UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

SETH STERN, ANGELA BINDNER, and MARIANNE SCHMITT, on their own behalf, on behalf of all others similarly situated, and on behalf of the JPMorgan Chase Health Care and Insurance Program for Active Employees and its component Medical Plan, Plaintiffs, v. JPMORGAN CHASE & CO., JPMORGAN CHASE BANK N.A., JPMORGAN CHASE U.S. BENEFITS EXECUTIVE, and JPMORGAN CHASE COMPENSATION & MANAGEMENT DEVELOPMENT COMMITTEE, Defendants.	Case No. 1:25-cv-02097 (JLR)

DECLARATION OF KAI RICHTER

I, Kai Richter, declare and state as follows:

1. I am Of Counsel at Cohen Milstein Sellers & Toll PLLC and am one of the attorneys representing Plaintiffs in the above-captioned action. I submit this transmittal declaration in opposition to Defendants' Motion to Dismiss.

2. Attached hereto as Exhibit 1 is a true and excerpt of the Form 5500 for the JPMorgan Chase Health Care and Insurance Program for Active Employees for 2023.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: July 25, 2025

/s/ Kai H. Richter
Kai H. Richter

EXHIBIT 1

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) ___

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ [ ]

Part II Basic Plan Information—enter all requested information

1a Name of plan
JPMORGAN CHASE HEALTH CARE AND INSURANCE PROGRAM FOR ACTIVE EMPLOYEES

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 04/01/1955

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)
JPMORGAN CHASE BANK, NATIONAL ASSOCIATION

545 WASHINGTON BLVD
12TH FLOOR, MAIL CODE NY1-G120
JERSEY CITY, NJ 07310

2b Employer Identification Number (EIN) 13-4994650

2c Plan Sponsor's telephone number 844-275-5762

2d Business code (see instructions) 522110

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.	09/19/2024	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

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)

CVS CAREMARK

05-0340626

(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	3117435	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

OHIO COORDINATED CARE INC.

1201 2ND AVENUE
SUITE 1400
SEATTLE, WA 98101

(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	2750932	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(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	2049424	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐