Health Care Participation

Effective 1/1/22

This section describes the general guidelines for participating in the JPMorgan Chase Medical, Dental and Vision Plans (the "Plans"). Participating in the Plans and their programs is optional — the choice is yours!

Be Sure to See *What Happens If …*

This section covers information about topics such as who is eligible, how to enroll, when you can change your coverage, when coverage ends, and opportunities to continue your coverage after it ends.

Be sure to also see the *What Happens If...* section, which describes how a wide variety of life events and situations can affect your benefits and/or give you an opportunity to adjust your coverage.

About This Summary

This section summarizes eligibility, enrollment and other participation information for the Medical, Dental and Vision Plans. Please retain this section for your records. Other sections may be needed in addition to this section to provide a complete summary plan description (SPD) and/or plan document for a plan, including the sections that describe the benefits the plan provides and Plan Administration.

These summaries/SPDs/plan documents do not include all of the details contained in the applicable insurance contracts, if any. For plans with applicable insurance contracts, if there is a discrepancy between the insurance contract and the summary/SPD/plan document, the insurance contract will control.

The JPMorgan Chase U.S. Benefits Program is available to most employees on a U.S. payroll 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 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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Who's Eligible?

In general, you are eligible to participate in the Medical, Dental, and Vision Plans if you are:

- Employed by JPMorgan Chase & Co., or one of its subsidiaries that has adopted the Plan, on a U.S. payroll and you are subject to FICA taxes;
- Paid hourly, salary, draw, commissions, or production overrides; and
- Regularly scheduled to work 20 or more hours per week.

Who's Not Eligible

An individual who does not meet the criteria under "Who's Eligible?" as well as an individual classified or employed in a work status other than as a common law salaried employee by his or her employer is not eligible for the Medical, Dental and Vision Plans, regardless of whether an administrative or judicial proceeding subsequently determines this individual to have instead been a common law salaried employee.

Examples of such individuals include an:

- Independent contractor/agent (or its employee);
- Intern; and/or
- Occasional/seasonal, leased, or temporary employee.

When You Become Eligible

Employees are eligible to participate in the Medical, Dental and Vision Plans as follows:

- If you are a full-time employee (regularly scheduled to work 40 hours per week), you are eligible to join the Plans on the first of the month after your date of hire.
- If you are a part-time employee (regularly scheduled to work at least 20 but less than 40 hours per week), you are eligible to join the Plans on the first of the month after 60 days from your date of hire.

Eligible Dependents

In addition to covering yourself under the Medical, Dental and Vision Plans, you can also cover your eligible dependents, but generally only under the same option you choose for yourself. (Please see Please see "Determining Primary Coverage" and its subsection, "Coordination with Medicare," in the *Plan Administration* at section for details on coverage provisions for individuals who are eligible for Medicare.)

Your eligible dependents under the Medical, Dental and Vision Plans — and under certain other plans as referenced in those plan sections of this Guide — include:

- Your spouse or domestic partner (see "Domestic Partners" on page 33 for more information); 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.

* Newly hired employees wishing to enroll their disabled dependent who is over the age of 26 in the Medical, Dental, Vision or Life & Accident Insurance plan can do so within the new hire enrollment period by contacting HR Answers for assistance in completing the disabled dependent enrollment process.

Please Note: You may continue coverage beyond age 26 for an unmarried child who is enrolled at the time of turning age 26 in that benefit and is deemed unable to support himself or herself because of a mental or physical disability that began before age 26 and who depends on you for financial support. Contact your health care company* 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 Medical, Dental, Vision or Life & Accident Insurance plan prior to turning age 26, unless coverage was elected during your new hire enrollment period for a disabled dependent over the age of 26.

* If you are not enrolled in one of the Medical plans but want to continue coverage for your dependent child over age 26 for the Dental, Vision or Life & Accident Insurance plan please contact Aetna to see if they qualify for continued coverage under these plans.

Important Note on Dependent Eligibility

You are responsible for understanding the dependent eligibility rules applicable to each Plan and abiding by them. Each year during Annual Benefits Enrollment, you must review your covered dependents and confirm that they continue to meet the eligibility requirements. It is important that you review both the dependent eligibility rules and the status of your dependents on file, and make any necessary adjustments during your enrollment period or within 31 days of a Qualified Status Change (QSC), 90 days if the qualifying event is the birth or adoption of a child.

The benefits you elect will be effective the date of the event. (**Please Note:** You will have 90 days from the QSC date to add any newly eligible dependents to the Medical Plan, including add and then removing that dependent should that dependent pass away within this 90-day period.). For more information on QSCs, see "Changing Your Coverage Midyear" on page 38. JPMorgan Chase reserves the right to conduct eligibility verifications on existing dependents at any time. If you fail to provide satisfactory proof (when requested) that your covered dependents meet the current eligibility requirements, you could face penalties ranging from loss of coverage for your dependents to termination of employment.

Within 30 days of adding a new dependent, a mailing will be sent to your home address on file with JPMC requesting materials to verify your dependent's eligibility (that is, birth certificate, marriage license, etc.). You must supply acceptable supporting documents and sign and return the supplied Confirmation of Eligibility within 60 days. If you fail to provide satisfactory proof that your dependent(s) meet the current eligibility requirements, your dependent's coverage will be terminated and you will be responsible for any claims paid by the Medical, Dental and Vision Plans.

For a listing of acceptable documentation to establish proof of your dependents' eligibility for coverage under the JPMorgan Chase U.S. Benefits Program, please see **Dependent Eligibility Requirements** on **My Health**.

Spouse

The term "spouse" refers to any person to whom you are legally married as recognized by U.S. federal law.

If JPMorgan Chase employs your spouse, domestic partner, or child, he or she can enroll in coverage as an employee in their own eligible coverage or as your dependent, but not as both*. If you want to cover your eligible child(ren), you or your spouse/domestic partner may provide this coverage. If you are covering a spouse/domestic partner who is also a JPMorgan Chase employee (i.e., company couple), you should update the "dependent is also an employee" indicator on the Dependent Enrollment page of the Benefit Web Center, available through **My Health**.

* Except for the Supplemental Term Life Insurance Plans. If your spouse is also a JPMorgan Chase employee, he or she can elect Employee Supplemental Term Life Insurance coverage as an employee and be also covered as your spouse under the Dependent Supplemental Term Life Insurance Plan.

Children

"Children" include the following:

- Your natural children;
- Your stepchildren (children of your current spouse);
- Children of your domestic partner (if your domestic partner is also enrolled in the Plan);
  - If you are covering the child of a domestic partner who is not your tax dependent, imputed income for that child will be applied.
- Your legally adopted children;
- Your foster children;
- Children under your legal guardianship (as established by a court order) whom you claim on your income tax return as dependents or for whom you provide more than 50% of their financial support;
- A child under age 18 who lives with you and 1) for whom adoption proceedings have already begun, and 2) whom you have the legal obligation to support (in whole or in part);

- Children who are alternate recipients under a Qualified Medical Child Support Order (QMCSO), as required by law; and
- A disabled child dependent who is over age 26 and meets the following criteria:
  - Is an unmarried, eligible child dependent
  - Is deemed not capable of supporting themselves due to a mental or physical disability that began prior to age 26
  - Is dependent on the employee for financial support
  - Is enrolled in a JPMC Medical, Dental, Vision or Life & Accident Insurance plan prior to turning 26 or is the dependent of a newly hired employee who has enrolled in a Medical, Dental, Vision, or Life & Accident Insurance plan during their new hire enrollment period

Domestic Partners

In addition to the dependents previously listed, you may also cover a "domestic partner" as an eligible dependent under the Medical, Dental, and Vision Plans if you're not currently covering a spouse. You generally must cover your domestic partner under the same option you select for your own coverage.

For the purposes of the Medical, Dental and Vision Plans, you and your domestic partner must:

- Be age 18 or older; and
- Not be legally married to, or the domestic partner of, anyone else; and
- Have lived together for at least the last twelve (12) months, are currently living together, and are committed to each other to the same extent as married persons are to each other, except for the traditional marital status and solemnities; and
- Be financially interdependent (share responsibility for household expenses); and
- Not be related to each other in a way that would prohibit legal marriage.

OR

- Have registered as domestic partners pursuant to a domestic partnership ordinance or law of a state or local government, or under the laws of a foreign jurisdiction.

You must certify that your domestic partner meets the eligibility rules as defined under the Plan before coverage can begin. You may also be asked to certify that your domestic partner and/or your domestic partner's children qualify as tax dependent(s) as determined by the Internal Revenue Code (IRC) to avoid any applicable imputed income.

Please Note: If you are covering a domestic partner who is not a tax dependent, imputed income for that domestic partner will be applied. Information about domestic partner coverage and the various tax consequences can be found on **My Health >Benefits Enrollment > 2022 U.S. Benefits Resources** > Covering a Domestic Partner Tip Sheet.

Qualified Medical Child Support Orders

If any of the Medical, Dental or Vision Plans receives a judgment, decree, or order known as a Qualified Medical Child Support Order (QMCSO) requiring the Plans to provide medical, dental and vision coverage to your child who is your dependent, the Plans will automatically change your benefits elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin and end on the dates the QMCSO order specifies. The Plans will comply with any subsequent QMCSO authorizing changes to coverage or termination of coverage for your child.

Enrolling

Because participating in the Medical, Dental and Vision Plans is optional, you must enroll to have coverage. If you decide to participate, when you enroll you will choose:

1. The option you want for the Medical Plan and the Dental Plan (the Vision Plan has only one option to choose from); and.
2. The coverage level for each Plan. You can choose different coverage levels for each Plan.

If you choose a coverage level other than employee-only coverage, you will also need to specify which of your eligible dependents you are enrolling.

Medical and Dental Plan Options

For details on the options available under the Medical Plan and the Dental Plan, see the subsections that describe each Plan:

Core Medical Plan

Dental

Elections a la Carte!

You don't have to enroll for all the Plans. You can choose only the Plans that you want. For example, you could enroll for the Medical and Dental Plans and waive coverage from the Vision Plan. Or you could enroll for the Dental and Vision Plans and waive coverage from the Medical Plan. It's up to you!

Coverage Levels

The coverage levels available in the Medical, Dental and Vision Plans are:

- Employee only;
- Employee plus spouse/domestic partner or employee plus child(ren); or
- Family (employee plus spouse/domestic partner plus child(ren)).

If you are eligible for coverage and do not enroll in a Plan, your eligible dependents cannot be enrolled in that Plan.

You are responsible for understanding the dependent eligibility rules and abiding by them (see "Important Note on Dependent Eligibility" on page 32).

An Important Note on Dependent Coverage

If your spouse or domestic partner is also employed by JPMorgan Chase, he or she can be covered as an employee **or** as your dependent, but not as both. If you want to cover your eligible children, you **or** your spouse/domestic partner (but not both of you) can choose to provide this coverage.

Tax Treatment of Domestic Partner Coverage

If you're covering a domestic partner as described in "Eligible Dependents" on page 31, there are tax implications of which you should be aware.

JPMorgan Chase is required to report the entire value of the medical and dental coverage for a "Domestic Partner" as taxable (or "imputed") income to you and to withhold for federal, state and FICA taxes on the imputed income. The imputed income includes the amount that both you and JPMorgan Chase contribute toward the cost of coverage.

Please Note: If you certify that your domestic partner and/or your domestic partner's children are your tax dependents, you will not be subject to taxation of imputed income on the tax dependents' coverage.

Enrolling a Domestic Partner

Additional information on enrolling and the tax consequences of covering a domestic partner can be found on **My Health**.

How to Enroll

Participation in the Medical, Dental and Vision Plans is optional. You can enroll in all three Plans, or just two of them, or one, or you can waive coverage from all three Plans.

If you want to enroll, the process varies, depending on whether you are a:

- Current, eligible employee, enrolling during Annual Benefits Enrollment;
- Newly hired employee; or
- Current, eligible employee, enrolling or changing your benefits outside of Annual Benefits Enrollment.

No Enrollment Needed for Wellness, EAP or Tobacco Cessation Programs, If Eligible

For benefits-eligible employees, no enrollment is necessary for the Wellness, EAP and Tobacco Cessation programs. These programs are provided to benefits-eligible employees, regardless of whether you enroll in the Medical Plan, and coverage under these programs does not begin or end with participation in the Medical Plan.

Enrolling if You Are an Employee

You have the ability to enroll in the Medical, Dental and Vision Plans once a year, during Annual Benefits Enrollment held in the fall (generally in the October time frame). Elections you make during Annual Benefits Enrollment are effective the following January 1.

At the beginning of each Annual Benefits Enrollment period, you'll receive information about the choices available to you and their costs. You need to review your available choices carefully and enroll in the Plans and options that best meet your needs.

You can view your available choices, their costs and make your elections through the Benefits Web Center on **My Health** or by calling HR Answers. Detailed instructions and deadlines will be included in the Annual Benefits Enrollment materials.

Remember, you can't change your choices during the year unless you have a Qualified Status Change. Please see "Changing Your Coverage Midyear" on page 38.

Enrolling if You Are a Newly Hired Employee

If you've just joined JPMorgan Chase and are enrolling for the first time, you need to make your choices through the Benefits Web Center on **My Health** or by calling HR Answers. If you are a full-time employee, you need to make your choices within 31 days of your date of hire. If you are a part-time employee, you need to make your choices within 31 days before becoming eligible.

- **If you are a full-time employee** (regularly scheduled to work 40 hours per week), you will receive information about benefits enrollment after your hire date with JPMorgan Chase. Your coverage will begin — meaning it will be effective — on the first of the month after your hire date, as long as you enroll within 31 days after your hire date. For example, if you are hired on June 17, you have between June 17 and July 18 to make your enrollment elections, and these elections will be effective on July 1.
- **If you are a part-time employee** (regularly scheduled to work at least 20 but less than 40 hours per week), your benefits effective date will be the first of the month following your 60-day waiting period, and you will receive your enrollment materials within 31 days before becoming eligible for coverage. You need to enroll within 31 days before your eligibility date.

You can access your benefits enrollment materials online at **My Health** > Benefits Enrollment.

If you are hired after October 1, you will be required to complete your newly eligible benefits enrollment elections for the current calendar year before making your enrollment elections for the subsequent calendar year.

Enrolling if You Have a Change in Work Status or Qualified Status Change

If you're enrolling during the year because you're a newly eligible employee due to a work status change, or if you have a Qualified Status Change (QSC), you'll have 31 days from the date of the change in status to make your new choices, including adding any eligible dependents directly impacted by the QSC. You can submit your choices through the Benefits Web Center on **My Health** or by calling HR Answers. Please see "Changing Your Coverage Midyear" on page 38.

Please Note: For a QSC, you have 31 days to add yourself or your dependent from the QSC date, except related to the birth/adoption of a child, in which case you have 90 days to add this eligible dependent (coverage will be retroactive to the date of the QSC). You will also have 90 days to add any newly eligible dependents to the Medical Plan should that dependent pass away within this 90-day period.

Related to Life and Accident Insurance, you have 90 days to add any new born/newly adopted/or first born child should they pass way within this 90-day period; please call HR Answers if this situation applies to you.)

If You Do *Not* Enroll

Coverage if You Do Not Enroll and You Are an Employee

If you're already participating in the Medical, Dental and/or Vision Plans and do not change your elections or cancel coverage during Annual Benefits Enrollment, you'll generally keep the same Medical, Dental and Vision Plan coverage for the next plan year (if available). However, you'll be subject to any changes in the Plans and coverage costs.

Re-enrollment May Differ for Other Plans

This *Health Care Participation* section applies to the JPMorgan Chase Medical, Dental and Vision Plans. Other JPMorgan Chase benefit plans may have different rules for enrollment.

For example, if you are participating in the Health Care Spending Account and/or the Dependent Day Care Spending Account in one year, you will not automatically continue participating for the next year.

Coverage if You Do Not Enroll and You Are a Newly Hired or Newly Eligible Employee

If you're a new hire or newly eligible employee and do not enroll before the end of the 31-day enrollment period as described under "Enrolling if You Are a Newly Hired Employee" on page 35, you will not have coverage in the Medical, Dental, or Vision Plans.

Coverage if You Do Not Enroll When You Have a Qualified Status Change

Adding Coverage: If you have a Qualified Status Change (QSC) that allows you (and any eligible dependents directly impacted by the QSC) to enroll in the Medical, Dental, Vision, or Life & Accident Insurance plans midyear and you do not enroll within the 31-day window (90-day window in the case of the birth/adoption of a child or death of a newly eligible dependent during the 90 day window) as described under "Enrolling if You Have a Change in Work Status or Qualified Status Change" on page 36, you will not have coverage in those Plans.

Deleting Coverage: If you have a QSC that causes your dependent to no longer be eligible for JPMorgan Chase Medical, Dental, Vision or Life & Accident Insurance* Plans, you should remove coverage for that dependent by submitting the change in the Benefits Web Center or call HR Answers within 31 days following the effective date of the change. If you fail to submit this change timely, you may call HR Answers to report the change and coverage for the dependent will be canceled effective the date you call HR Answers.

* You must contact HR Answers to remove your dependent from Life & Accident Insurance. You cannot submit a change on the Benefits Web Center.

Please see "Changing Your Coverage Midyear" on page 38.

When Coverage Begins

If you are an employee, the coverage you elect during Annual Benefits Enrollment takes effect at the beginning of the next plan year (January 1).

For benefits-eligible employees, no enrollment is necessary for Wellness, EAP and Tobacco Cessation programs and participation is not dependent upon enrolling in the Medical Plan. Your coverage begins on your date of hire or when you become benefits eligible.

If you are a newly hired or newly eligible employee, the coverage you elect as a new hire takes effect as follows:

- If you are a full-time employee (regularly scheduled to work 40 hours per week), coverage begins on the first of the month after your date of hire.
- If you are a part-time employee (regularly scheduled to work at least 20 but less than 40 hours per week), coverage begins on the first of the month after 60 days from your date of hire.

If you have a change in work status or Qualified Status Change, the coverage you elect because of a qualifying event (such as those described under "Changing Your Coverage Midyear" on page 38) will take effect as of the day of the qualifying event, if you enroll within 31 days of the event (90-day window in the case of the birth/adoption of a child or if your newly eligible dependent passes away during the 90-day window) and you have already met the Plan's eligibility requirements. Please see "Changing Your Coverage Midyear" on page 38.

When Payroll Contributions Begin

Your Medical, Dental and Vision Plan payroll contributions for the cost of coverage start when your coverage begins. Your contributions are automatically deducted from your pay in equal installments 24 times a year. This applies if you are a semimonthly paid employee or a biweekly paid employee. If you are paid biweekly and the month has three pay periods, no contributions will be taken from the third pay period.

If you have coverage but are not actively working because of an unpaid leave of absence, you will be directly billed for any required contributions on an after-tax basis.

Retroactive Contributions as Necessary

Be advised that payroll contributions are owed based upon your coverage effective date. Due to timing of payroll cycles, employees may experience retroactive payroll deductions where prior payroll contributions were due but not deducted due to timing of payroll processing. This can occur for any coverage election or change including new elections or midyear changes due to a qualifying event.

Changing Your Coverage Midyear

The Medical, Dental and Vision Plan elections you make during Annual Benefits Enrollment will stay in effect through the next plan year (or the current plan year if you enroll during the year as a newly eligible employee). However, you may be permitted to change your elections before the next Annual Benefits Enrollment if you have a Qualified Status Change (QSC). A QSC does not permit you to change your health care company during the year under the Medical Plan. **Please Note:** Any changes you make during the year must be consistent with your QSC. More information on QSCs is located in the *What Happens If* section.

Important Note About Providers Leaving Networks

If your doctor leaves a network, it does not qualify as an event that allows you to change coverage during the year. Each year during the fall Annual Benefits Enrollment, you may want to check with your provider to ensure that he or she plans to continue to participate in the network of your health care company.

Qualified Events

Qualified Status Changes (QSCs) include:

- Marriage/Domestic Partnership/Civil Union
  - You get married or establish a domestic partnership or civil union
  - You get legally separated, divorced or end a domestic partnership or civil union
- Children
  - You have a baby, complete an adoption, or assume guardianship
  - Your child no longer qualifies for JPMorgan Chase benefits
- Family Members
  - You or your family member loses benefits coverage under another employer's plan
  - You or your family member gains benefits coverage under another employer's plan
  - Your child/elder care arrangements change
  - A family member who is covered by JPMorgan Chase benefits dies
- Moving
  - You move out of your Medical or Dental Plan option's service area

Making the Changes

You need to enroll and/or add your eligible dependents **within 31 days following the Qualified Status Change (QSC)** (90 days if the qualifying event is the birth or adoption of a child) for benefits to be effective on the date of the event. **Please Note:** See "If You Do *Not* Enroll" on page 36 for details on what happens if you miss the 31-day enrollment period. (You will have 90 days from the QSC to add any newly eligible dependents to the Medical Plan should that dependent pass away within this 90-day period. Related to Life & Accident Insurance, you have 90 days to add any new born/newly adoptive/or first born child should they pass way within this 90-day period; please call HR Answers if this situation applies to you.)

You can make these elections through the Benefits Web Center on **My Health** or by calling HR Answers.

Please Note: Documentation of dependent eligibility will be required when a dependent is added for coverage and may be requested at any time by JPMorgan Chase or the claims administrator. JPMorgan Chase or an administrator appointed by JPMorgan Chase regularly conducts dependent eligibility verification to ensure that all covered dependents meet the current eligibility requirements of the JPMorgan Chase U.S. Benefits Program. For details, please see "Important Note on Dependent Eligibility" on page 32.

Allowable Changes

The chart below details the allowable changes due to a Qualified Status Change (QSC).

For domestic partnerships, the partnership must have been in effect for at least 12 continuous months, along with other criteria, before it makes the partner eligible to be covered by any JPMorgan Chase plan or program as a dependent.

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner ("DP") Child
Marriage	Add	Add	Add
Domestic Partner Commitment	Add	Add	Add
Divorce, Legal Separation, or Termination of DP Commitment	Add	Drop	Drop
Death of Spouse/DP	Add*	Drop	Drop
Birth/Adoption/Legal Guardianship	Add	Add	Add
Child Gains Eligibility	Add	Add	Add
DP's Child Becomes Eligible	Add	Add	Add
Child Gains Eligibility Due to QMCSO	Add	N/A	Add
Child/DP Child No Longer Eligible	N/A	N/A	Drop
Death of Child/DP Child	N/A	N/A	Drop
You or Covered Dependent Gains Other Coverage	Drop/reduce number of dependents	Drop/reduce number of dependents	Drop/reduce number of dependents
You or Covered Dependent Loses Other Coverage	Add	Add	Add
Change in Dependent Care Provider or Fees	N/A	N/A	N/A
Move Out of Provider Service Area	Change option	Change option	Change option

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner ("DP") Child
If you are enrolled in the JPMC Core Medical Plan and move to AZ or OH	You will automatically be enrolled in the JPMC Simplified Medical Plan, for the rest of the calendar year. Your health care company (Aetna/Cigna) and election (Option 1 or 2) will not change.	You will automatically be enrolled in the JPMC Simplified Medical Plan, for the rest of the calendar year. Your health care company (Aetna/Cigna) and election (Option 1 or 2) will not change.	You will automatically be enrolled in the JPMC Simplified Medical Plan, for the rest of the calendar year. Your health care company (Aetna/Cigna) and election (Option 1 or 2) will not change.
If you are enrolled in JPMC Simplified Medical Plan and move out of AZ or OH (including to California)	You will automatically be enrolled in the JPMC Core Medical Plan, for the rest of the calendar year. Your health care company (Aetna/Cigna) and election (Option 1 or 2) will not change. You will not have the option of enrolling in Kaiser.	You will automatically be enrolled in the JPMC Core Medical Plan, for the rest of the calendar year. Your health care company (Aetna/Cigna) and election (Option 1 or 2) will not change. You will not have the option of enrolling in Kaiser.	You will automatically be enrolled in the JPMC Core Medical Plan, for the rest of the calendar year. Your health care company (Aetna/Cigna) and election (Option 1 or 2) will not change. You will not have the option of enrolling in Kaiser.
If you are enrolled in the JPMC Medical Plan Kaiser HMO Option and move out of California (or out of the Kaiser service area)	You will automatically be enrolled in Cigna Option 2, Core or Simplified Medical Plan, based on your new home state. You can contact HR Answers within 31 days of your move to change your options (Aetna/Cigna, Option 1 or 2)	You will automatically be enrolled in Cigna Option 2, Core or Simplified Medical Plan, based on your new home state. You can contact HR Answers within 31 days of your move to change your options (Aetna/Cigna, Option 1 or 2)	You will automatically be enrolled in Cigna Option 2, Core or Simplified Medical Plan, based on your new home state. You can contact HR Answers within 31 days of your move to change your options (Aetna/Cigna, Option 1 or 2)

* Call HR Answers

HIPAA Special Enrollment Rights

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides special enrollment rights to employees and eligible dependents who decline coverage under the Medical, Dental and Vision Plans because they have other health care coverage. HIPAA's special enrollment rights apply in certain cases in which you and/or your dependents decline Medical, Dental or Vision Plan coverage because you have health care coverage through another source — and then lose that coverage. These rights also apply if you acquire an eligible dependent.

If you or your eligible dependent declined coverage under the Medical, Dental, or Vision Plan, you may enroll for health care coverage within 31 days of a qualifying event (90 days if the qualifying event is the birth or adoption of a child or if a newly eligible dependent should pass during this 90-day period) for coverage to be effective the date of the event. If you miss the 31-day window, you will not be able to make a change until the following Annual Benefits Enrollment. Qualifying events include:

- You and/or your eligible dependents lose other health care coverage because you no longer meet the eligibility requirements (because of legal separation, divorce, death, termination of employment, or reduced work hours);

- If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption (90 days for birth/adoption). If you are eligible for coverage but do not enroll, your dependent cannot enroll;
- Employer contributions for other coverage ends; or
- The other coverage was provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the COBRA coverage period ends.

If you qualify for this HIPAA special enrollment, your coverage under the Medical, Dental and/or Vision Plans will begin on the date of the event provided you enroll within the appropriate time frame and pay the required contributions.

Effective April 1, 2009, if you or your eligible dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may enroll for JPMorgan Chase coverage, as long as you make your request within 60 days of the event.

When Coverage Ends

Coverage and participation under the Medical, Dental, and Vision Plans will end on the last day of the month in which:

- Your employment with JPMorgan Chase is terminated for any reason (and you don't elect COBRA coverage, if available);
- You cancel coverage or participation because of a Qualified Status Change (QSC) (cancellation must be consistent with the QSC);
- You stop making required contributions;
- You no longer meet the eligibility requirements of the Plans;
- You have been on an approved long-term disability leave and have been receiving LTD benefits under the LTD Plan for 24 months (see the *Long-Term Disability* section for more details);
- The Plan is discontinued; or
- You pass away.

When Dependent Coverage Ends

Coverage for your dependents ends the earlier of when your coverage ends or when the dependent no longer meets the dependent eligibility requirements. For more details on dependent eligibility, see "Eligible Dependents" on page 31.

- For your spouse, this means the last day of the month in which you pass away (unless you are eligible for retiree medical, dental, or vision coverage) or you divorce.
- For your domestic partner and/or children of your domestic partner, this means the last day of the month in which the domestic partner ceases to meet the eligibility requirements.
- For your child, this means the last day of the month in which he or she turns age 26.
  - **Please Note:** You can continue medical, dental, vision, and life & accident insurance coverage beyond age 26 for an unmarried child who is enrolled in that benefit and is deemed not capable of supporting himself or herself due to a mental or physical disability that began before the age limits described above and who is dependent on you for financial support. To continue coverage for a disabled dependent, that dependent must be enrolled in the Medical, Dental, Vision or Life & Accident Insurance plan at the time they turn age 26, unless coverage was elected during your new hire enrollment period for a disabled dependent over the age of 26. If your dependent loses coverage at 26, you will **not** be able to add them to your coverage at a later date.

Continuing Health Coverage Under COBRA

Health care and wellness program benefits for you, and your covered dependents, end as of the last day of the month in which you leave the firm. If you are currently enrolled in the Medical Plan (including the Medical Reimbursement Account [MRA]), Dental Plan, Vision Plan, or Health Care Spending Account, you may elect to continue this coverage for you and your covered dependents for up to 18 months by enrolling in the coverage available through the Consolidated Omnibus Budget Reconciliation Act (COBRA). Also under COBRA, you may elect to continue participating in certain wellness-related programs offered through a single "bundled" election, described under "What's Included with COBRA Medical Plan Coverage" on page 42.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents have the right to continue health care coverage at your own expense for a certain period of time if your JPMorgan Chase-provided health care coverage ends because of certain circumstances—called "qualifying events."

Your covered dependents include your spouse and your eligible dependent children who are covered at the time of a qualifying event (your "qualified beneficiaries," as defined below). For domestic partners, JPMorgan Chase may provide COBRA-like health coverage if the domestic partner was covered under the JPMorgan Chase Medical Plan, Dental Plan, Vision Plan, and/or Employee Assistance Program at the time coverage ended.

COBRA coverage applies to the:

- The Medical Plan, including the Prescription Drug Plan, the MRA (see "The MRA and COBRA" on page 47 for more information), Wellness Screenings at your doctor's office or qualifying labs and Tobacco Cessation program;
- Dental Plan;
- Vision Plan;
- Health Care Spending Account (through the end of the year in which the qualifying event occurs); and
- Onsite Health and Wellness Centers access, wellness screenings, tobacco cessation program and Employee Assistance Program as a bundled election, even if not electing any other benefits under COBRA.

What's Included with COBRA Medical Plan Coverage

If you elect COBRA Medical Plan coverage, the following are included:

- The Medical Plan which you were enrolled in as an active employee, including the Prescription Drug Plan and the MRA (see "The MRA and COBRA" on page 47 for more information);
- Wellness Screenings at your doctor's office or qualifying labs; and
- Tobacco cessation program.

If you do not elect COBRA Medical Plan coverage, we are required to offer you the ability to elect to continue participation in certain wellness-related programs. These programs are offered through a single "bundled" election. However, we strongly encourage you to consider the value in electing such programs:

- Access to the JPMorgan Chase on-site Health & Wellness Centers;
- Employee Assistance Program (EAP);
- Tobacco cessation program; and
- Wellness Screening at your doctor's office or qualifying labs.

If you elect COBRA coverage for these services, you are eligible to earn Wellness Rewards (a taxable incentive payable through payroll) by completing the Initial Wellness Activity(ies) during the annual designated timeframe. This maximum amount of Initial Wellness Rewards you can earn is determined by your Medical Plan eligibility: JPMC Core Medical Plan $200, JPMC Simplified Medical Plan $100.

Additionally, your covered spouse/domestic partner is not eligible to earn any Additional Wellness Activities.

If you elect COBRA Medical Plan coverage and would like to continue to have access to the Employee Assistance Program and the JPMorgan Chase onsite Health & Wellness Centers, you should purchase the COBRA "bundled" coverage listed above.

Please Note: If you elect both COBRA Medical Plan coverage and COBRA "bundled" coverage, you will not be charged twice for the Tobacco cessation and Wellness Screening programs.

More details about coverage under COBRA are available by calling HR Answers.

Qualified Beneficiary

Individuals eligible for COBRA continuation coverage are called "qualified beneficiaries." A qualified beneficiary includes the covered spouse and eligible dependent children of a covered employee, and, in certain cases, the covered employee.

Under current law, to be considered a qualified beneficiary, an individual must generally be covered under a group health plan on the day before a qualifying event occurs that causes a loss in coverage (such as termination of employment or a divorce from or death of the covered employee). In addition, a newborn child or a child who is placed for adoption with the covered employee during the period of COBRA continuation coverage is also considered a qualified beneficiary.

Qualifying Events

You, your spouse, and your dependent children may elect COBRA coverage for varying lengths of time, depending on the circumstances under which your JPMorgan Chase health care coverage ends:

- **If Your Employment Terminates or Your Work Hours Are Reduced.** If you lose coverage because your employment terminates (for any reason other than gross misconduct) or your work hours are reduced, you and/or your covered dependents may purchase COBRA coverage for up to 18 months. Certain events may extend this 18-month COBRA continuation period:
  - If your covered dependents experience any second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
  - If you become eligible for Medicare while employed (even if this is not a qualifying event for your covered dependents because they do not lose coverage) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your covered dependents may elect COBRA continuation for up to 36 months from the date that you become eligible for Medicare.
- **If Your Covered Dependents Lose Coverage.** If your spouse and/or your dependent children lose coverage because of any of the circumstances listed below, they may purchase COBRA coverage for up to 36 months from the date that coverage ends because:
  - You pass away;
  - You divorce your spouse or become legally separated;
  - You become eligible for Medicare; or
  - Your dependent child loses dependent eligibility status under the terms of the plan (for example, the end of the month in which your dependent child reaches age 26).
- **If You or Your Covered Dependents Become Disabled.** If you or one of your covered dependents becomes disabled under the Social Security Administration guidelines within 60 days of a qualifying event, or you are disabled at the time COBRA coverage is initially offered, you and your covered dependents may continue COBRA coverage for an additional 11 months beyond the initial 18 months, to a total of 29 months. You must notify HR Answers, the COBRA Administrator, within 60 days after Social Security issues a determination of disability status and before the initial 18-month COBRA coverage period ends. You also must notify the COBRA Administrator within 30 days after Social Security determines the end of disability status for you or your covered dependent.

If a second qualifying event occurs at any time during this 29-month disability coverage period, your covered dependents (but not you) may continue COBRA coverage for an additional seven months, to a total of 36 months.

Continuation Coverage for a Domestic Partner Dependent

A domestic partner or the children of a domestic partner who are not your tax dependents are not eligible for COBRA continuation coverage under federal law. However, JPMorgan Chase provides COBRA-like coverage if your domestic partner (and his or her eligible children) was covered under the JPMorgan Chase Medical Plan, Dental Plan and Vision Plan, at the time coverage ended. Call HR Answers for more information.

The Employee Assistance Program is available under COBRA-like continuation coverage for all eligible dependents, although wellness screenings are limited to your domestic partner only (not eligible dependents). Access to on-site Health and Wellness Centers is not available to your domestic partner or any of your eligible dependents.

The rate for domestic partner continuation coverage will be the same as the COBRA rate. Contributions will be made on an after-tax basis and will represent the full value of the coverage plus 2%. If you pass away while continuing your own coverage under COBRA, coverage may be continued by your covered domestic partner for a total of 36 months.

If a second qualifying event occurs anytime within the original 18-month period, COBRA continuation coverage may be extended for an additional 18 months, for a total period of 36 months.

Giving Notice of a COBRA Qualifying Event

If your employment terminates, your work hours are reduced, or you pass away, and this results in a loss of benefits under the Medical, Dental, or Vision Plans, the COBRA Administrator automatically will notify you or your covered eligible dependents about your right to elect continued coverage under COBRA. You will receive the necessary election forms to your home address of record within 14 days from the date that the COBRA Administrator is notified of your eligibility for COBRA coverage.

However, if you divorce or your eligible dependent child loses dependent status under the terms of the plan, you or one of your covered dependents must call HR Answers within 60 days of any such event. If notice is not received within that 60-day period, your dependents will not be entitled to elect COBRA continuation coverage. Notice must be provided to the COBRA Administrator and must include the following information: the name of the employee or qualified beneficiaries requesting coverage, the qualifying event and the date of the qualifying event. In addition, you may be asked to provide supporting documentation such as a divorce decree. Otherwise, your covered dependents will not be eligible to elect continued coverage under COBRA.

If a qualified beneficiary experiences a second qualifying event that would entitle him or her to additional months of continuation coverage, he or she must notify the COBRA Administrator. This notice must include the:

- Name of the employee;
- Name of the qualified beneficiary receiving COBRA coverage; and
- Type and date of the second qualifying event.

This notice must be provided within 60 days from the date of the second qualifying event (or, if later, the date coverage would normally be lost because of the second qualifying event). In addition, the qualified beneficiary may be asked to provide a copy of a death certificate or divorce decree.

When the plan is notified that one of these events has happened, the qualified beneficiary will automatically be entitled to the extended period of COBRA continuation coverage. If a qualified beneficiary fails to provide the appropriate notice and requested supporting documentation during this 60-day notice period, the qualified beneficiary will not be entitled to extended continuation coverage.

Updating Your Personal Contact Information

To ensure that you receive information to enroll in COBRA, please contact HR Answers to update your personal contact information as well as your dependent's contact information.

If you are a former employee and you have a newborn or adopt a child while you are on COBRA continuation coverage and you enroll the new child for coverage, the new child will be considered a qualified beneficiary rather than an after-acquired dependent. This gives the child additional rights, such as the right to continue COBRA benefits even if you pass away during the COBRA period, and the right to an additional 18 months of coverage if a second qualifying event occurs during the initial 18-month COBRA period after your termination or retirement.

Choosing COBRA Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the:

- Date you and/or your covered eligible dependents would lose coverage because of the qualifying event; or
- Date you are notified of your and/or your covered eligible dependents' right to continue coverage because of the qualifying event (that is, the date of your COBRA Enrollment Notice).

If you make no election during the 60-day period, you waive your right to continue coverage. Each qualifying beneficiary has an independent right to elect COBRA coverage. Covered employees may elect coverage on behalf of their spouses, and parents may elect coverage on behalf of their children.

You will receive COBRA materials approximately two weeks after the date they are notified of the qualifying event. These materials will describe the enrollment instructions and time frames for making your elections. You will have a period of 60 days from the date of your qualifying event to elect COBRA coverage. **Important Notes:** You must make an election at the time COBRA coverage is offered—it is not automatically provided. Also, if you elect COBRA your coverage will stay with the carrier and current option you were with when you were active (Aetna or Cigna, Option 1 or Option 2); this also applies to Dental coverage. If you are still enrolled in COBRA during Annual Enrollment you will be able to change carriers then.

Premium Due Dates

If you elect to continue coverage under COBRA, you must pay the first two premiums (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums are due on the first calendar day of the month for that month's coverage, and must be paid within 30 days of each due date. If you elect to continue your coverage under COBRA but do not make timely payments in full (even if you do not receive a bill), your coverage will be terminated retroactively to the time frame applicable to your last full payment and will not be reinstated.

Coverage During the Continuation Period

With respect to Medical Plan, Dental Plan and Vision Plan coverage, you and your covered dependents may choose to continue the coverage option that you had as an active employee. You and your covered dependents may subsequently change coverage during the next Annual Benefits Enrollment, if a qualified change in status occurs, or at other times, to the same extent that active employees may do so.

COBRA Coverage Costs

If you choose to continue coverage under COBRA, you will generally pay the full cost* for yourself and/or your qualified beneficiaries, plus a 2% administrative fee. If COBRA coverage is extended because of a disability, the rates for coverage during the additional 11 months are 150% of the full cost.

If a second qualifying event occurs during the initial 18-month period of COBRA coverage, the 102% rate applies to you and your qualified beneficiaries for the full 36 months of COBRA coverage, even if you or one of your covered dependents becomes disabled. However, if a second qualifying event occurs during an extended disability coverage period, then the rates of coverage will continue at the higher disability coverage rates explained above.

* The cost of COBRA is based on your plan elections and your Total Annual Cash Compensation (TACC), as defined by the Plan. Your TACC is frozen as of the last day of active employment with JPMorgan Chase.

Company-Subsidized COBRA Coverage

If you are eligible for benefits under the U.S. Severance Pay Plan, you will receive a COBRA subsidy and will pay the active employee rate for medical coverage under COBRA for the lesser of 1) six months; or 2) the number of months of severance benefits you receive. For calculation purposes, four weeks of severance pay equal one month, and fractional months are rounded up to the next higher whole number of months (for example, 11 weeks would be rounded up to three months). This subsidy will apply to medical and dental coverage only (the Vision Plan, Health Care Spending Account Plan, and the Wellness Program are not subsidized by JPMorgan Chase, including under COBRA for individuals receiving severance benefits). Your eligibility for company-subsidized COBRA coverage is conditioned upon JPMorgan Chase's receipt of the executed Release. Regardless of whether you were ever informed that you are eligible for benefits under the U.S. Severance Pay Plan, JPMorgan Chase's discretionary determination that you engaged in misconduct or violated the company's Code of Conduct before or during the COBRA subsidy period or that you could have been terminated for cause will render you ineligible for a COBRA subsidy and premiums due will be recalculated retrospectively. Unsubsidized COBRA coverage (102% of the total cost of coverage) will be available after the end of the subsidized portion of the COBRA period for the remainder of the 18-month COBRA continuation period.

Company-subsidized COBRA coverage is also available for your eligible, covered survivors, if you pass away as an active employee. Continuing coverage is available at the active employee costs for up to 36 months.

How Continued Coverage Could End

Under COBRA rules, coverage will end for you and/or your covered dependents when the first of the following occurs:

- Your COBRA coverage period ends;
- You do not make the required premium payments for coverage on a timely basis;
- You obtain coverage under another group plan that does not exclude or limit coverage for pre-existing conditions. However, if the new plan does have pre-existing conditions or limits, you can continue your COBRA coverage for that specific condition up to the end of your original maximum COBRA period (18 or 36 months, depending on your situation);
- You and/or your covered dependents become eligible for Medicare. However, if you become eligible for Medicare before your covered dependents, your covered dependents may be eligible to continue coverage through COBRA for up to 36 months from the date of the original qualifying event;
- In the case of an extended disability coverage period, you or your covered dependent is no longer considered disabled under Social Security guidelines;
- For newborns and children adopted by or placed for adoption with you during your COBRA continuation period, the date your COBRA coverage period ends, unless a second qualifying event occurs; or
- JPMorgan Chase terminates the plan.

The MRA and COBRA

If you had an MRA as an active employee, you can use any remaining balance in your MRA to pay for eligible out-of-pocket medical and prescription drug expenses through the end of the month in which you terminate or while enrolled in COBRA medical coverage.

If you enroll in COBRA medical coverage, you can continue to earn Wellness Rewards to increase the value of your MRA, up to the full annual MRA earnings amount (see "The MRA" in the *Core Medical Plan section*). While enrolled in COBRA:

- Your MRA balances will roll over from one calendar year to the next; and
- You can use any remaining balance in your MRA through automatic claim payment or debit card payment method depending on the method you elect.
- Wellness Rewards are determined by the Medical Plan in which you are enrolled:
  - JPMC Core Medical Plan $1,000 or $1,400 if covering a spouse/domestic partner
  - JPMC Simplified Medical Plan $740 or $1,110 if covering a spouse/domestic partner

If you do not enroll in COBRA medical coverage, you cannot earn additional Wellness Rewards beyond your termination of employment. You can use your existing MRA funds to pay for out-of-pocket costs incurred prior to the end of the month of your termination date. For example, if you terminate as of January 5, 2022, any out-of-pocket medical and prescription drug expenses incurred through January 31, 2022, are eligible, but you must submit an MRA Claim Form by December 31, 2023, to receive a reimbursement. Any remaining MRA balance will be forfeited (unless you are retirement eligible in which case the balance remains intact and can be used to offset medical and prescription drug expenses until the account is depleted; administrative fees may be incurred).

If you completed the Initial Wellness Activity(ies) during the designated time frame in a given year, you will earn the corresponding wellness rewards in your MRA in January of the following year, presuming you are actively employed at that time or you elect COBRA Medical.

Those employees who terminate before the award date in mid-January and do not elect COBRA will not receive funds for completing the Initial Wellness Activity(ies).

If you elect COBRA medical coverage, no administrative fees are deducted from your MRA.

Special Rule for Health Care Spending Account Participants

Former employees may be eligible to continue participation in the Health Care Spending Account under COBRA, if you have not used your entire account balance prior to the date your participation would end. To continue participating under COBRA, you must make after-tax contributions equal to 102% of the total monthly contribution you were making to the Health Care Spending Account before your participation ended. Coverage may not be continued into the next plan year.

Please Note: You may want to elect to continue your participation in the Health Care Spending Account under COBRA if you have not used your entire account balance before your termination date and you anticipate that you will incur expenses after that date. Otherwise, only those expenses incurred through the end of the month in which your employee coverage ends will be eligible for reimbursement.

Additional Questions About COBRA Coverage

If you have additional questions about your COBRA coverage, please contact at (877) JPMChase ((877) 576-2427), or (212) 552-5100, if calling from outside the United States. Service Representatives are available Monday – Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays.

Defined Terms

As you read this section, you'll come across some important terms related to the accounts. To help you better understand the accounts, many of those important terms are defined here.

Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical, Dental, Vision and Spending Accounts Plans payroll contributions are generally taken on a before-tax basis.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Medical, Dental and Vision Plans. JPMorgan Chase is not involved in deciding appeals for any benefit claim denied under the Medical, Dental and Vision Plans. All fiduciary responsibility and decisions regarding a claim for a denied benefit under the Plan rest solely with the claims administrator. **Please Note**: Claims and appeals relating to eligibility to participate in the Medical, Dental and Vision Plans are decided by the plan administrator. Consult the *Plan Administration* section for details.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise end. This *Health Care Participation* section provides details on COBRA coverage. Publications 502, 503 and 15B are Internal Revenue Service (IRS) publications that can be used as a guide to determine eligible and ineligible expenses under the Health Care Spending Account, Dependent Care Spending Account and Transportation Spending Accounts. You can request a copy by calling the Internal Revenue Service (IRS) at (800) 829-FORM ((800) 829-3676), or you can view these publications by logging on to www.irs.gov.
Medical Reimbursement Account	A Medical Reimbursement Account ("MRA," also known as a Health Reimbursement Account" or "HRA") is a tax-free account established on your behalf at your health care company when you enroll in the Medical Plan. You (and your covered spouse/domestic partner) can earn Wellness Rewards for your MRA by completing Initial Wellness Activities and Additional Wellness Activities. This account is JPMC-funded only; you cannot contribute to your MRA. You can use the funds in your MRA to pay for eligible out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments).
Medicare	Medicare is Health Insurance for the Aged and Disabled provisions of Title XVIII of the Social Security Act of the United States, as enacted or later amended. Coverage is available to most U.S. residents age 65 and older, those with a disability for at least 29 months, and those with end-stage renal disease (ESRD). Generally, Medicare is the primary coverage for individuals who are age 65 and older, unless those individuals are actively working.
Qualified Status Change	The JPMorgan Chase benefits you elect during each Annual Benefits Enrollment will generally stay in effect throughout the plan year, unless you elect otherwise, because of a Qualified Status Change (QSC). If you have a QSC, you have 31 days from the qualifying event to make benefits changes; 90 days from the qualifying event if the event is the birth or adoption of a child. The benefits you elect will be effective the date of the event if you make the elections timely. (**Please Note:** You will have 90 days from the QSC date to add any newly eligible dependents to the Medical Plan, should that dependent pass away within this 90-day period.) **Please Note:** Regardless of whether you experience a qualified change in status, you cannot change your health care company during the year.