hereto.

Court may consider them in resolving Defendants' Motion for Judgment on the Pleadings. *See Singh v. Deloitte LLP*, 650 F. Supp. 3d 259, 267 (S.D.N.Y. 2023).

Signed on this 3rd day of June, 2026.

/s/ Jaime A. Santos
Jaime A. Santos

EXHIBIT I

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	---	--

Part I Annual Report Identification Information	
For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)

Part II Basic Plan Information —enter all requested information	
<p>1a Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p> <hr/> <p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p> <p><u>545 WASHINGTON BLVD</u> <u>12TH FLOOR, MAIL CODE NY1-G120</u> <u>JERSEY CITY, NJ 07130</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>502</u></p> <hr/> <p>1c Effective date of plan <u>04/01/1955</u></p> <hr/> <p>2b Employer Identification Number (EIN) <u>13-4994650</u></p> <hr/> <p>2c Plan Sponsor's telephone number <u>302-455-3494</u></p> <hr/> <p>2d Business code (see instructions) <u>523110</u></p>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/04/2018	BERNADETTE J BRANOSKY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor BENEFITS DIRECTOR OF JPMORGAN CHASE BERNADETTE J. BRANOSKY JPMORGAN CHASE BANK, N.A. 545 WASHINGTON BLVD 12TH FLOOR, MAIL CODE NY1-G120 JERSEY CITY, NJ 07130	3b Administrator's EIN 37-1589439 3c Administrator's telephone number 551-205-1805
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 139802
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).	
a(1) Total number of active participants at the beginning of the plan year	6a(1) 137937
a(2) Total number of active participants at the end of the plan year	6a(2) 138454
b Retired or separated participants receiving benefits	6b 1534
c Other retired or separated participants entitled to future benefits	6c 0
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 139988
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e
f Total. Add lines 6d and 6e	6f
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4G 4H 4L 4Q	

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
--	--

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> <u>10</u> A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
---	--

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>502</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
CONNECTICUT GENERAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>06-0303370</u>	<u>62308</u>	<u>M10088A</u>	<u>304</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
----------------	--

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	7e(5)
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
 b Dental
 c Vision
 d Life insurance
 e Temporary disability (accident and sickness)
 f Long-term disability
 g Supplemental unemployment
 h Prescription drug
 i Stop loss (large deductible)
 j HMO contract
 k PPO contract
 l Indemnity contract
 m Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	0
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	0
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	270900
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶ <u>502</u></p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
CONNECTICUT GENERAL LIFE INSURANCE COMPANY & AFFILIATES

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>06-0303370</u>	<u>62308</u>	<u>3174696</u>	<u>21984</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
----------------	--

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(2) Dividends and credits		
(3) Interest credited during the year		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a Health (other than dental or vision)
- b Dental
- c Vision
- d Life insurance
- e Temporary disability (accident and sickness)
- f Long-term disability
- g Supplemental unemployment
- h Prescription drug
- i Stop loss (large deductible)
- j HMO contract
- k PPO contract
- l Indemnity contract
- m Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)	
	(4) Earned ((1) + (2) - (3)).....	9a(4)	0
b	Benefit charges (1) Claims paid.....	9b(1)	
	(2) Increase (decrease) in claim reserves.....	9b(2)	
	(3) Incurred claims (add (1) and (2)).....	9b(3)	0
	(4) Claims charged.....	9b(4)	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions.....	9c(1)(A)	
	(B) Administrative service or other fees.....	9c(1)(B)	
	(C) Other specific acquisition costs.....	9c(1)(C)	
	(D) Other expenses.....	9c(1)(D)	
	(E) Taxes.....	9c(1)(E)	
	(F) Charges for risks or other contingencies.....	9c(1)(F)	
	(G) Other retention charges.....	9c(1)(G)	
	(H) Total retention.....	9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....	9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....	9d(1)	
	(2) Claim reserves.....	9d(2)	
	(3) Other reserves.....	9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....	9e	

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	9291121
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶ <u>502</u></p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UNITED HEALTHCARE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>36-2739571</u>	<u>79413</u>	<u>0704749</u>	<u>1</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
----------------	--

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(2) Dividends and credits		
(3) Interest credited during the year		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)	
	(4) Earned ((1) + (2) - (3)).....	9a(4)	0
b	Benefit charges (1) Claims paid.....	9b(1)	
	(2) Increase (decrease) in claim reserves.....	9b(2)	
	(3) Incurred claims (add (1) and (2)).....	9b(3)	0
	(4) Claims charged.....	9b(4)	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions.....	9c(1)(A)	
	(B) Administrative service or other fees.....	9c(1)(B)	
	(C) Other specific acquisition costs.....	9c(1)(C)	
	(D) Other expenses.....	9c(1)(D)	
	(E) Taxes.....	9c(1)(E)	
	(F) Charges for risks or other contingencies.....	9c(1)(F)	
	(G) Other retention charges.....	9c(1)(G)	
	(H) Total retention.....	9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....	9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....	9d(1)	
	(2) Claim reserves.....	9d(2)	
	(3) Other reserves.....	9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....	9e	

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	21524
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶ <u>502</u></p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>22-1211670</u>	<u>68241</u>	<u>50684</u>	<u>141029</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid <u>127966</u>	(b) Total amount of fees paid <u>0</u>
---	---

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
AMERICAN BENEFITS AND COMP SYSTEMS
99 PARK AVENUE
25TH FLOOR
NEW YORK, NY 10016

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>127966</u>	<u>0</u>	<u>SUPPLEMENTAL COMMISSIONS</u>	<u>3</u>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds:	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	6b
c	Premiums due but unpaid at the end of the year	6c
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b 0
c	Additions: (1) Contributions deposited during the year	7c(1)
	(2) Dividends and credits	7c(2)
	(3) Interest credited during the year	7c(3)
	(4) Transferred from separate account	7c(4)
	(5) Other (specify below)..... ▶	7c(5)
	(6) Total additions	7c(6) 0
d	Total of balance and additions (add lines 7b and 7c(6))	7d 0
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
	(2) Administration charge made by carrier	7e(2)
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)..... ▶	7e(4)
(5) Total deductions	7e(5) 0	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f 0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)		
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
	(4) Earned ((1) + (2) - (3)).....		9a(4)	0
b	Benefit charges (1) Claims paid.....	9b(1)		
	(2) Increase (decrease) in claim reserves.....	9b(2)		
	(3) Incurred claims (add (1) and (2)).....		9b(3)	0
	(4) Claims charged.....		9b(4)	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions.....	9c(1)(A)		
	(B) Administrative service or other fees.....	9c(1)(B)		
	(C) Other specific acquisition costs.....	9c(1)(C)		
	(D) Other expenses.....	9c(1)(D)		
	(E) Taxes.....	9c(1)(E)		
	(F) Charges for risks or other contingencies.....	9c(1)(F)		
	(G) Other retention charges.....	9c(1)(G)		
	(H) Total retention.....		9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
	(2) Claim reserves.....		9d(2)	
	(3) Other reserves.....		9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a		33210048
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶ <u>502</u></p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
PROVIDENT LIFE & CASUALTY INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>62-0331200</u>	<u>68195</u>	<u>155376, 155377,</u>	<u>1528</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<p>(a) Total amount of commissions paid <u>554591</u></p>	<p>(b) Total amount of fees paid <u>465734</u></p>
---	--

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MANAGEMENT COMPENSATION GROUP SOUTHEAST INC
55 BROADWAY SUITE 701
NEW YORK, NY 10006

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>554591</u>	<u>338327</u>	<u>INSURANCE FEES</u>	<u>3</u>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
NFP INSURANCE SERVICE INC. BLDG 2, STE 125
1250 CAPITAL OF TEXAS HWY
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>0</u>	<u>127407</u>	<u>INSURANCE FEES</u>	<u>3</u>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
----------------	--

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(2) Dividends and credits		
(3) Interest credited during the year		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) **▶ INDIVIDUAL DISABILITY INSURANCE**

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)		
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
	(4) Earned ((1) + (2) - (3)).....		9a(4)	0
b	Benefit charges (1) Claims paid.....	9b(1)		
	(2) Increase (decrease) in claim reserves.....	9b(2)		
	(3) Incurred claims (add (1) and (2)).....		9b(3)	0
	(4) Claims charged.....		9b(4)	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions.....	9c(1)(A)		
	(B) Administrative service or other fees.....	9c(1)(B)		
	(C) Other specific acquisition costs.....	9c(1)(C)		
	(D) Other expenses.....	9c(1)(D)		
	(E) Taxes.....	9c(1)(E)		
	(F) Charges for risks or other contingencies.....	9c(1)(F)		
	(G) Other retention charges.....	9c(1)(G)		
	(H) Total retention.....		9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
	(2) Claim reserves.....		9d(2)	
	(3) Other reserves.....		9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a		3947324
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>502</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
PRUDENTIAL INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>22-1211670</u>	<u>68241</u>	<u>51291-LTC</u>	<u>2457</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
--------------------------------------	-------------------------------

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			
(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds:	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	6b
c	Premiums due but unpaid at the end of the year	6c
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b 0
c	Additions: (1) Contributions deposited during the year	7c(1)
	(2) Dividends and credits	7c(2)
	(3) Interest credited during the year	7c(3)
	(4) Transferred from separate account	7c(4)
	(5) Other (specify below)..... ▶	7c(5)
	(6) Total additions	7c(6) 0
d	Total of balance and additions (add lines 7b and 7c(6))	7d 0
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
	(2) Administration charge made by carrier	7e(2)
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)..... ▶	7e(4)
(5) Total deductions	7e(5) 0	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f 0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
 b Dental
 c Vision
 d Life insurance
 e Temporary disability (accident and sickness)
 f Long-term disability
 g Supplemental unemployment
 h Prescription drug
 i Stop loss (large deductible)
 j HMO contract
 k PPO contract
 l Indemnity contract
 m Other (specify) **▶LONG TERM CARE**

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	0
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	0
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	2751500
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>502</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
AETNA LIFE INSURANCE CO.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>06-6033492</u>	<u>11183</u>	<u>800218</u>	<u>21231</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
--------------------------------------	-------------------------------

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds:	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	6b
c	Premiums due but unpaid at the end of the year	6c
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b 0
c	Additions: (1) Contributions deposited during the year	7c(1)
	(2) Dividends and credits	7c(2)
	(3) Interest credited during the year	7c(3)
	(4) Transferred from separate account	7c(4)
	(5) Other (specify below)..... ▶	7c(5)
	(6) Total additions	7c(6) 0
d	Total of balance and additions (add lines 7b and 7c(6))	7d 0
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
	(2) Administration charge made by carrier	7e(2)
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)..... ▶	7e(4)
(5) Total deductions	7e(5) 0	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f 0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a Health (other than dental or vision)
- b Dental
- c Vision
- d Life insurance
- e Temporary disability (accident and sickness)
- f Long-term disability
- g Supplemental unemployment
- h Prescription drug
- i Stop loss (large deductible)
- j HMO contract
- k PPO contract
- l Indemnity contract
- m Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)			
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)			
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)			
	(4) Earned ((1) + (2) - (3)).....		9a(4)		0
b	Benefit charges (1) Claims paid.....	9b(1)			
	(2) Increase (decrease) in claim reserves.....	9b(2)			
	(3) Incurred claims (add (1) and (2)).....		9b(3)		0
	(4) Claims charged.....		9b(4)		
c	Remainder of premium: (1) Retention charges (on an accrual basis) --				
	(A) Commissions.....	9c(1)(A)			
	(B) Administrative service or other fees.....	9c(1)(B)			
	(C) Other specific acquisition costs.....	9c(1)(C)			
	(D) Other expenses.....	9c(1)(D)			
	(E) Taxes.....	9c(1)(E)			
	(F) Charges for risks or other contingencies.....	9c(1)(F)			
	(G) Other retention charges.....	9c(1)(G)			
	(H) Total retention.....		9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)		
	(2) Claim reserves.....		9d(2)		
	(3) Other reserves.....		9d(3)		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e		

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a		10004566
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b		

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶ <u>502</u></p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
HYATT LEGAL PLANS, INC.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>34-1650967</u>	<u>0000</u>	<u>1570010</u>	<u>30303</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds:	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	6b
c	Premiums due but unpaid at the end of the year	6c
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b 0
c	Additions: (1) Contributions deposited during the year	7c(1)
	(2) Dividends and credits	7c(2)
	(3) Interest credited during the year	7c(3)
	(4) Transferred from separate account	7c(4)
	(5) Other (specify below)..... ▶	7c(5)
	(6) Total additions	7c(6) 0
d	Total of balance and additions (add lines 7b and 7c(6))	7d 0
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
	(2) Administration charge made by carrier	7e(2)
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)..... ▶	7e(4)
(5) Total deductions	7e(5) 0	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f 0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 8** Benefit and contract type (check all applicable boxes)
- | | | | |
|---|--|---|--|
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input checked="" type="checkbox"/> Other (specify) ▶ GROUP LEGAL | | | |

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	0
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	0
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	
10 Nonexperience-rated contracts:			
a Total premiums or subscription charges paid to carrier.....		10a	4311080
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.		10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶ <u>502</u></p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>13-5581829</u>	<u>65978</u>	<u>0173132</u>	<u>169915</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid <u>0</u>	(b) Total amount of fees paid <u>144471</u>
--	--

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
AMERICAN BENEFITS AND COMP SYS INC. 99 PARK AVE 25TH FLOOR NEW YORK, NY 10016-1601

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>0</u>	<u>144471</u>	<u>SUPPLEMENTAL AND NON-MONETARY COMPENSATION</u>	<u>3</u>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
----------------	--

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(2) Dividends and credits		
(3) Interest credited during the year		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
 b Dental
 c Vision
 d Life insurance
e Temporary disability (accident and sickness)
 f Long-term disability
 g Supplemental unemployment
 h Prescription drug
i Stop loss (large deductible)
 j HMO contract
 k PPO contract
 l Indemnity contract
m Other (specify) **▶ ACCIDENTAL DEATH & DISMEMBERMENT**

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	0
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	0
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	50622919
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>502</u></p>
---	--	-------------------

<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>
---	--

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>22-2777159</u>	<u>47029</u>	<u>30041790</u>	<u>118141</u>	<u>01/01/2017</u>	<u>12/31/2017</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
---	--------------------------------------

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information	
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds:	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	6b
c	Premiums due but unpaid at the end of the year	6c
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b 0
c	(1) Contributions deposited during the year	7c(1)
	(2) Dividends and credits	7c(2)
	(3) Interest credited during the year	7c(3)
	(4) Transferred from separate account	7c(4)
	(5) Other (specify below)..... ▶	7c(5)
	(6) Total additions	7c(6) 0
d	Total of balance and additions (add lines 7b and 7c(6))	7d 0
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
	(2) Administration charge made by carrier	7e(2)
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)..... ▶	7e(4)
(5) Total deductions	7e(5) 0	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f 0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
 b Dental
 c Vision
 d Life insurance
 e Temporary disability (accident and sickness)
 f Long-term disability
 g Supplemental unemployment
 h Prescription drug
 i Stop loss (large deductible)
 j HMO contract
 k PPO contract
 l Indemnity contract
 m Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	0
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	0
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	15399329
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p>SCHEDULE C (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Service Provider Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2017</p> <hr/> <p>This Form is Open to Public Inspection.</p>
---	---	---

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

<p>A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u></p>	<p>B Three-digit plan number (PN) ▶ <u>502</u></p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u></p>	<p>D Employer Identification Number (EIN) <u>13-4994650</u></p>	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

UNITED HEALTHCARE SERVICES, LLC

47-0854646

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 49 50	NONE	65530507	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

CONNECTICUT GENERAL LIFE INS. CO.

06-0303370

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 56 62	NONE	27813377	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

CAREMARK

95-3382344

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	2001645	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

METROPOLITAN LIFE INSURANCE COMPANY

13-5581829

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	1898954	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

CIGNA INTERNATIONAL

06-0303370

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50 62	NONE	1014935	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

JPMORGAN CHASE BANK NA

13-4994650

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
72 21	PLAN TRUSTEE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	12863	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CONNECTICUT GENERAL LIFE INS. CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMERICAN SPECIALTY HEALTH 33-0571188	\$0.37/PARTICIPANT TO DEFRAY CIGNA'S INFRASTRUCTURE AND OTHER COST TO IMPLEMENT AND ADMINISTER ON AN ONGOING BASIS THE EXPANDED ACCESS TO THE COVERED PHYSICAL THERAPY, AND OCCUPATIONAL THERAPY PROVIDER NETWORK/DISCOUNTS	

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CONNECTICUT GENERAL LIFE INS. CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CARECORE 46-4861112	\$0.34/PARTICIPANT TO DEFRAY CIGNAS COST FOR IMPLEMENTATION AND MAINTENANCE OF ITS AGREEMENT WITH CARECORE FOR RADIATION THERAPY	

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CONNECTICUT GENERAL LIFE INS. CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CARECORE 46-4861112	\$0.92/PARTICIPANT TO DEFRAY CIGNAS COST FOR IMPLEMENTATION AND MAINTENANCE OF ITS AGREEMENT WITH CARECORE FOR MEDICAL ONCOLOGY	

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CONNECTICUT GENERAL LIFE INS. CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
SAGAMORE HEALTH NETWORK P.O. BOX 6051 INDIANAPOLIS, IN 46206	\$0.10/PARTICIPANT TO PAY NETWORK ADMINISTRATION FEES

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CONNECTICUT GENERAL LIFE INS. CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
MEDSOLUTIONS, INC. 62-1615395	\$0.58/PARTICIPANT FOR ACCESS TO CERTAIN CIGNA CONTRACTED HI-TECH RADIOLOGY SERVICE PROVIDERS

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CONNECTICUT GENERAL LIFE INS. CO.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
MEDSOLUTIONS, INC. 20-5953092	\$0.07/PARTICIPANT TO DEFRAY COSTS FOR INFRASTRUCTURE CHANGES REQUIRED TO UTILIZE THIS VENDOR'S MUSCULOSKELETAL MANAGEMENT PROGRAM

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CONNECTICUT GENERAL LIFE INS.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CASTLIGHT HEALTH 26-1989091	\$4.27/PARTICIPANT TO DEFRAY CIGNA'S COST FOR INFRASTRUCTURE CHANGES REQUIRED TO FACILITATE IMPLEMENTATION OF THIS VENDOR'S CUSTOMER TRANSPARENCY AND ENGAGEMENT SVCS AND REIMBURSEMENT FOR PROVIDING COE, CCD, PAID CLAIMS FILES AND ACCESS TO COST EST INFO

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CONNECTICUT GENERAL LIFE INS.	12 13 31 38 49 50 56 62	0

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
ZELIC 26-1790538	\$0.03/PARTICIPANT TO DEFRAY CIGNAS COST FOR THE INFRASTRUCTURE CHANGES REQUIRED TO UTILIZE THIS VENDORS MEDICAL PROVIDER NETWORK/DISCOUNTS

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part III	Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)
-----------------	---

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection
For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>		
A Name of plan <u>JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES</u>	B Three-digit plan number (PN) ▶ <u>502</u>	
C Plan sponsor's name as shown on line 2a of Form 5500 <u>JPMORGAN CHASE BANK, NATIONAL ASSOCIATION</u>	D Employer Identification Number (EIN) <u>13-4994650</u>	

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	1b(1)	88796488
(2) Participant contributions	1b(2)	1781673
(3) Other.....	1b(3)	15091210
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	5
(2) U.S. Government securities.....	1c(2)	
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred	1c(3)(A)	
(B) All other.....	1c(3)(B)	
(4) Corporate stocks (other than employer securities):		
(A) Preferred	1c(4)(A)	
(B) Common	1c(4)(B)	
(5) Partnership/joint venture interests	1c(5)	
(6) Real estate (other than employer real property)	1c(6)	
(7) Loans (other than to participants)	1c(7)	
(8) Participant loans	1c(8)	
(9) Value of interest in common/collective trusts.....	1c(9)	
(10) Value of interest in pooled separate accounts.....	1c(10)	
(11) Value of interest in master trust investment accounts	1c(11)	
(12) Value of interest in 103-12 investment entities	1c(12)	
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	22515652
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	
(15) Other	1c(15)	

		(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:		
(1)	Employer securities	1d(1)	
(2)	Employer real property	1d(2)	
e	Buildings and other property used in plan operation	1e	
f	Total assets (add all amounts in lines 1a through 1e)	1f	136357691 128185028
Liabilities			
g	Benefit claims payable	1g	129154000 127445000
h	Operating payables	1h	7203691 740028
i	Acquisition indebtedness	1i	
j	Other liabilities	1j	
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	136357691 128185028
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	0 0

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

		(a) Amount	(b) Total
Income			
a	Contributions:		
(1)	Received or receivable in cash from: (A) Employers	2a(1)(A)	1245147874
	(B) Participants	2a(1)(B)	592999271
	(C) Others (including rollovers)	2a(1)(C)	
(2)	Noncash contributions	2a(2)	
(3)	Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)	1838147145
b	Earnings on investments:		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	
	(B) U.S. Government securities	2b(1)(B)	
	(C) Corporate debt instruments	2b(1)(C)	
	(D) Loans (other than to participants)	2b(1)(D)	
	(E) Participant loans	2b(1)(E)	
	(F) Other	2b(1)(F)	
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	0
(2)	Dividends: (A) Preferred stock	2b(2)(A)	
	(B) Common stock	2b(2)(B)	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	90732
	(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)	90732
(3)	Rents	2b(3)	
(4)	Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	0
(5)	Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
	(B) Other	2b(5)(B)	
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		-207
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		1838237670

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)	1738399868	
(3) Other	2e(3)	1578354	
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		1739978222
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees			
(2) Contract administrator fees.....	2i(2)	98259448	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		98259448
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		1838237670

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		0
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unqualified (2) Qualified (3) Disclaimer (4) Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? Yes No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: FAW CASSON & CO., LLP

(2) EIN: 52-0619968

d The opinion of an independent qualified public accountant is **not attached** because:

(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.).....

b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)

	Yes	No	Amount
4a		X	
4b		X	

	Yes	No	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c	X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d	X	
e Was this plan covered by a fidelity bond?	4e	X	500000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f	X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g	X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h	X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k	X	
l Has the plan failed to provide any benefit when due under the plan?	4l	X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No
 If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____ (See instructions.)

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES**

**Financial Statements
As of and For the Years Ended
December 31, 2017 and 2016
And Supplemental Schedules
As of and For the Year Ended December 31, 2017
Together with
Independent Auditor's Report**

JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES

FINANCIAL STATEMENTS AND SUPPLEMENTAL SCHEDULES

Table of Contents

	<u>Page Number(s)</u>
<u>Independent Auditor's Report</u>	1
Financial Statements:	
<u>Statements of net assets available for benefits</u>	2
<u>Statements of changes in net assets available for benefits</u>	3
<u>Statements of plan benefit obligations</u>	4
<u>Statements of changes in plan benefit obligations</u>	5
<u>Notes to financial statements</u>	6 - 13
Supplemental Schedules:	
<u>Schedule of assets (held at end of year)</u>	14
<u>Schedule of reportable transactions</u>	15 - 16



FAW CASSON
CERTIFIED PUBLIC ACCOUNTANTS • BUSINESS CONSULTANTS

INDEPENDENT AUDITOR'S REPORT

TO THE PARTICIPANTS AND PLAN ADMINISTRATOR OF
JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES

REPORT ON THE FINANCIAL STATEMENTS

We have audited the accompanying financial statements of JPMorgan Chase Health Care and Insurance Program for Active Employees, which comprise the statements of net assets available for benefits and of plan benefit obligations as of December 31, 2017 and 2016, and the related statements of changes in net assets available for benefits and of changes in plan benefit obligations for the years then ended, and the related notes to the financial statements.

MANAGEMENT'S RESPONSIBILITY FOR THE FINANCIAL STATEMENTS

Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

AUDITOR'S RESPONSIBILITY

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Plan's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

OPINION

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of JPMorgan Chase Health Care and Insurance Program for Active Employees as of December 31, 2017 and 2016, and the changes in its financial status for the years then ended in accordance with accounting principles generally accepted in the United States of America.

REPORT ON SUPPLEMENTAL INFORMATION

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of (1) assets (held at end of year) as of December 31, 2017 and (2) reportable transactions for the year ended December 31, 2017, together referred to as "supplemental information," are presented for the purpose of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

FAW CASSON & CO., LLP

Dover, Delaware
October 3, 2018

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES**

Statements of Net Assets Available for Benefits

December 31,	2017	2016
Assets		
Total investments at fair value	\$ 22,515,652	\$ 11,331,646
Total investments	22,515,652	11,331,646
Receivables:		
Employer contributions	88,796,488	87,350,925
Employee contributions	1,781,673	1,887,092
Claims, premiums, and administration fee refunds	3,763,304	13,107,408
Accrued interest	9,867	3,724
Total receivables	94,351,332	102,349,149
Insurance claims deposits	11,318,039	13,433,932
Cash (noninterest bearing)	5	9,242,964
Total assets	128,185,028	136,357,691
Liabilities		
Accrued administrative expenses	184,254	6,625,487
Long-term care premiums payable	555,774	578,204
Total liabilities	740,028	7,203,691
Net assets available for benefits	\$ 127,445,000	\$ 129,154,000

The accompanying notes to financial statements are an integral part of these statements.

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES**

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31,	2017	2016
Additions		
Contributions:		
Employer	\$ 1,245,147,874	\$ 1,252,801,050
Employee	592,999,271	567,494,030
Total contributions	1,838,147,145	1,820,295,080
Investment activities:		
Investment income	90,732	36,615
Net appreciation/(depreciation) in fair value of investments	(207)	7,377
Net increase from investment activities	90,525	43,992
Total additions	1,838,237,670	1,820,339,072
Deductions		
Claim payments to participants and health care providers	1,610,278,552	1,574,383,264
Premium payments for healthcare and insurance	129,830,316	129,008,317
Administrative expenses	98,259,448	108,157,228
Employee Assistance Program fee payments	1,578,354	1,548,301
Total deductions	1,839,946,670	1,813,097,110
Net change during the year	(1,709,000)	7,241,962
Net assets available for benefits, beginning of year	129,154,000	121,912,038
Net assets available for benefits, end of year	\$ 127,445,000	\$ 129,154,000

The accompanying notes to financial statements are an integral part of these statements.

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES**

Statements of Plan Benefit Obligations

December 31,	2017	2016
Estimated liability for benefits payable including claims incurred but not reported ("IBNR")	\$ 127,445,000	\$ 129,154,000
Postemployment benefit obligations:		
Medical, dental, and life insurance benefits for disabled participants	65,335,250	72,347,471
Disabled life liability	5,383,159	6,587,506
Total postemployment benefit obligations	70,718,409	78,934,977
Plan benefit obligations, end of year	\$ 198,163,409	\$ 208,088,977

The accompanying notes to financial statements are an integral part of these statements.

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES**

Statements of Changes in Plan Benefit Obligations

Years Ended December 31,	2017	2016
Estimated liability for benefits payable including IBNR claims:		
Plan obligations at beginning of year	\$ 129,154,000	\$ 121,912,038
Increase/(decrease) in plan benefit obligations attributable to:		
Net change in IBNR claims	(1,709,000)	7,241,962
Plan IBNR obligation, end of year	127,445,000	129,154,000
Postemployment benefit obligations, beginning of year	78,934,977	78,006,585
Increase/(decrease) in plan obligations attributable to:		
Benefits earned	27,348,451	37,448,690
Interest	165,399	194,342
Benefits reclassified to amounts currently payable	(28,795,872)	(39,287,581)
Changes in actuarial assumptions and other gains/(losses)	(6,934,546)	2,572,941
Net change during the year	(8,216,568)	928,392
Postemployment benefit obligations, end of year	70,718,409	78,934,977
Plan benefit obligations, end of year	\$ 198,163,409	\$ 208,088,977

The accompanying notes to financial statements are an integral part of these statements.

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
Notes to Financial Statements
December 31, 2017 and 2016**

1. Description of the Plan

The JPMorgan Chase Health Care and Insurance Program for Active Employees (the "Plan") is an employee health and welfare plan. The Plan is sponsored by JPMorgan Chase Bank, National Association ("JPMorgan Chase Bank, N.A."), a wholly-owned bank subsidiary of JPMorgan Chase & Co. ("JPMorgan Chase"), which is a leading global financial services firm and one of the largest banking institutions in the United States of America ("U.S."), with operations worldwide. JPMorgan Chase Bank, N.A. is a national banking association that has retail branches in 23 states and operates nationally as well as through non-U.S. bank branches and subsidiaries, and representative offices.

The following is a general description of the Plan. Refer to the Plan's Summary Plan Description and governing legal Plan document for a more complete description of the Plan.

General

The Plan provides coverage for medical, dental, vision, long-term disability ("LTD"), life insurance, accidental death and dismemberment ("AD&D"), group legal, and employee assistance benefits to participating employees, certain former employees on LTD and certain terminated employees ("Participants") of JPMorgan Chase and certain affiliated companies thereof ("Participating Employers"), as well as eligible dependents. These benefits are provided through self-insurance and commercial insurance contracts.

Assets of the Plan are held in a trust ("Trust"), which is administered by JPMorgan Chase Bank, N.A., as the Trustee. In its capacity as Trustee, JPMorgan Chase Bank, N.A. is responsible for the investment and safeguarding of the assets of the Plan. The Plan Administrators are appointed by the Board of Directors of JPMorgan Chase or JPMorgan Chase Bank, N.A. The Plan is subject to, and complies with, the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Selection Committee is responsible for appointing members of the Employee Plans Investment Committee ("EPIC") to control and manage the operations and administration of the assets of the trusts, including the appointment of a trustee and/or investment manager for the management of the assets of the trusts. (Effective January 16, 2018, the fiduciary responsibility for investing and managing the plan assets moved from EPIC to the Retirement Plan Investment Committee ("RPIC").) The JPMorgan Chase Health Care and Insurance Plans Appeals Committee hears eligibility appeals for certain plan options. The carriers for medical plan options utilize external review companies to hear claim appeals.

Eligibility

Participation in the Plan, including the choice of options and levels of coverage, is voluntary and solely the decision of the Participants. Except as otherwise provided below, all active full-time and part-time employees of the Participating Employers on the U.S. payroll who are regularly scheduled to work 20 hours or more per week ("Eligible Employees") are eligible to participate in any of the benefits available under the Plan. All benefits are effective the first day of the month after the hire date for full-time employees; and the first day of the month after 60 days from the hire date for part-time employees, provided an election is made within a designated 31-day enrollment period or during the annual enrollment period. Full-time employees are generally defined as those who are regularly scheduled to work 40 hours per week, and eligible part-time employees are those who are regularly scheduled to work at least 20 hours or more per week but less than 40 hours. Generally, the coverage that a Participant chooses during the annual enrollment period becomes effective as of January 1 of the following plan year, and it will stay in effect throughout the plan year unless there is a qualifying change in family or employment status when a Participant may be permitted to change their coverage. Eligible dependents may include the Participant's spouse or a domestic partner, and children up to the end of the month in which they attain age 26, assuming they meet certain requirements. Dependent children who are not capable of supporting themselves due to a mental or physical disability may continue their coverage under the Plan beyond age 26.

Coverage on termination of employment

Generally, participation in the Plan ends on the last day of the month in which a Participant terminates employment with JPMorgan Chase for medical, dental, vision and employee assistance plan benefits. In addition, employees who cease employment ("Former Employees") are entitled to continue to participate in the Plan for up to 18 months (which may be extended for a further period of time in the event of disability), as provided and in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). All other benefits end on the last day of employment. Employees on LTD are eligible to participate in the Plan for the first 24 months after going on approved LTD (i.e., 30 months after the first date of disability), after which time they will also be eligible to participate in the COBRA program. If the Former Employee meets the age and service requirements for retiree medical benefits, he/she may also be eligible to participate in the retiree medical plan at that time.

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
Notes to Financial Statements
December 31, 2017 and 2016**

Medical plan options

The medical plan provides two Consumer Driven Health Plan (“CDHP”) options, administered by Cigna and UnitedHealthCare (“UHC”). These medical plan options contain certain features such as 100% coverage with no deductible for in-network preventive care and certain preventive generic medications. The medical plan options have in-network and out-of-network benefits and separate deductibles and coinsurance levels that differ based on total annual cash compensation. The difference between the two medical plan options is that Option 1 has lower deductibles and coinsurance maximums and higher payroll contributions, while Option 2 has higher deductibles and coinsurance maximums and lower payroll contributions. A health reimbursement account - called the Medical Reimbursement Account (“MRA”) - is available for Participants to use to pay for eligible out-of-pocket medical and prescription drug expenses. The MRA is funded by JPMorgan Chase and includes funds that can be earned by all employees enrolled in the medical plan.

The prescription drug coverage under the medical plan is provided through the Prescription Drug Plan, which is administered by CVS Caremark. The Prescription Drug Plan gives Participants the option of having prescriptions filled at a retail pharmacy (in-network or any other pharmacy) or through a mail-order service. Long-term prescriptions are generally filled through Caremark’s mail order program or at a CVS pharmacy. Participants covered under these options pay a co-payment or coinsurance amount for filling each prescription drug which varies based on type of drug (generic, preferred brand and non-preferred brand), and whether it is filled at a retail or mail-order pharmacy (after meeting an annual deductible).

The Plan’s Employee Assistance Program (“EAP”) is administered by MHN. The EAP provides employees and their eligible dependents with access to confidential professional counseling for personal problems such as family conflict, substance abuse, stress, marital discord and personal finances. The cost of this program is fully funded by Participating Employers.

Dental plan options

The Dental Plan provides Participants with the following two types of coverage options:

1. Preferred Dentist Program (“PDP”) option, which provides dental coverage through either in-network or out-of-network dentists. In-network care is generally covered at a higher percent cost with lower annual deductibles as compared with out-of-network care. MetLife serves as the claims administrator for this option.
2. Dental Health Maintenance Organization (“DHMO”) option, which offers a broad range of dental services on a prepaid basis provided by dentists associated with the network. The claims administrators for this option are Aetna, Inc. and Cigna.

Medical and Dental plan contributions

The cost of benefits coverage provided by the Plan is shared by the Participating Employers and the Participants. The cost to Participants depends on the option and the level of coverage selected, total annual cash compensation, whether or not the employee and covered dependents use tobacco, whether or not the employee and covered spouse/domestic partner complete an online Wellness Assessment and biometric Wellness screening, where the Participant lives and covered family members. Prior to the start of the Plan year, employer and employee contributions are determined based on the projected total annual Plan costs. Employees pay for coverage with before-tax-dollars. Participating Employers may make additional contributions to the Trust during the year depending upon actual Plan costs. The projected total annual cost of claims for hospitalization, prescription drugs, medical and surgical benefits is based generally on past and emerging experience patterns. A terminated employee who elects to continue coverage under COBRA, pays contributions to the Plan equal to 102% of the terminated employee’s projected total annual Plan cost.

Employees may also elect to participate in The JPMorgan Chase Health Care Spending Account Plan which allows individuals to pay for eligible health care expenses that are not covered by the Plan through payroll deductions on a before-tax basis. The administration expenses related to this Plan are paid by JPMorgan Chase and not the Plan.

Long-term disability plan

The LTD Plan is an insured plan which provides replacement income to participating employees when they are unable to work for an extended period of time due to illness or injury. By participating in the Plan, employees may continue to participate in certain other benefit plans for a specified period of time (e.g., medical, dental, basic life insurance, and pension) if they incur a LTD and are approved by the LTD Plan’s insurance carrier.

Eligibility for long-term disability plan participation

Eligible employees who earn less than \$60,000 in total annual cash compensation are provided LTD coverage of 60% of total annual cash compensation, up to a monthly maximum benefit of \$3,000, fully paid by JPMorgan Chase, without making an election. Eligible employees who earn \$60,000 or more in total annual cash compensation must make an

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
Notes to Financial Statements
December 31, 2017 and 2016**

election within the 31-day enrollment period specified by the Plan Administrator. These participants may elect employee-paid LTD levels of benefit coverage of 50% or 60% of total annual cash compensation. Eligible compensation is limited to \$400,000 for those electing 60% coverage and \$480,000 for those electing 50% coverage. In all cases the maximum monthly LTD benefit is \$20,000. Employees who earn more than this limit can purchase additional LTD coverage under a fully portable Individual Disability Insurance Policy that would provide an additional maximum monthly LTD benefit of up to \$15,000. Coverage, which must be elected during an annual enrollment period, becomes effective as of January 1 of the following plan year, and is subject to approval by the Plan's claims administrator.

Evidence of Insurability ("EOI") is generally required if an Eligible Employee first elects to participate in the Plan after his/her new hire enrollment period or if a Participant elects to increase the amount of coverage at a later enrollment period. EOI is not required for a new hire provided the election to participate in the Plan is made within the 31-day enrollment period.

JPMorgan Chase has engaged Prudential to serve as the Plan's insurance carrier for the group LTD benefit and Unum for the Individual Disability Insurance Policy. Under the terms of the insurance policy, an employee participating in the Plan becomes eligible for LTD benefits if the insurance carrier determines that the Participant is unable to work due to sickness or disability. Benefit payments commence after 182 days of absence from work due to a disability. However, no benefits are payable if, during the first 12 months of coverage, a Participant becomes disabled due to a condition for which the Participant had a diagnosis or received treatment during the six months immediately preceding coverage under the Plan. This would include receiving treatment, consultation, care, or services (including diagnostic measures), or taking prescribed drugs or medicines for the condition in the six months prior to the effective date of coverage. It is solely Prudential/Unum's decision as to whether a Participant qualifies for benefits under the Plan. Thereafter, the duration of benefits is based upon the type of disability and age of the Participant at the time benefits commence. Benefits continue as long as the individual's condition meets the definition of a disability and the individual continues to provide the necessary evidence of his/her disability.

The LTD benefit amount is offset by any other disability-related compensation such as, but not limited to, U.S. Social Security disability and workers' compensation.

For participants who pay the full cost of coverage through after-tax payroll deductions, which varies with the level of coverage elected, total annual cash compensation and the employee's tobacco user status, benefits received are not subject to U.S. federal, state and local income taxes. For participants who are provided company paid LTD coverage, benefits received are fully taxable.

Basic life insurance plan

The Plan purchased a life insurance contract from Prudential to provide insurance coverage to Participants. (Effective January 1, 2017, the Plan's life insurance carrier is MetLife.) The amount of the insurance coverage is equal to each Participant's eligible compensation, which, for most Participants, is their annual salary/regular pay, rounded to the next \$1,000 increment, up to a maximum of \$100,000. (Effective January 1, 2017, the amount of life insurance will be based on total annual cash compensation rather than eligible compensation.) Coverage generally ceases upon termination of employment with JPMorgan Chase except for certain LTD recipients and for terminated employees who elect to convert their insurance coverage to an individual policy. The amount of coverage for LTD Participants is equal to the Participant's eligible compensation (up to a maximum of \$100,000) immediately prior to the disability.

If an insured Participant is diagnosed with a terminal illness that is expected to result in death within 12 months, the terminally ill Participant can apply for an "accelerated benefit" equal to 75% of the amount of basic life insurance and supplemental term life insurance coverage up to a maximum amount of \$500,000. The life insurance benefit payable to the decedent's beneficiary will be reduced by any amount advanced to the decedent.

Under the Internal Revenue Code ("Code"), the amount of the life insurance premium attributable to the value of the Basic Life Insurance coverage in excess of \$50,000 is defined as imputed income to the Participant, which is subject to U.S. federal, state and local income tax. Accordingly, the Participating Employers report such amounts to the IRS as taxable income to the affected Participants. A Participant with eligible compensation in excess of \$50,000 can choose to limit the Participant's basic life insurance amount to \$50,000. EOI rules will apply if the Participant wishes to increase the coverage later.

The Plan is a fully insured plan and is funded entirely through contributions by the Participating Employers. Contributions to the Plan are based on the projected total annual amounts of premiums that will be paid by Participating Employers on behalf of Participants.

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
Notes to Financial Statements
December 31, 2017 and 2016**

Other fully insured plan benefits

The Plan provides Participants the option to elect employee and dependent supplemental term life insurance, employee and dependent AD&D insurance, vision care, and group legal services which are all fully insured with various insurance companies. Participants pay the full cost of the benefits elected.

The Plan has purchased an insurance contract from Prudential to provide supplemental term life insurance coverage. (Effective January 1, 2017, the Plan's supplemental term life insurance carrier is MetLife.) The amount of insurance coverage that can be elected is as follows: employee coverage may be purchased in \$10,000 increments up to the lesser of ten times the employee's eligible compensation or \$3 million, spouse/domestic partner insurance coverage may be purchased in \$10,000 increments from \$10,000 up to \$300,000, and coverage per child is either \$5,000 or \$10,000. (Effective January 1, 2017, the amount of supplemental term life insurance for employees will be based on total annual cash compensation rather than eligible compensation. Further, child life insurance will have two additional levels of coverage to choose from: \$15,000 and \$20,000.) Employees pay for this coverage with after-tax-dollars.

The Plan has purchased an insurance contract from Prudential to provide AD&D insurance coverage. (Effective January 1, 2017, the Plan's AD&D insurance carrier is MetLife.) The amount of insurance coverage that can be elected is as follows: employee coverage may be purchased in \$10,000 increments up to ten times the employee's eligible compensation, up to a maximum of \$3 million, spouse/domestic partner insurance coverage may be purchased in \$10,000 increments from \$10,000 up to \$600,000, and coverage per child may be purchased in \$10,000 increments from \$10,000 up to \$100,000. Employees pay for this coverage with after-tax-dollars.

The Plan purchased an insurance contract from Prudential to provide long-term care ("LTC") insurance coverage. This coverage is available only to Participants who elected coverage prior to July 1, 2013, which they pay for using after-tax-dollars. There are seven daily maximum benefit options that could be elected; and coverage is available for employees, their spouse/domestic partner, and the parents and grandparents of both the employee and their spouse/domestic partner. The group LTC insurance policy was terminated effective December 31, 2017; members could elect to continue an individual policy directly with Prudential.

The Plan has purchased an insurance contract from VSP Vision Care, to provide eye care insurance coverage. Coverage is available for the employee, their spouse/domestic partner and eligible dependents. Employees pay for this coverage with before-tax-dollars.

The Plan has purchased an insurance contract from Hyatt Legal Plans, Inc., to provide coverage that includes attorney's fees for routine legal services related to personal and family legal issues. Coverage is available for employees, their spouse/domestic partner, and eligible dependents. Employees pay for this coverage with after-tax-dollars.

Insurance claims deposits

The Plan maintains prepaid cash deposits at JPMorgan Chase Bank, N.A. as required by certain third-party administrators to facilitate the payment of medical and dental claims. Insurance claims are paid from deposits, and the Plan replenishes the imprest amount weekly.

Account limit

The Plan uses Section 501(c)(9) trusts under the Code to fund healthcare and other benefits. All Participating Employer contributions to the trust are tax-deductible as long as Plan balances do not exceed the actuarially certified account limits for the applicable year.

Administrative expenses

The Plan pays administrative expenses for processing claims. JPMorgan Chase has elected to pay certain wellness program expenses on behalf of the Plan. The Participating Employers paid other expenses directly attributable to the administration of the Plan, which are not reflected in the financial statements.

2. Summary of significant accounting policies

Basis of presentation

The accounting and financial reporting policies of the Plan conform to accounting principles generally accepted in the United States of America ("U.S. GAAP").

Use of estimates in the preparation of financial statements

The preparation of financial statements requires Plan management to make estimates and assumptions that affect the reported amounts of assets, liabilities, Plan benefit obligations, changes in net assets available for benefits, liability for

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
Notes to Financial Statements
December 31, 2017 and 2016**

Incurred but not reported ("IBNR") claims, claims payable and disclosure of contingent assets and liabilities. Actual results could differ from these estimates.

Investment valuation and income recognition

All investments are recorded at fair value. For information related to the Plan's valuation methodologies for its investments, see Note 3.

Claims, premiums, and administrative fee refunds

The Plan may receive prescription drug rebates and administrative fee refunds from service providers under the terms of the contracts. The Plan may also receive fully insured premium refunds due to changes in the number of covered participants or coverage amounts. Such refunds are recorded when earned.

Liability for claims incurred but not reported

The Plan also maintains a reserve for IBNR claims, which is computed by AON Consulting utilizing actuarial methods that take into consideration prior claims experience and the expected time period from the date such claims are incurred to the date that the related claims are submitted to and paid by the Plan.

Claim payments to participants and healthcare providers

Claim payments are recorded when paid.

Administrative expenses

Expenses are recorded when incurred.

Plan benefit obligations

The estimated liability for medical and dental benefits, including the estimated liability for IBNR claims for Participants, is determined for the self-insured options based on past and emerging experience patterns. The Claims Administrators are responsible for processing and paying all claims submitted by Participants.

The postemployment benefit obligations represent the liability related to currently disabled individuals and their eligible dependents. For certain individuals participating in a heritage LTD benefit plan, the actuarial present values of the postemployment benefit obligations have been determined by the Plan's actuary. These values are estimated by applying actuarial assumptions to historical claims and cost data to estimated future annual claims costs per Participant. Such estimates are adjusted for the time value of money (through a discount rate for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

The significant actuarial assumptions used to determine the estimated postemployment benefit obligation for LTD benefits for this portion of the population under the Plan as of December 31, 2017 and 2016, were as follows:

- Interest discounts were at a rate of 2.82% and 2.85% at December 31, 2017 and 2016, respectively.
- Rates of Post Disability Death and Recovery were based on the Group Long-Term Disability Basic Table (select and ultimate) as published by the Society of Actuaries Committee to Recommend Disability Valuation Tables (January 28, 1987).
- Benefit reductions due to rehabilitation are ignored in calculating reserves due to the high probability of relapse to full claim status.

The foregoing assumptions were based on the presumption that the Plan would continue. If the Plan were to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligations.

The postemployment benefit obligation related to the remainder of the population, which are individuals who went on LTD within the past 24 months and their eligible dependents, is calculated based on historical claim data.

The excess of Plan benefit obligations over net assets at December 31, 2017 and 2016, of \$70,718,409 and \$78,934,977, respectively, was attributable to the postemployment benefit obligations, the funding of which was not covered by the current contribution rate. It is expected that the deficiency will be funded through future contributions from Participating Employers.

Heritage LTD claims are payable by the following insurance providers (depending on the original plan sponsor and the date of claims): The Hartford, Liberty Mutual, Prudential and Unum. All of these related LTD claims are excluded from the Plan benefit obligations except for claims made on or after January 1, 2011, and Plan benefit obligations do not include any estimated liability for IBNR claims.

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
Notes to Financial Statements
December 31, 2017 and 2016**

Differences between financial statements and IRS Form 5500

The Plan does not reflect as liabilities in the Statements of Net Assets Available for Benefits the estimated liability for benefits payable including IBNR claims. The U.S. Department of Labor, however, requires that these amounts be reported as a liability on IRS Form 5500, Annual Return/Report of Employee Benefit Plan ("Form 5500").

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500:

December 31,	2017	2016
Net assets available for benefits per the financial statements	\$ 127,445,000	\$ 129,154,000
Less: Estimated benefits/claims payable	(127,445,000)	(129,154,000)
Net assets available for benefits per Form 5500	\$ -	\$ -

The following is a reconciliation of benefits/claims paid to Participants and healthcare providers per the financial statements to the Form 5500:

Year ended December 31,	2017
Benefits/claims payments per the financial statements	\$ 1,610,278,552
Premium payments for healthcare and insurance per financial statements	129,830,316
Add: Estimated benefits/claims payable at December 31, 2017	127,445,000
Less: Estimated benefits/claims payable at December 31, 2016	(129,154,000)
Benefits/claims paid and payable per Form 5500	\$ 1,738,399,868

Accounting and reporting developments**Financial Accounting Standards Board ("FASB") Standards Issued but not yet Adopted**

Standard	Summary of guidance	Effects on financial statements
Financial instruments - credit losses <i>Issued June 2016</i>	<ul style="list-style-type: none"> Replaces existing incurred loss impairment guidance and establishes a single allowance framework for financial assets carried at amortized cost, which will reflect the Plan's estimate of credit losses over the full remaining expected life of the financial assets. 	<ul style="list-style-type: none"> Required effective date: January 1, 2021. Management of the Plan does not believe implementation of the guidance will have a material impact on the Plan's financial statements.

3. Fair value measurements**Determination of fair value**

Following is a description of the Plan's valuation methodologies for assets measured at fair value. The Plan has an established and well-documented process for determining fair values. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value is based upon quoted market prices, where available.

The Plan uses various methodologies and assumptions in the determination of fair value. The use of different methodologies or assumptions by other market participants compared with those used by the Plan could result in a different estimate of fair value at the reporting date.

During 2017, no changes were made to the Plan's valuation model that had, or are expected to have, a material impact on the Plan's Statements of Changes in Net Assets Available for Benefits.

Valuation hierarchy

A three-level valuation hierarchy has been established under U.S. GAAP for disclosure of fair value measurements. The valuation hierarchy is based on the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 - inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.
- Level 2 - inputs to the valuation methodology include quoted prices for similar assets and liabilities in active markets, and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument.

JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
Notes to Financial Statements
December 31, 2017 and 2016

- Level 3 - one or more inputs to the valuation methodology are unobservable and significant to the fair value measurement.

A financial instrument's categorization within the valuation hierarchy is based on the lowest level of input that is significant to the fair value measurement.

Following is a description of the valuation methodologies used for instruments measured at fair value, including the general classification of such instruments pursuant to the valuation hierarchy.

Assets

Registered investment company

This investment is a public investment vehicle this is valued based on the calculated net asset value ("NAV") of the fund. This fund produces a daily NAV that is validated by a sufficient level of observable activity (i.e., purchases and sales at NAV), the NAV is used to value the fund investment, and it is classified in level 1 of the valuation hierarchy.

The investment strategies for registered investment companies vary, and they may invest directly and indirectly in a broad range of equities, debt and derivative investments with the objective of mirroring or exceeding the total return of certain market indices (e.g., S&P 500 Index, Russell 1000 Index, Bloomberg Barclays U.S. Aggregate Bond Index). Strategies may vary based on global macroeconomic views, expected directional movements in the financial markets, market capitalization (e.g., large, medium or small cap stocks), and other strategies. Certain of these investments could be subject to restrictions on redemption in the future; and they may be sold based on the level of capital markets activity, market levels, the performance of the broader economy and investment-specific issues.

The Plan has no unfunded commitments related to investments that are valued at NAV.

Money market fund

These investments are valued based on NAV and are classified within level 1 of the valuation hierarchy.

The following table presents the financial instruments carried at fair value as of December 31, 2017 and 2016, by major product category.

Assets measured at fair value on a recurring basis

December 31,	2017	2016
Registered investment company	\$ 208,930	\$ 206,253
Money market fund	22,306,722	11,125,393
Total assets measured at fair value	<u>\$ 22,515,652</u>	<u>\$ 11,331,646</u>

(a) For the years ended December 31, 2017 and 2016, there were no transfers between fair value hierarchy levels.

4. Transactions with affiliated parties

Certain plan investments are managed by parties that meet the definition of affiliated parties as defined by the Plan. The following summary of transactions qualify as party-in-interest transactions for the years ended December 31, 2017 and 2016.

	Aggregate cost of purchases		Aggregate proceeds from sales and redemptions	
	2017	2016	2017	2016
JPM U.S. Treasury Plus MM Fund Institutional Shares	\$ 637,700,956	\$ 433,469,923	\$ 626,519,625	\$ 431,118,751
JPM Managed Income Fund	2,887	514,872	3	4,000,000

5. Tax status

The Trust established under the Plan has qualified for tax-exempt status under provisions of Section 501(c)(9) of the Code. Under this provision of the Code, income earned by the trust is not taxable. The Plan has been amended since the trust received a favorable tax determination letter from the IRS. However, the Plan Administrator believes that the Trust, as amended, continues to qualify and to operate in compliance with the requirements of the Code. Therefore, no provision for income taxes has been included in the Plan's financial statements.

U.S. GAAP requires management of the Plan to evaluate tax positions taken by the Plan and recognize an income tax liability if the Plan has taken uncertain tax positions that more-likely-than-not would not be sustained upon examination by applicable taxing authorities. Management of the Plan has analyzed tax positions taken by the Plan and has concluded

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
Notes to Financial Statements
December 31, 2017 and 2016**

that, as of December 31, 2017 and 2016, there were no uncertain tax positions taken, or expected to be taken, that would require recognition of a liability or that would require disclosure in the financial statements. The Plan is subject to routine audits by taxing authorities. However, currently no audits are in progress for any tax period.

6. Commitments and contingencies

In accordance with the provisions of U.S. GAAP for contingencies, the Plan accrues for a litigation-related liability when it is probable that such a liability has been incurred and the amount of the loss can be reasonably estimated. Plan management evaluates the Plan's outstanding legal proceedings, if any, periodically to assess whether any litigation reserve is required, and makes adjustments in such reserves, upwards or downwards, as appropriate, based on Plan management's best judgment after consultation with counsel.

While the outcome of litigation is inherently uncertain, Plan management believes, based upon its current knowledge, after consultation with counsel, in light of all information known to it at December 31, 2017, that there are no pending or threatened legal proceedings affecting the Plan that would require the establishment of a litigation reserve. There is no assurance that the Plan will not need to establish a reserve, or to adjust the amount of such a reserve, for a litigation-related liability in the future.

7. Risks and uncertainties

The Plan's investments include financial instruments that are exposed to various risks such as interest rate, market, credit and country risks. Due to the level of risk associated with certain financial instruments, it is at least reasonably possible that changes in the values of financial instruments will occur in the near term and such changes could materially affect the amounts reported in the Statements of Net Assets Available for Benefits.

The Plan's exposure to a concentration of credit risk is limited by the diversification of the investment instruments in the registered investment company, which are further diversified into various financial instruments, including securities issued or guaranteed by the U.S. government or its agencies.

The Plan's prepaid cash deposits are held in a noninterest-bearing cash account at JPMorgan Chase Bank, N.A. The deposits are insured by the Federal Deposit Insurance Corporation ("FDIC") up to \$250,000. None of the Plan's other investments are insured by the FDIC.

Plan contributions are made and the actuarial present value of benefit obligations are reported based on certain assumptions including but not limited to interest rates, health care inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

8. Plan termination

JPMorgan Chase intends to continue the Plan, but reserves the right to amend, modify or terminate the Plan at any time. Upon termination of any Trust, the assets must be used to satisfy all liabilities to existing beneficiaries and then to provide various benefits to existing Participants. Eligible claims covered by the Plan will be paid according to the terms of the Plan.

9. Subsequent events

In preparing the financial statements, management of the Plan has performed an evaluation of material events that occurred subsequent to December 31, 2017, and through October 3, 2018, the date these financial statements were available to be issued. There were no material subsequent events that occurred that would require disclosure or recognition in these financial statements.

JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
 FOR ACTIVE EMPLOYEES
 PLAN NUMBER: 502 - EIN: 13/4994650
 SCHEDULE OF ASSETS (HELD AT END OF YEAR) AT DECEMBER 31, 2017
 (IRS FORM 5500 - SCHEDULE H - PART IV - LINE 4I)

(A)	(B)	(C)	(D)	(E)
IDENTITY OF ISSUE, BORROWER, LESSOR, OR SIMILAR PARTY		DESCRIPTION OF INVESTMENT INCLUDING MATURITY DATE, RATE OF INTEREST, COLLATERAL, PAR OR MATURITY VALUE	COST	CURRENT VALUE
REGISTERED INVESTMENT COMPANY (MUTUAL FUND):				
*	JPM MANAGED INCOME FUND	20,872 UNITS	\$ 209,138	\$ 208,930
MONEY MARKET FUND:				
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	22,306,722 UNITS	22,306,722	22,306,722
	TOTAL INVESTMENTS		<u>\$ 22,515,860</u>	<u>\$ 22,515,652</u>
* PARTY-IN-INTEREST AS DEFINED BY ERISA				

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
PLAN NUMBER: 502 - EIN: 13/4994650
SCHEDULE OF REPORTABLE TRANSACTIONS AT DECEMBER 31, 2017
(IRS FORM 5500 - SCHEDULE H - PART IV - LINE 4J)**

(A)	(B)	(C)	(D)	(G)	(H)	(I)
IDENTITY OF PARTY INVOLVED	DESCRIPTION OF ASSET (INCLUDING INTEREST RATE AND MATURITY IN CASE OF A LOAN)	PURCHASE PRICE	SELLING PRICE	COST OF ASSET	CURRENT VALUE OF ASSETS ON TRANSACTION DATE	NET GAIN (LOSS)
SINGLE TRANSACTIONS UNDER SECTION 2520.103-6(C) (L) (I):						
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	\$ 1.00		\$ 12,270,490	\$ 12,270,490	\$ -
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		\$ 1.00	13,231,983	13,231,983	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,248,681	11,248,681	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	10,307,185	10,307,185	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,320,235	11,320,235	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	15,968,525	15,968,525	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		30,294,775	30,294,775	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	24,171,884	24,171,884	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,264,534	17,264,534	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		12,634,392	12,634,392	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	14,261,475	14,261,475	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		21,474,754	21,474,754	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	18,727,739	18,727,739	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		17,746,982	17,746,982	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,746,982	17,746,982	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		18,736,912	18,736,912	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	20,785,847	20,785,847	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,744,617	11,744,617	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,477,497	17,477,497	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,236,179	13,236,179	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	20,230,149	20,230,149	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,787,831	11,787,831	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	16,296,898	16,296,898	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,114,007	13,114,007	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	15,676,184	15,676,184	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,881,007	11,881,007	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	11,601,592	11,601,592	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,508,999	13,508,999	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	14,182,826	14,182,826	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,217,230	13,217,230	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	21,180,258	21,180,258	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		16,603,259	16,603,259	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,659,459	17,659,459	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,920,146	11,920,146	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	12,848,890	12,848,890	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,289,017	13,289,017	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	14,299,766	14,299,766	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		17,302,613	17,302,613	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,264,560	17,264,560	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,269,282	13,269,282	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	12,139,864	12,139,864	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,587,519	13,587,519	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	13,911,616	13,911,616	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,424,793	13,424,793	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	14,243,259	14,243,259	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,884,982	11,884,982	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	10,974,596	10,974,596	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,187,952	13,187,952	-

JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
 FOR ACTIVE EMPLOYEES
 PLAN NUMBER: 502 - EIN: 13/4994650
 SCHEDULE OF REPORTABLE TRANSACTIONS AT DECEMBER 31, 2017
 (IRS FORM 5500 - SCHEDULE H - PART IV - LINE 4J)

(A)	(B)	(C)	(D)	(G)	(H)	(I)
IDENTITY OF PARTY INVOLVED	DESCRIPTION OF ASSET (INCLUDING INTEREST RATE AND MATURITY IN CASE OF A LOAN)	PURCHASE PRICE	SELLING PRICE	COST OF ASSET	CURRENT VALUE OF ASSETS ON TRANSACTION DATE	NET GAIN (LOSS)
SERIES TRANSACTIONS UNDER SECTION 2520.103-6(C) (L) (II):						
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES					-
	637,700,956 UNITS, 319 BUYS	1.00		637,700,956	637,700,956	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES					-
	626,519,625 UNITS, 242 SELLS		1.00	626,519,625	626,519,625	-

NOTE 1: THE THRESHOLD FOR REPORTING TRANSACTIONS UNDER DEPARTMENT OF LABOR PROVISIONS IS FIVE PERCENT OF THE FAIR VALUE OF THE PLAN'S ASSETS AT THE BEGINNING OF THE YEAR OF \$136,357,691. FIVE PERCENT OF THIS AMOUNT IS \$6,817,885.

NOTE 2: COLUMNS '(E) LEASE RENTAL' AND '(F) EXPENSE INCURRED WITH TRANSACTION' HAVE BEEN OMITTED AS THERE IS NO DATA TO REPORT IN THESE COLUMNS.

*RELATED PARTY TRANSACTIONS.

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
PLAN NUMBER: 502 - EIN: 13/4994650
SCHEDULE OF REPORTABLE TRANSACTIONS AT DECEMBER 31, 2017
(IRS FORM 5500 - SCHEDULE H - PART IV - LINE 4J)**

(A)	(B)	(C)	(D)	(G)	(H)	(I)
IDENTITY OF PARTY INVOLVED	DESCRIPTION OF ASSET (INCLUDING INTEREST RATE AND MATURITY IN CASE OF A LOAN)	PURCHASE PRICE	SELLING PRICE	COST OF ASSET	CURRENT VALUE OF ASSETS ON TRANSACTION DATE	NET GAIN (LOSS)
SINGLE TRANSACTIONS UNDER SECTION 2520.103-6(C) (L) (I):						
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	\$ 1.00		\$ 12,270,490	\$ 12,270,490	\$ -
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		\$ 1.00	13,231,983	13,231,983	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,248,681	11,248,681	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	10,307,185	10,307,185	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,320,235	11,320,235	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	15,968,525	15,968,525	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		30,294,775	30,294,775	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	24,171,884	24,171,884	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,264,534	17,264,534	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		12,634,392	12,634,392	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	14,261,475	14,261,475	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		21,474,754	21,474,754	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	18,727,739	18,727,739	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		17,746,982	17,746,982	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,746,982	17,746,982	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		18,736,912	18,736,912	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	20,785,847	20,785,847	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,744,617	11,744,617	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,477,497	17,477,497	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,236,179	13,236,179	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	20,230,149	20,230,149	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,787,831	11,787,831	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	16,296,898	16,296,898	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,114,007	13,114,007	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	15,676,184	15,676,184	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,881,007	11,881,007	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	11,601,592	11,601,592	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,508,999	13,508,999	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	14,182,826	14,182,826	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,217,230	13,217,230	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	21,180,258	21,180,258	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		16,603,259	16,603,259	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,659,459	17,659,459	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,920,146	11,920,146	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	12,848,890	12,848,890	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,289,017	13,289,017	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	14,299,766	14,299,766	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		17,302,613	17,302,613	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	17,264,560	17,264,560	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,269,282	13,269,282	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	12,139,864	12,139,864	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,587,519	13,587,519	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	13,911,616	13,911,616	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,424,793	13,424,793	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	14,243,259	14,243,259	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		11,884,982	11,884,982	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES		1.00	10,974,596	10,974,596	-
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	1.00		13,187,952	13,187,952	-

**JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES**

PLAN NUMBER: 502 - EIN: 13/4994650

**SCHEDULE OF REPORTABLE TRANSACTIONS AT DECEMBER 31, 2017
(IRS FORM 5500 - SCHEDULE H - PART IV - LINE 4J)**

(A)	(B)	(C)	(D)	(G)	(H)	(I)
IDENTITY OF PARTY INVOLVED	DESCRIPTION OF ASSET (INCLUDING INTEREST RATE AND MATURITY IN CASE OF A LOAN)	PURCHASE PRICE	SELLING PRICE	COST OF ASSET	CURRENT VALUE OF ASSETS ON TRANSACTION DATE	NET GAIN (LOSS)
SERIES TRANSACTIONS UNDER SECTION 2520.103-6(C) (L) (II):						
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES					-
	637,700,956 UNITS, 319 BUYS	1.00		637,700,956	637,700,956	-
	* JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES					-
	626,519,625 UNITS, 242 SELLS		1.00	626,519,625	626,519,625	-

NOTE 1: THE THRESHOLD FOR REPORTING TRANSACTIONS UNDER DEPARTMENT OF LABOR PROVISIONS IS FIVE PERCENT OF THE FAIR VALUE OF THE PLAN'S ASSETS AT THE BEGINNING OF THE YEAR OF \$136,357,691. FIVE PERCENT OF THIS AMOUNT IS \$6,817,885.

NOTE 2: COLUMNS '(E) LEASE RENTAL' AND '(F) EXPENSE INCURRED WITH TRANSACTION' HAVE BEEN OMITTED AS THERE IS NO DATA TO REPORT IN THESE COLUMNS.

*RELATED PARTY TRANSACTIONS.

JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM
FOR ACTIVE EMPLOYEES
PLAN NUMBER: 502 - EIN: 13/4994650
SCHEDULE OF ASSETS (HELD AT END OF YEAR) AT DECEMBER 31, 2017
(IRS FORM 5500 - SCHEDULE H - PART IV - LINE 4f)

(A)	(B)	(C)	(D)	(E)
IDENTITY OF ISSUE, BORROWER, LESSOR, OR SIMILAR PARTY		DESCRIPTION OF INVESTMENT INCLUDING MATURITY DATE, RATE OF INTEREST, COLLATERAL, PAR OR MATURITY VALUE	COST	CURRENT VALUE
REGISTERED INVESTMENT COMPANY (MUTUAL FUND):				
*	JPM MANAGED INCOME FUND	20,872 UNITS	\$ 209,138	\$ 208,930
MONEY MARKET FUND:				
*	JPM U.S. TREASURY PLUS MM FUND INSTITUTIONAL SHARES	22,306,722 UNITS	22,306,722	22,306,722
	TOTAL INVESTMENTS		<u>\$ 22,515,860</u>	<u>\$ 22,515,652</u>
* PARTY-IN-INTEREST AS DEFINED BY ERISA				