

Kaiser HMO Overview

Offered to U.S. benefits-eligible employees living in California

Effective January 1, 2022

Effective January 1, 2022, U.S. benefits-eligible employees who live in California, will be offered an additional medical plan option – the Kaiser HMO Option, managed by Kaiser Permanente. The Kaiser HMO Option will be offered in addition to Option 1 and Option 2 with Aetna or Cigna. **The Kaiser Permanente Health System offers services in most – but not all – California zip codes.** If available in your area, Kaiser HMO will be one of the options you see when visiting the Benefits Web Center during Annual Benefits Enrollment. If you live in an area where Kaiser does not offer services, you will see only Options 1 and 2 with Aetna or Cigna.

Under the Kaiser HMO Option, most services – such as primary care and specialist office visits, urgent care visits, x-rays, and lab work – have copays and are not subject to the deductible. There is a \$1,000 deductible that applies to a small subset of services (e.g., hospital care, outpatient surgery). After meeting the deductible, you'll pay the applicable coinsurance amount. After you reach your annual out-of-pocket maximum, you won't have to pay copay or coinsurance for covered services for the rest of the calendar year. Kaiser Permanente is the administrator of the Kaiser HMO Prescription Drug Plan.

Kaiser HMO Option: How it works

Kaiser Permanente is a fully integrated health system that employs physicians and other medical staff and owns hospitals, facilities, and pharmacies. As is common in an HMO, a primary care physician (PCP) will be responsible for wholly managing your care and your family's care, including the coordination of care with other providers, such as specialists. Therefore, you will need to select a Kaiser PCP for each covered family member.

What's important to note is that **out-of-network care is not covered under the Kaiser HMO Option, except for emergencies.** If you enroll in the Kaiser HMO, you will need to receive all non-emergency services from Kaiser doctors, facilities and affiliated providers starting on Jan. 1, 2022. Non-emergency services you receive from non-Kaiser doctors, facilities and affiliated providers will not be covered by the Kaiser HMO Option starting Jan. 1, 2022. Therefore, you should strongly consider the appropriateness of electing Kaiser if you are in active treatment for a serious medical condition (e.g. chemotherapy for cancer) or are pregnant and are unwilling to change all of your doctors and facilities where you receive care immediately starting Jan. 1, 2022.

If you're considering enrolling in the Kaiser HMO and covering a dependent who resides outside of California (for example, a child attending college), there are limited covered services available to this dependent while outside of California – primarily virtual doctor visits and emergency care. Given this, you should carefully consider whether the Kaiser HMO Option will meet the needs of you and your family.

This overview provides details of the Kaiser HMO features, including prescription drug coverage and explains how other aspects of your health care benefits work, including the Medical Reimbursement Account (MRA). It also includes detailed information about the many wellness features, tools and resources that can help you manage your well-being. Our goal is to help you better understand your benefits so you can make informed decisions about the health care option that works best for you and your family in 2022 and beyond.

Complete a Wellness Screening and Wellness Assessment for 2022 MRA Funds

Save \$500 on your 2022 medical payroll contributions and earn \$200 in your 2022 Medical Reimbursement Account (MRA) when you complete both a biometric Wellness Screening **and** online Wellness Assessment between November 21, 2020 and November 19, 2021 (11:59 p.m. ET). Plus, when your covered spouse/domestic partner also completes both activities during this timeframe, you'll save an additional \$500 on your 2022 medical payroll contributions and earn an additional \$100 in your 2022 MRA. **However, you will not be eligible to earn funds in your 2022 MRA funds for Additional Wellness Activities.** See details starting on page 8.

Coverage effective after September 1, 2021?

Employees who become eligible for benefits coverage after September 1, 2021 will automatically save \$500 (or \$1,000 if covering a spouse/domestic partner) on both 2021 and 2022 medical payroll contributions without completing the Initial Wellness Activities in 2021. They will have until the 2022 Initial Wellness Activities deadline (to be communicated in 2022) to earn 2022 MRA dollars for completing the Initial Wellness Activities; however, if they complete the Initial Wellness Activities by November 19, 2021 (11:59 p.m. ET), they will earn \$200 in their 2021 MRA and \$200 in their 2022 MRA. Covered spouses/domestic partners will earn \$100 in the employee's 2021 MRA and \$100 in the employee's 2022 MRA.

Details can be found on **My Health**.

On a leave of absence? See details on page 9.

*The Kaiser HMO Option is part of the JPMC Medical Plan and is available only to those U.S. benefits-eligible employees residing in California, where Kaiser Permanente is available. The Kaiser HMO Overview is a Summary of Material Modification to the JPMC Medical Plan. For complete plan details, see the Summary Plan Descriptions (SPDs) found on **My Health** > Learn About the JPMC Benefits Program > Benefits Plan Details (Summary Plan Descriptions).*

How the Kaiser HMO Option Works

Kaiser Permanente is a fully integrated health system that employs physicians and other medical staff and owns hospitals, facilities, and pharmacies. That makes getting the care you need when you need it, simple and convenient.

- There are technically two Kaiser HMO Options in California: Northern and Southern. (You'll see which Kaiser HMO is available to you as you enroll on the Benefits Web Center or by calling Kaiser Permanente.) Both HMOs offer the same copays, deductibles and out-of-pocket maximums; and the medical plan services and prescription drugs covered are primarily the same. If you have questions, contact Kaiser Permanente at **1-800-204-6561**, Monday through Friday between 8 a.m. and 6 p.m., Pacific Time.
- Plan benefits are offered through Kaiser Permanente's network of doctors, hospitals, labs, outpatient facilities and pharmacies.
- **Important note:** Out-of-network care is not covered under the Kaiser HMO Option, except for emergencies. This means only services provided by a Kaiser provider at a Kaiser office/facility/hospital will be covered by the Kaiser HMO Option. Generally, if you receive non-emergency care outside of a Kaiser provider/setting, you will be responsible for the full cost of that care.
- A primary care physician (PCP) will be responsible for wholly managing your care and your family's care, including the coordination of care with other providers, such as specialists. You are required to select a Kaiser PCP for each covered family member. You can change your PCP at any time, for any reason.
 - Go to Kaiser's website accessible through **My Health > My Medical Plan Website** or directly at my.kp.org/jpmc to search for PCPs.
- You will generally need referrals to see a specialist.
- For most services, like primary care and specialist visits, urgent care visits, x-rays, lab work and imaging, you have copays—a fixed out-of-pocket amount—with no deductible to meet. (See the charts on pages 3-4.)
 - In-network preventive care, including physical exams and recommended preventive screenings, is covered at 100% with no cost to you.
- There is a \$1,000 individual deductible (\$2,000 for family) to meet that only applies to a small subset of services (e.g., hospital care, outpatient surgery). Once you meet the deductible, then the Plan will begin sharing in costs of these services – this is known as “coinsurance”. (See the charts on pages 3-4 for information on the coinsurance amounts for applicable services.)
- The Kaiser HMO's out-of-pocket maximum (\$2,000 for individual; \$4,000 for family)—your financial “safety net”—limits the total amount you are required to pay out-of-pocket each year. The out-of-pocket maximum includes the deductible as well as both medical and prescription drug amounts (i.e., a combined maximum).
- Prescription drug coverage is managed by Kaiser Permanente. There is no prescription deductible. Prescription drug coverage copays are based on the drug category and where you fill your prescription. Preventive generic and brand drugs are covered at 100%, with no cost to you. Kaiser maintains its own list of covered drugs, also known as its formulary. This list is different than the covered drug list managed by CVS Caremark. If you are currently taking prescriptions which are not covered by Kaiser (and enroll in Kaiser in 2022), you will need to transition to the drugs covered by the Kaiser HMO Option or pay the full cost of the drugs. (See page 6 for details.)
- The Kaiser HMO can be used in conjunction with a Medical Reimbursement Account (MRA) to help pay for eligible out-of-pocket medical and prescription drug expenses. The MRA is funded by JPMorgan Chase when you take action and complete designated Wellness Activities. Employees cannot contribute funds to an MRA. (More details about the MRA starts on page 8.)
- Your MRA, Health Care Spending Account (HCSA), and Dependent Care Spending Account (DCSA) will be administered by Cigna.

Defined Terms

Copay – The fixed dollar amount you pay for certain covered services.

Coinsurance – The way that you and the Plan share a percentage of the costs for certain covered services.

Deductible – The amount you pay upfront each calendar year before the Plan begins to pay benefits.

Overview of Plan Information

The charts below and on the following pages present an overview of plan features for the Kaiser HMO. For more information and details, see the Kaiser Permanente Evidence of Coverage document which can be found on **My Health** > Learn About the JPMC Benefits Program > Benefits Plan Details (Summary Plan Descriptions), available in early 2022.

Deductibles

The Kaiser HMO has deductibles that apply to a small subset of services, which varies based on coverage level.

COVERAGE LEVELS	DEDUCTIBLE
Employee (Also serves as “per person” ¹ amount)	\$1,000 ¹
Family	\$2,000

Copayments (Copays) and Coinsurance

In the Kaiser HMO, for the majority of services you have copays with no deductible to meet. The plan deductible only applies to a small subset of services, then you and the Plan will share in the cost of services, known as coinsurance.

Remember: You are required to select a Primary Care Physician (PCP) for each covered family member and you need referrals to see a specialist in the Kaiser HMO.

MEDICAL SERVICE	COPAY & COINSURANCE AMOUNTS
Well child/preventive care visit (also includes routine prenatal care)	No charge
Primary care visit (PCP, Pediatrician, OB/GYN)	\$20 copay with no deductible
Specialist visit	\$30 copay with no deductible
Urgent care visit	\$20 copay with no deductible
Virtual doctor visit	No charge
Outpatient procedure/surgery	20% coinsurance after deductible
Emergency* room (ER) visit	20% coinsurance, deductible does not apply
Hospitalization (inpatient admission)	20% coinsurance after deductible
X-rays and lab tests	\$10 copay with no deductible
Advanced imaging (CT/MRI/PET) – per service	20% coinsurance up to a maximum of \$100, deductible does not apply
Physical therapy, speech therapy, occupational therapy service	\$20 copay per visit with no deductible, no visit limits
Chiropractic visit	\$30 copay with no deductible; 20 visit limit per year
Acupuncture (restrictions apply)	\$30 copay with no deductible; 20 visit limit per year
Ambulance - per ride	\$150, deductible does not apply
MENTAL HEALTH	
Inpatient psychiatric care	20% coinsurance after deductible
Outpatient individual therapy visits	\$20 per visit, deductible does not apply
Outpatient group therapy visits	\$10 per visit, deductible does not apply
Inpatient detoxification	20% coinsurance after deductible
Infertility Services	20% coinsurance after deductible; IVF, GIFT & ZIFT, 3 cycle lifetime limit

¹ For the deductibles, the “per person” rule allows the employee or any covered dependent(s) (e.g., spouse/domestic partner or child) to reach an individual deductible, after which the deductible is satisfied for the year for that person. Covered individuals who have not met the deductible may combine to meet the family deductible level. If no one person has met the individual deductible, the expenses of all covered individuals can combine to meet the family deductible level.

ADDITIONAL BENEFITS	
Durable Medical Equipment	20% coinsurance, deductible does not apply
Skilled Nursing Facility	20% coinsurance after deductible, 120 day limit per benefit period
Home Health	No charge, 120 visit limit per year
Hospice Care	No charge
Hearing Aids	\$1,500 allowance per ear, per aid; every 36 months

* True emergency as determined based on what a prudent person would consider an emergency, not on the final diagnosis reached by doctors.

Annual Out-Of-Pocket Maximums

These annual out-of-pocket maximums are across both medical and prescription drugs. Details on the Prescription Drug Plan starts on page 6. Please Note: These annual out-of-pocket maximums are inclusive of the deductibles.

COVERAGE LEVELS	OUT-OF-POCKET MAXIMUMS ²
Employee (Also serves as the “per person” maximum)	\$2,000
Family	\$4,000

NOTE: The Core Medical Plan has separate out-of-pocket maximums (and deductibles) for Medical and Prescription Drugs, but Kaiser HMO combines those two amounts. This makes it easier for you to track to a single number to determine your costs.

Per-Person Rule: For the out-of-pocket maximums, the “per person” rule allows the employee or any covered dependent(s) [e.g., spouse/domestic partner or child] to reach an individual out-of-pocket maximum, after which the out-of-pocket maximum is satisfied for the year for that person. Covered individuals who have not met the out-of-pocket maximum may combine to meet the remainder of the out-of-pocket maximum for family coverage level. If no one person has met the individual out-of-pocket maximum, the expenses of all covered individuals can combine to meet the out-of-pocket maximum for family coverage level.

Types of Services

The Kaiser HMO Plan is an insured medical plan option. Kaiser Permanente is the claims administrator and fiduciary of the Kaiser HMO Plan. For more information and details, see the Kaiser Permanente Evidence of Coverage document which can be found on **My Health > Learn About the JPMC Benefits Program > Benefits Plan Details (Summary Plan Descriptions)**, available in early 2022.

Total Annual Cash Compensation (TACC)

Under the Medical Plan, Total Annual Cash Compensation (TACC) is used to determine your Medical Plan contribution pay tier, deductibles, copays and the annual in-network out-of-pocket maximum. For the Kaiser HMO, TACC is used to determine your contribution pay tier only; other plan features do not vary based on TACC.

Your TACC is:


- Your annual rate of base salary plus applicable job differential pay (for example, shift pay) as of each August 1, plus
- Any cash earnings from any incentive plans (for example, annual incentive compensation, commissions, draws, overrides, and special recognition payments or incentives) that are paid to or deferred by you for the previous 12-month period ending each July 31.
- Overtime is not included.

For purposes of determining the Medical Plan contribution pay tier that applies to you, your TACC is recalculated as of each August 1 to take effect the next January 1, and will remain unchanged throughout the year. For most employees hired on or after August 1, TACC will be equal to base salary plus job differentials. You can find your TACC on the Benefits Web Center. Just click **Your Profile > Personal Information > Personal Details**.

Separate definitions may apply to employees in certain positions who are paid on a draw-and-commission basis. If this situation applies to you, you will be notified in writing.

² Out-of-pocket maximums include the deductibles.

Please Note: Your TACC is measured as of August 1 and remains unchanged for purposes of determining Medical Plan contribution pay tier that applies to you for the next calendar year.

TIER	TOTAL ANNUAL CASH COMPENSATION	EMPLOYEE PAYS
1	Less than \$45,000	Least  Most
2	\$45,000 - \$59,999	
3	\$60,000 - \$79,999	
4	\$80,000 - \$149,999	
5	\$150,000 - \$249,999	
6	\$250,000 - \$349,999	
7	\$350,000 and above	

Medical Payroll Contributions

You and JPMorgan Chase share in the cost of coverage under the Kaiser HMO. Your contributions toward the cost of coverage are deducted from your pay on a before-tax basis before federal (and, in most cases, state and local) income taxes are withheld. The amount you pay in 2022 depends on:

- Number and type of eligible dependents³ you cover,
- Level of your TACC in effect for the plan year,
- If you and/or your covered spouse/domestic partner completed **both** a biometric Wellness Screening and online Wellness Assessment between November 21, 2020 and November 19, 2021, and/or
- If you and/or covered spouse/domestic partner use tobacco. The 2022 tobacco user surcharge will be \$80 per month, or \$960 annually, for each adult. If you identify both you and your covered spouse/domestic partner as tobacco users for 2022, the surcharge will be \$160 per month or \$1,920 annually.

Tobacco Cessation

Get the support you need to quit tobacco by enrolling in the Tobacco Cessation Program. You'll receive coaching over the phone and online support, a copy of a Quit Guide, and free quitting aids at no cost (e.g., patches, gum). You also avoid the 2022 tobacco user surcharge if you complete the Tobacco Cessation Program by Dec. 3, 2021.

Provided by: *Quit for Life*. Call 1-866-QUIT-4-LIFE (1-866-784-8454). You can also access the program through **My Health** > Wellness Activities & Services.

Dependent Coverage

In addition to covering yourself under the Kaiser HMO, you can also cover your eligible dependents, but generally only under the same option you choose for yourself. Your eligible dependents under the Kaiser HMO include:

- Your spouse/domestic partner (see the tip sheet, [Covering a Domestic Partner](#) found on **My Health**); and
- Your and/or your spouse's/domestic partner's children up to the last day of the month in which they reach age 26, regardless of student or marital status, financial dependence on parents, residency with parents, or eligibility for coverage under another health plan. To cover your domestic partner's children, you must elect coverage for your domestic partner.

Please Note: You may continue coverage beyond age 26 for an unmarried child who depends on you for financial support, is enrolled in that benefit and is deemed unable to support him/herself because of a mental or physical disability that began before age 26. Contact Kaiser Permanente for more information and specific requirements before your dependent turns 26. To continue coverage for a disabled dependent, that dependent must be enrolled in the JPMorgan Chase Medical Plan prior to turning age 26.

Important! You are responsible for understanding the dependent eligibility rules applicable to each Plan and abiding by them. For details, see the tip sheet, [Dependent Eligibility Requirements](#) or the Core Medical Plan Summary Plan Description (SPD) found on **My Health** > Learn About the JPMC Benefits Program.

³ If you cover children, you will be charged for up to a maximum of three children, regardless of how many additional children you choose to cover (you can cover all of your children, as long as they meet eligibility requirements).

If you are adding a dependent to your coverage for 2022, you'll need to provide that dependent's Social Security Number and provide required substantiation documents. Go to the **My Health > Benefits Web Center** and you'll be prompted for the Social Security Number when adding each dependent for coverage.

Transition of Dependents to Kaiser HMO

If you have already provided dependent eligibility support documentation and your dependents were authorized to be covered under the JPMorgan Chase Medical Plan in 2021, you do **not** need to provide documentation again for those same dependents if you change health care companies for 2022.

Prescription Drug Coverage

Your prescription drug coverage is part of the Kaiser HMO and is administered by Kaiser Permanente. You won't need to make a separate election for prescription drug coverage; it's covered by your Kaiser HMO election. Kaiser has its own pharmacies, which must be used to fill your prescription drugs.

Please note: Kaiser's list of covered drugs (formulary) is different than CVS Caremark's. Therefore, if you are currently taking prescription drugs and are contemplating enrolling in the Kaiser HMO Option for 2022, you should review the Kaiser covered drug list online or speak with a Kaiser representative to understand whether your prescription drug will be covered by the Kaiser HMO Option. If you are currently taking prescriptions that are not covered by Kaiser (and enroll in Kaiser in 2022), you will need to transition to the drugs covered by the Kaiser HMO Option or pay the full cost of the drugs.

Contact Kaiser at **1-800-204-6561** if you have questions about your drug coverage or visit my.kp.org/jpmc.

Free Preventive Generic and Brand Drugs

To encourage preventive care, eligible preventive generic and brand drugs are covered at 100% with no cost to you. Preventive drugs are medications that can help prevent the onset of a condition if you are at risk or help you manage your health if you have a condition.

The Kaiser Permanente Preventive Drug List includes generic and brand drugs covered at 100%, as determined by Kaiser Permanente.

If You Take a Non-Covered Drug

If you choose to take a non-covered drug, you will pay the **full cost** of the drug. This could be a costly option.

Categories of Prescription Drugs

Your prescription drug coverage depends on the type of drug your doctor prescribes and where you fill your prescription. Prescription drugs are split into two main categories – traditional drugs and specialty drugs.

Traditional drugs, also known as non-specialty drugs, are usually the ones which most people are familiar with and represent the majority of prescription drugs used. This includes medicines used to treat common conditions like high blood pressure, diabetes and asthma, and most short-term medicines used to treat acute conditions like coughs, flu and infections. Traditional drugs generally don't have special handling or shipping requirements, and are lower cost.

Specialty drugs are generally used to treat complex medical conditions such as rheumatoid arthritis, multiple sclerosis and psoriasis. These drugs include biological drugs, often require special handling, such as refrigeration, and are usually higher cost.

Types of Prescription Drugs within the Traditional and Specialty Categories

Kaiser Permanente maintains its own list of covered drugs, also known as its formulary, which covers three tiers of drugs:

- **Traditional generic drugs** that have equivalent ingredients to brand-name drugs, but generally cost less.
- **Traditional preferred brand name drugs** that have been patented by the companies that developed them and placed on a preferred drug list by Kaiser Permanente. They're generally more expensive than generic drugs.
- **Specialty drugs, including both generics and brands.**

Please note:

- Eligible preventive generic and brand drugs are covered at 100% with no cost to you.
- Not all pharmaceutical manufacturer coupon or copay assistance cards are accepted at Kaiser pharmacies. If you are using a copay card and would like to know if it is accepted, contact Kaiser at **1-800-204-6561**.

You can use your Medical Reimbursement Account (MRA) to help pay for eligible prescription drug expenses (copays and coinsurance).

Overview of Your Prescription Drug Coverage

Important!

These copay amounts are maximum amounts. If the drug costs less than the copay, you pay the lesser amount.

PRESCRIPTION DRUG BENEFIT PROVISIONS	KAISER HMO
Retail	
Preventive drugs	Covered 100%
Generic drugs	\$10 copay
Brand drugs	\$30 copay
Non-preferred generic and brand name drugs	Not covered; pays at generic, brand, specialty cost if approved exception
Specialty drugs	20% coinsurance with no deductible, up to \$150 maximum per prescription
Pharmacy deductible	Not Applicable
Days supply	Up to 30 days
Mail-Order	
Preventive drugs	Covered 100%
Generic drugs	\$20 copay
Brand drugs	\$60 copay
Non-preferred generic and brand name drugs	Not covered; pays at generic, brand, specialty cost if approved exception
Specialty drugs	20% coinsurance with no deductible, up to \$150 maximum per prescription
Pharmacy deductible	Not Applicable
Days supply	Up to 100 days

How to Fill Your Prescription Drugs

Kaiser has its own pharmacies, which must be used. You generally do not have the flexibility to fill a prescription at a local retail pharmacy (for example, CVS retail pharmacies). Most prescriptions can be filled through mail order or online for home delivery or same-day pickup. When selecting mail order, you will receive a 100-day supply.

Kaiser maintains its own list of covered drugs, also known as its formulary. Certain drugs may have quantity limits or are excluded from coverage. **Therefore, if you are currently taking prescription drugs not covered by Kaiser, you'll need to switch to a covered alternative or pay the full cost of the drug.** As such, you should strongly consider if the Kaiser HMO Option is right for you for 2022 if you are unwilling to change prescription drugs (if your current prescription is not covered by Kaiser). To speak to a Kaiser clinician with questions about prescription drugs you're currently taking, call Kaiser at 1-800-204-6561. **Please note:** You may want to refill any prescription drugs you are currently taking before your transition to Kaiser to avoid any interruption in your medications.

Contact Kaiser or go to the Kaiser Permanente website for information

To find additional information, including how to locate a local Kaiser pharmacy near you and a list of covered and excluded drugs (formularies), contact Kaiser at 1-800-204-6561 or by visiting my.kp.org/jpmc.

Kaiser HMO Wellness Program

Medical Reimbursement Account (MRA) and Medical Payroll Contribution Savings

A key part of our Medical Plan and wellness strategy is to engage employees in specific Wellness Activities by providing MRA funds. JPMorgan Chase contributes money to your MRA to help you pay for eligible out-of-pocket medical and prescription drug expenses. You cannot contribute your own money to the MRA. Cigna will administer your MRA.

How You Can Earn Funds for Your 2022 MRA

INITIAL WELLNESS ACTIVITIES (BIOMETRIC WELLNESS SCREENING AND ONLINE WELLNESS ASSESSMENT)

Save \$500 on your 2022 medical payroll contributions and earn \$200 in your 2022 Medical Reimbursement Account (MRA) when you complete both a biometric Wellness Screening **and** online Wellness Assessment between November 21, 2020 and November 19, 2021 (11:59 p.m. ET). Plus, when your covered spouse/domestic partner also completes both activities during this timeframe, you'll save an additional \$500 on your 2022 medical payroll contributions and earn an additional \$100 in your 2022 MRA. **The Kaiser HMO Option does not offer incentives for completing Additional Wellness Activities.** That's because the Kaiser model is an integrated coordinated care model where activities like coaching and treatment decision support are part of the care you receive from your providers – and not carved out as separate activities to be completed and incented. The savings generated from this more limited wellness incentive program have been reinvested back into the Kaiser HMO Option.

- If the Wellness Screening was completed at your doctor's office, make sure the *Wellness Screening Results Form* (found on **My Health** > Wellness Activities & Services > Wellness Screening and Assessment) is submitted as soon as possible, but no later than November 19, 2021.
- You have until June 30, 2022, to open a case with Cigna if you believe your Initial Wellness Activities were completed by the deadline and are not reflected in your medical payroll contributions.

Important: Starting in January 2022, your 2022 medical payroll contributions will initially reflect these savings. If you and/or your covered spouse/domestic partner chooses **not** to complete both activities between **Nov. 21, 2020 – Nov. 19, 2021**, your medical payroll contributions will increase in March 2022 for both you and/or your covered spouse/domestic partner. The full \$500 (or \$1,000) increase will be applied in equal installments to each pay from the first effective pay in March through December 2022.

Transition of your MRA from the Core Medical Plan to the Kaiser HMO

If you enroll in the Kaiser HMO for 2022, Cigna will be the administrator of your MRA. Cigna will also be the administrator of your spending accounts – Health Care Spending Account (HCSA) and Dependent Care Spending Account (DCSA) – if you elect to participate in these plans in 2022.

If you were enrolled with Cigna in 2021, your account will remain with them and you will have immediate access to your funds starting on January 1, 2022 to pay for eligible 2022 medical and prescription drug expenses with Kaiser. If you had a debit card with Cigna, you can continue to use that same debit card. If you had elected automatic claims payment with Cigna, your election will change to debit card coincident with your enrolling in Kaiser and a debit card will be mailed to your home from Cigna in late December 2021.

If you were enrolled with Aetna in 2021, your MRA balance will automatically transfer in April 2022 to Cigna; this will allow Aetna to pay residual 2021 claims on your behalf. You will continue to have access to your account on PayFlex.com (an Aetna subsidiary) throughout 2022 to view and submit claims for eligible 2021 expenses. As the debit card election is the only payment option available with Kaiser HMO, a debit card will be mailed to your home from Cigna in late December 2021.

For additional details on the Health Care Spending Account (HCSA) see page 9; for Transition to Debit Card details, see page 12.

If you become eligible for benefits coverage — and/or you add your spouse/domestic partner for medical coverage — after September 1, 2021:

Employees who become eligible for benefits coverage after September 1, 2021 will automatically save \$500 (or \$1,000 if covering a

spouse/domestic partner) on both 2021 and 2022 medical payroll contributions without completing the Initial Wellness Activities in 2021. They will have until the 2022 Initial Wellness Activities deadline (to be communicated in 2022) to earn 2022 MRA dollars for completing the Initial Wellness Activities; however, if they complete the Initial Wellness Activities by November 19, 2021 (11:59 p.m. ET), they will earn \$200 in their 2021 MRA and \$200 in their 2022 MRA. Covered spouses/domestic partners will earn \$100 in the employee's 2021 MRA and \$100 in the employee's 2022 MRA.

If you are on an approved Leave of Absence:

Employees who are on an approved Leave of Absence for at least 45 consecutive days between September 1 and November 19, 2021, and do not complete their biometric Wellness Screening and online Wellness Assessment during that timeframe will automatically save \$500 in 2022 on their medical payroll contributions (or \$1,000 if they cover a spouse/domestic partner). Other provisions of the JPMorgan Chase Medical Plan and Wellness Program will continue to apply.

What's a biometric Wellness Screening and online Wellness Assessment?

Biometric Wellness Screening — a biometric health check that measures blood pressure, body mass index (BMI), blood sugar, cholesterol, triglycerides and A1C. These numbers are indicators of overall health that have proven to help more people understand their health, uncover health risks and receive earlier treatment. See [How to complete your biometric Wellness Screening](#) found on **My Health**. To see your options, use the [Wellness Screening Portal](#) on **My Health**.

Online Wellness Assessment — a survey that asks questions about your biometric numbers, current health condition, diet, lifestyle, health goals, sleep patterns and more. The information you provide generates a wellness score of your overall health and tips on how to achieve your health goals. See [How to complete your online Wellness Assessment with Cigna](#) found on **My Health**.

Together, your Wellness Screening and Assessment results provide you with helpful information about what you're doing well, recommendations for improving your health and potential issues to discuss with your doctor.

JPMorgan Chase does not receive the data from your Wellness Screening and Wellness Assessment. That information goes directly to your health care company. See Privacy information on page 12 for more details.

Wellness Rewards if You Don't Enroll in a JPMorgan Chase Medical Plan for 2022

You (the employee) will still be able to earn Wellness Rewards up to \$200 in 2022, payable (and taxable) through payroll in January 2022 when you complete **both** a biometric Wellness Screening and an online Wellness Assessment between November 21, 2020 – November 19, 2021. Wellness Rewards are not available to spouses/domestic partners of employees who do not enroll in the JPMorgan Chase Medical Plan.

Note: Wellness Rewards for employees not enrolled in the JPMorgan Chase Medical Plan are intended for those whose medical insurance does not provide similar cash incentives.

You can find more information on your Wellness Rewards program on **My Health** > [Not Enrolled in JPMC Medical?](#)

Health Care Spending Account (HCSA)

During Annual Benefits Enrollment, you can elect to contribute to a Health Care Spending Account (HCSA) on a before-tax basis up to the annual maximum for 2022 to pay for eligible out-of-pocket health care expenses. With respect to eligible medical and prescription drug out-of-pocket expenses, your MRA funds are used first.

You may use your HCSA for these eligible expenses after your MRA funds are depleted:

- Medical and prescription drug copays, deductibles and coinsurance

You may use your HCSA for these eligible expenses immediately as MRA funds cannot be used:

- Costs for over-the-counter medications for which you have a prescription and all forms of insulin (even if you do not have a prescription);
- Dental deductibles and coinsurance **not** covered under any Dental Plan you may be enrolled in; **and**
- Eyeglasses and contact lenses for amounts **not** covered under any Vision Plan you may be enrolled in.

What is an HCSA?

Also known as a Flexible Spending Account, an HCSA is a tax-free way for you to pay for eligible out-of-pocket health care expenses. It means you'll save money on certain expenses that are not reimbursed by your medical (including your MRA), dental, or vision plans.

Note: Certain expenses, such as those for cosmetic surgery or health care premiums, are not reimbursable under the HCSA.

The HCSA is generally subject to the “use it or lose it” rule. This means that you lose unused funds that are left in your account at year-end. However, COVID-19-related regulations changed some of the rules for the HCSA. These special rules are no longer applicable beginning in 2022.

- **Election changes throughout 2022:** You can only make changes to your HCSA contribution election if you have a qualified status change (QSC) — such as marriage, birth of a child, etc. **Please note:** The 2021 special provision allowing you to make changes without experiencing a QSC is not applicable beginning January 1, 2022.
- **HCSA carryover of balances from 2021 to 2022:** Your full remaining 2021 balance will automatically carry over into your 2022 account, once claims you have in 2021 and submitted by the March 31, 2022 deadline have been processed/reimbursed. Your carryover balance can then be used for reimbursement of eligible expenses you have in 2022.
- **HCSA carryovers become limited:** Starting with the 2022 plan year, carryovers from prior year HCSA balances will be limited to the IRS maximum (most recently \$550). **Please note:** The special provision allowing you to carry over full HCSA balances ends with the 2021 rollover balance.
- **New plan rule for HCSA Carryovers:** Under a new plan rule, if you do not choose to contribute to the HCSA in a given plan year, any balance you carried over from a prior year will be forfeited at the end of the year if you do not use it.
How this works: If you do not choose to contribute in 2022:
 - 2021 unused balances under \$25 will not carry over and will be forfeited.
 - You can still access your 2021 carryover balance(s) if you have at least \$25 in your HCSA; however, you must use this balance for eligible expenses by December 31, 2022 and submit those claims by the 2022 claims filing deadline – March 31, 2023. Any remaining 2021 balances after this date will be forfeited.
- If you don’t think you’ll spend your carryover balance from 2021 in 2022, consider electing to make a small contribution to your HCSA for 2022, which will allow the carryover of your balance to 2023. Remember, though, that the carryover from 2022 to 2023 will be limited to the IRS maximum (most recently \$550).
- Any balance that remains in your HCSA at the end of 2021 can be carried over to use toward 2022 eligible out-of-pocket health care expenses. So, keep any projected carryover amounts in mind when making your decision about how much to contribute in 2022.

Your 2022 MRA funds and any MRA funds that carry over from 2021 must be used **first** to pay for eligible out-of-pocket medical and prescription drug expenses before you can use your HCSA funds. It’s important to take this into consideration when planning your 2022 HCSA election.

Carry Over MRA Funds From Year to Year

Any unused MRA funds at year-end will automatically carry over to the next year to pay for eligible out-of-pocket medical and prescription drug expenses (copays, deductibles and coinsurance). Be sure to factor in any unused MRA funds from the prior year when considering any Health Care Spending Account (HCSA) elections during Annual Enrollment each year as MRA funds are used first for eligible medical and prescription drug expenses. Keep in mind that, if you enroll in the Kaiser HMO Option in 2022, you can earn MRA funds for Initial Wellness Activities only. Unused MRA funds are forfeited upon termination unless you are eligible to enroll in retiree medical coverage or elect COBRA. More information can be found in the [As You Leave guide](#) found on me@jpmc.

HCSA Claim Filing Deadline

The claim filing deadline for 2021 expenses is March 31, 2022. The claim filing deadline for 2022 expenses is March 31, 2023. Be sure to file your claims before this deadline.

Who Administers Your HCSA?

If you enroll in Kaiser for 2022, Cigna will be the administrator of your HCSA.

Transition of your HCSA

If you were enrolled in the HCSA in 2021 and Cigna administered your HCSA, Cigna will remain your administrator and you do not need to take any action related to your account. Your account will be available for 2022 expenses beginning on January 1.

If you were enrolled in the HCSA in 2021 and Aetna administered your account, any remaining 2021 account balance will automatically transfer to Cigna (your new HCSA administrator) in April 2022, after the 2021 claims run out period. This will allow Aetna to process final 2021 claims prior to transitioning your account to Cigna. Your 2022 election amount will be available for expenses beginning on January 1 through your Cigna debit card.

Your Dependent Care Spending Account (DCSA)

Cigna will be the administrator of your DCSA (as well as your MRA and HCSA). If Cigna administered your DCSA, your account will remain with Cigna. If Aetna administered your DCSA, your remaining 2021 DCSA balance will transfer to Cigna in April 2022.

Comparing Your MRA and HCSA

MRA (a feature of your Medical Plan)	HCSA (an account you elect separately)
<p>Your MRA is funded exclusively by JPMorgan Chase and consists of:</p> <ul style="list-style-type: none">Initial Wellness Funds: For completing both the Wellness Screening and Wellness Assessment.Unused MRA funds carryover from year to year.	<p>Your HCSA is funded by you via payroll deductions, on a before-tax basis, based on the election you make during enrollment.</p> <p>Any balance that remains in your HCSA at the end of 2021 can be carried over to use toward 2022 eligible out-of-pocket health care expenses. (If you decide not to contribute in 2022, up to \$550 of HCSA funds automatically carry over; however, you must use those funds by Dec. 31, 2022 (note: any unused amounts less than \$25 will not carry over; they will be forfeited.) So, keep any projected carryover amounts in mind when making your decision about how much to contribute in 2022.</p> <p>Carryover from 2022 to 2023 will be limited to the IRS maximum (most recently \$550). The special provision allowing carryover of full HCSA balances ends with the 2021 carryover balance.</p>
<p>The MRA can be used only for eligible out-of-pocket medical and prescription drug expenses, including medical and prescription drug copayments, deductibles and coinsurance.</p> <p>MRA funds cannot be used for other expenses (e.g., dental and vision).</p> <p>See the tip sheet, MRA, HCSA and Payment Options on My Health > Benefits Enrollment > 2022 Benefits Resources.</p>	<p>Your HCSA can be used to pay for the same out-of-pocket costs paid by your MRA, after you have used up your MRA funds; AND</p> <p>Other eligible out-of-pocket health care costs, such as dental and vision, which cannot be paid out of your MRA.</p> <p>See the tip sheet, MRA, HCSA and Payment Options on My Health > Benefits Enrollment > 2022 Benefits Resources.</p>

Payment Method for your MRA/HCSA

When you enroll in the Kaiser HMO, you will receive a Debit Card from Cigna (your account administrator) which will allow you to pay your portion of eligible expenses from your MRA and HCSA (if you elect to participate in the HCSA). **You do not have the option of automatic claims payment with Kaiser HMO.**

With the Debit Card, you have the option of using your Debit Card or paying with your personal funds for eligible expenses. Keep in mind that you will need to keep your receipts and be prepared to substantiate any Debit Card claims, as required by the IRS. The same Debit Card accesses funds from both your MRA and HCSA, if applicable.

If you pay with your personal funds for eligible expenses, you can later submit an online claim form for reimbursement from your Aetna or Cigna MRA or HCSA or a paper claim form (via mail or fax). The paper reimbursement form can be found on **My Health** and the Cigna website.

Transition to Debit Card

- **If you were enrolled with Cigna in 2021 and:**
 - Had a **debit card** with Cigna, you can continue to use that same debit card.
 - Elected **automatic claim payment** with Cigna in 2021, Cigna will continue to process your eligible 2021 claims through the claims run out period. Beginning January 1, 2022, your election will change to debit card, which will be mailed to your home by Cigna in late December 2021. Use your new debit card for new services starting on January 1, 2022; you cannot use your debit card to pay for care with dates of service prior to January 1, 2022.
- **If you were enrolled with Aetna in 2021 and:**
 - Had a **debit card** issued by PayFlex (an Aetna subsidiary), your PayFlex card will stop working on January 1, 2022. You will automatically receive a debit card at your home address issued by Cigna in late December 2021 and should begin using that card starting on January 1, 2022; you cannot use your debit card to pay for care with dates of service prior to January 1, 2022. **Please note:** If you have expenses related to 2021 claims, you will need to pay using other funds and then file for reimbursement from your MRA or HCSA. (You'll file 2021 claims with Aetna through March 31, 2022 and file claims with Cigna after that date.)
 - Elected **automatic claim payment** with PayFlex, you will automatically receive a debit card at your home address issued by Cigna in late December 2021 and should begin using that card starting on January 1, 2022; you cannot use your debit card to pay for care with dates of service prior to January 1, 2022. PayFlex will continue to process 2021 claims against your MRA or HCSA until March 31, 2022. If you have 2021 claims to process after this date, you will need to file those with Cigna.

Please note: Cigna will also be the administrator for the Dependent Care Spending Account (DCSA). Debit cards are not available for the DCSA and all claims will have to be manually submitted (fax, mail, online, Cigna app).

Take Advantage of Onsite JPMC Health & Wellness Centers and Employee Assistance Program

At the JPMC Health & Wellness Centers, you have access to basic medical services and educational resources – many at no charge to you. The Centers provide medical care, treatment, and resources when you need them at work to supplement the care and direction you get from your own doctor. Doctors are also available at most JPMC Health and Wellness Centers to provide additional onsite care when you need it. More information is available on **My Health** > Wellness Activities & Services.

Use the Employee Assistance Program (EAP) and Work-Life services for free, confidential, short-term counseling and referrals to help you and your family handle stress, depression, relationship issues, addiction and eating disorders, and other emotional well-being concerns. You can receive up to five free EAP counseling sessions per issue – even before you use your medical benefits.

Call 1-877-576-2007 or go online:

- **From work: type go/eap into your intranet browser and select U.S. region.**
- **From home: eapandworklife.com**

Your Privacy is Important

The privacy of your health information is important to you and to JPMorgan Chase. We are committed to protecting your personal health information, and complying with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). This means that when you complete a Wellness Screening or a Wellness Assessment, participate in any health coaching activities, or receive health care treatment of any kind, your personal health information is not disclosed to anyone, including JPMorgan Chase, without your authorization and except as permitted by HIPAA. (For detailed information about your HIPAA Privacy Rights, please see the Privacy Notice found on **My Health**).

My Health

Health and wellness questions can arise at any time. With **My Health**, you have a centralized resource with 24/7 access to information related to your Medical Plan and health care company, your MRA, wellness activities, tip sheets on how the plan works, the Benefits Web Center for enrollment information, and much more for you and your covered spouse/domestic partner.

As an employee, **My Health** provides one-stop access to all of your medical plan, prescription plan, and MRA information on a personalized basis. Simply use your Single Sign-On password to access **My Health**. You can access **My Health** from work or through the internet:

- From work: **My Health** via me@jpmc or type “go/myhealth” into your intranet browser.

- From internet: myhealth.jpmorganchase.com

Spouse/DP Access to My Health: The internet URL can be used by both employees and spouses/domestic partners anywhere. Spouses/Domestic Partners can access **My Health** without a password, but their health care company's website will require their own username and password.

Expert Medical Advice

If enrolled in the Kaiser HMO, you and your covered family members have access to Expert Medical Advice through Grand Rounds. It's free and voluntary.

Leading expert physicians are available to review documentation on an initial diagnosis you've received, recommended treatment plan for a condition or diagnosis, complex medical condition, scheduled surgery/major procedure and medications you are taking.

For more information, go to **My Health** > Medical Specialty Services To access Expert Medical Advice, contact Grand Rounds:

- Online: www.grandrounds/jpmc
- Phone: 1-888-868-4693; 8 a.m. to 9 p.m., Eastern Time, Monday through Friday
- Mobile app: download from the iPhone or Android app store (search: Grand Rounds)
- JPMC Health & Wellness Center (employees only)

What Happens If You Move During the Year

If you are a resident of California for the entire year, the Medical Plan option you enrolled in for that year will be the only plan you are eligible for and can participate in. Even if you have a qualified status change (e.g. have a baby), while you may be eligible to make certain changes to your benefits plans in a given year, you cannot change the plan option you selected for January 1 (Option 1, Option 2, Kaiser HMO Option) or the health care company you selected (Aetna, Cigna, Kaiser Permanente). However, if you are enrolled in the Medical Plan and move into or out of the state of California in a calendar year, your Medical Plan enrollment will change as follows:

If you are enrolled in the JPMC Medical Plan and move out of California in 2022:

- Beginning January 1, 2022, if you are enrolled in Option 1 or 2 of the JPMC Medical Plan and move to Arizona or Ohio during the calendar year, you'll automatically be enrolled in the JPMC Simplified Medical Plan, effective when you submit your address change. Please note that your health care company (Aetna/Cigna), election (Option 1 or 2) and dependent coverage will remain the same and cannot be changed as a result of your move.
- If you are enrolled in the Kaiser HMO Option and move out of California during the calendar year, in order to ensure continued coverage in the Medical Plan in the absence of Kaiser being available outside of California, you will automatically be enrolled in Cigna Option 2, Core or Simplified, based on your new home state effective when you submit your address change. However, you are strongly encouraged to review your options (Aetna/Cigna, Option 1 or 2) and change your election as needed by contacting HR Answers within 31 days of your move.

If you are enrolled in the JPMC Medical Plan and move to California in 2022:

- If you are enrolled in Option 1 or 2 of the JPMC Medical Plan and move to California during the calendar year, you will remain in the JPMC Medical Plan and your health care company (Aetna/Cigna), election (Option 1 or 2) and dependent coverage will remain the same and cannot be changed as a result of your move.
- If you are enrolled in Option 1 or 2 of the JPMC Simplified Medical Plan and move from Arizona/Ohio to California during the calendar year, you'll automatically be enrolled in the JPMC Medical Plan, effective when you submit your address change. Please note that your health care company (Aetna/Cigna), election (Option 1 or 2) and dependent coverage will remain the same and cannot be changed as a result of your move.

Questions?

Additional information to help you make informed health care choices at any time can be found on **My Health**.

You may also contact:

For questions about the Kaiser HMO (Coverage, Claims or Costs), including prescription drugs	
Kaiser Permanente <i>Kaiser can answer any medical and prescription drug plan related questions including claims questions, how to find a provider and questions about the network</i>	1-800-204-6561 ; 8 a.m. to 6 p.m. Pacific Time, Monday through Friday
For questions about Initial Wellness Activities and MRA/HCSA/DCSA	
Cigna <i>Cigna can answer questions related to the Wellness Assessment and Screening, and transition of your MRA/HCSA/DCSA</i>	1-800-790-3086 ; 24/7
For enrollment and general benefits questions	
HR Answers	You can send a question to HR Answers through me@jpmc , or call 1-877-JPMChase (1-877-576-2427) or 1-212-552-5100 if calling from outside the United States; 8 a.m. to 7 p.m. Eastern Time, Monday through Friday Quick Path: Enter your Standard ID or Social Security Number; press 2; enter your PIN; press 6.
For additional help when working with your health care company about: claims, health-related inquiries, and health care reform	
Health Advocate	1-866-611-8298 ; 8 a.m. to 9 p.m. Eastern Time, Monday through Friday
For Expert Medical Advice	
Grand Rounds	1-888-868-4693 ; 8 a.m. to 9 p.m., Eastern Time, Monday through Friday

The JPMorgan Chase U.S. Benefits Program is generally available to most full-time and part-time U.S. dollar-paid, salaried employees who are regularly scheduled to work 20 hours or more a week and who are employed by JPMorgan Chase & Co. or one of its subsidiaries to the extent that such subsidiary has adopted the JPMorgan Chase U.S. Benefits Program. This information does not include all of the details contained in the applicable insurance contracts, plan documents, and trust agreements. If there is any discrepancy between this information and the governing documents, the governing documents will control. JPMorgan Chase & Co. expressly reserves the right to amend, modify, reduce, change, or terminate its benefits and plans at any time. The JPMorgan Chase U.S. Benefits Program does not create a contract or guarantee of employment between JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

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