The Retiree Medical Plan

Effective 1/1/20

The Retiree Medical Plan is available to pre-Medicare-eligible retirees. It is also available to pre-Medicare-eligible dependents of pre-Medicare or Medicare-eligible retirees and to pre-Medicare-eligible dependents of Medicare-eligible individuals receiving long-term disability benefits from JPMorgan Chase. The Retiree Medical Plan provides benefits to help pre-Medicare-eligible individuals and their families get and pay for needed medical treatment and provides a prescription drug benefit.

Note: Effective December 31, 2014, JPMorgan Chase generally terminated retiree health coverage (medical, prescription drug, dental and vision) for individuals who are Medicare-eligible and are retired, are receiving benefits under the Long Term Disability (LTD) Plan, or are covered dependents of these individuals once they are Medicare-eligible. Instead, Medicare-eligible participants have access to individual health care coverage available through Via Benefits, a private Medicare exchange, which is not coverage sponsored by JPMorgan Chase.

The JPMorgan Chase U.S. Retiree Benefits Program is available to individuals who met the applicable retiree benefits age and service criteria when their employment terminated with JPMorgan Chase or a heritage organization. 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, including its U.S. Retiree Benefits Program. The JPMorgan Chase U.S. Retiree Benefits Program does not create a contract or guarantee of employment between JPMorgan Chase and any individual.

Questions?

For questions about enrollment and eligibility, contact HR Answers at (877) JPMChase [(877) 576-2427] or (212) 552-5100, if calling from outside the United States. Service Representatives are available Monday through Friday, from 8 a.m. to 7 p.m. Eastern Time, except certain U.S. holidays.

For customer service representative assistance from your health care company, call the number on the back of your ID card:

Aetna
(800) 468-1266
8 a.m. to 8 p.m. all time zones, Monday - Friday

Cigna
(800) 790-3086
24/7

CVS Caremark
(866) 209-6093
24/7

To enroll, or access Medical Plan options, or for provider directories, access the Benefits Web Center using Single Sign-On password: **My Health** > Benefits Web Center. You can access **My Health** at https://myhealth.jpmorganchase.com.

Medicare-eligible individuals should contact Via Benefits for questions about coverage offerings at (844) 448-7300, 8 a.m. to 9 p.m., Eastern Time, Monday through Friday, except certain U.S. holidays

Medical Claim forms for out-of-network benefits can be obtained by calling your health care company at the number on the back of your ID card. Alternately, you can access **My Health** > Claim forms.

About this Summary Plan Description

This document is the Retiree Medical Plan section of the summary plan descriptions for the JPMorgan Chase U.S. Retiree Benefit Program. The U.S. Department of Labor requires JPMorgan Chase to routinely provide benefits plan summaries to plan participants. Please retain this information for your records. This document also constitutes the plan document for the Retiree Medical Plan. It does not include all of the details contained in the applicable insurance contracts. If there is a discrepancy between the applicable insurance contracts and this document, the insurance contracts will control.

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Medical Coverage Highlights

My Health

My Health is your central online resource for the JPMorgan Chase Retiree Benefits Program. From **My Health**, you can easily connect to the Medical Plan carriers' websites to find in-network provider directories, access treatment cost estimators, check claims status, view Explanations of Benefits (EOBs), track your Medical Reimbursement Account balance and much more. **My Health** also has benefits materials, tip sheets and other information on health and wellness.

Your Retiree Medical Plan Options

Option 1 and Option 2 of the Retiree Medical Plan, each offered through Aetna and Cigna are "Consumer Driven Health Plan" options. Both options cover the same medically necessary services and supplies, including prescription drugs. **Please Note:** There is not a Simplified Medical Plan offering.

The key difference between the two options is the level of contribution versus deductible and coinsurance maximums. Option 1 has higher monthly contributions but lower annual deductibles and annual coinsurance maximums, while Option 2 has lower monthly contributions but higher deductibles and annual coinsurance maximums.

Option 1 and Option 2 benefits are offered through a network of participating health care providers (for example, doctors, hospitals, labs and outpatient facilities that belong to Aetna's and Cigna's networks). You can visit any provider each time you need care, even if they're not in the network. However, the most cost-effective care will always be available through in-network providers who have agreed to accept pre-negotiated rates.

- Eligible in-network preventive care (including physical exams and recommended preventive screenings) and eligible preventive generic drugs are covered at 100% with no deductible, coinsurance or copayments.
- In-network primary care office visits are covered at 90% with no deductible. Primary care physicians include doctors who practice family medicine, internal medicine (and are contracted with Aetna or Cigna as Primary Care Physicians, obstetrics/gynecology, and pediatrics). Visits to convenience care clinics, such as CVS Minute Clinic®, are also considered primary care visits.
- When you receive other medical services, you'll need to satisfy an annual deductible — a set amount that you pay out-of-pocket — before the Plan shares in the cost for care. There are separate deductibles for in- and out- of-network care and for prescription drugs.
- After you satisfy the deductible, the Plan pays a percentage (generally 80% in-network and 50% out-of-network) of the cost. Your share — called coinsurance, the amount you and the Plan share for certain expenses — after the deductible is typically 20% of the cost of in-network care and 50% of the cost for out-of-network care. The amount of coinsurance you have to pay each year is limited by separate annual in-network and out-of-network coinsurance maximums, which act as a financial safety net. In- network charges do not apply toward the out-of-network deductible or coinsurance maximum — and vice versa.
- After you meet the out-of-network deductible, benefits for out-of- network care are limited to R&C charges. These charges are based on average claims data in your area and are determined by your health care company in its discretion to be appropriate fees. Out-of-network charges are typically higher than the pre-negotiated rates for in-network care. You are responsible for paying any amount above R&C charges.
- If you see an in-network provider, you will generally not have to pay anything at the point of service and you will not have to file a claim. Your provider will typically submit your claim electronically to your health care company using the information on your ID card.
- Prescription drug benefits are part of your coverage. Prescription drug coverage has a different plan design than other Retiree Medical Plan features and is subject to a separate deductible and a separate safety net in the form of per-prescription maximums and an annual out-of-pocket maximum.

Your Health Care Company	Coverage under Option 1 and Option 2 is administered by Aetna and Cigna. In addition to choosing Option 1 or Option 2 when you enroll in the Retiree Medical Plan, you select which health care company you would like to administer your option. Both Aetna and Cigna are large, established companies that offer broad nationwide provider networks. They also offer strong, well-established clinical programs and provide tools and resources to help you research and understand your health treatment alternatives.
Your Coverage Level	You can choose to cover: ▪ You only; ▪ You and your spouse/domestic partner; or you and your child(ren); or ▪ Your family (you, your spouse/domestic partner, and your children).
Covered Services	Covered services will generally include: ▪ Hospitalization; ▪ Surgical procedures; ▪ Physician's office visits; ▪ Lab services/X-rays; ▪ Emergency room services; ▪ Maternity care; ▪ Mental health and substance abuse care; and ▪ Prescription drugs. The Retiree Medical Plan also covers various preventive care services. Services and procedures must be considered medically necessary to be covered.

Participating in the Retiree Medical Plan

The general guidelines for participating in the JPMorgan Chase Retiree Medical Plan are described in this section.

Eligibility

Your participation in the JPMorgan Chase Retiree Medical Plan is optional. In general, you are eligible to participate if you're a retiree of JPMorgan Chase (at least age 55 with 15 total years of service on the date you retired, or under the rules of retirement in effect at the time you left JPMorgan Chase & Co) and are not yet eligible for Medicare. You're also eligible to participate if you're a pre-Medicare-eligible dependent of a pre-Medicare or Medicare-eligible retiree, or a pre-Medicare-eligible dependent of a Medicare-eligible individual receiving long-term disability benefits from JPMorgan Chase.

Different criteria may apply to individuals who meet certain heritage organization date of hire, age and service requirements, and to individuals affected by a position elimination that qualifies for severance pay and related benefits.

In addition, there are two types of coverage:

- "Access Only" (or unsubsidized) coverage for which you pay the full cost with no subsidy from JPMorgan Chase, and
- Subsidized coverage for which the company pays a portion of the cost.

The specific eligibility requirements for each are outlined in the following charts.

Summary of Eligibility Requirements for Access Only (or Unsubsidized) Retiree Medical Coverage	
Age and Service When Employment with JPMorgan Chase Ends	General eligibility requirements: • You must be at least age 55 as of your termination date, and • You must have at least 15 years of total service as of your termination date. Alternative eligibility requirements in the event of a position elimination that qualifies for severance pay and related benefits: • If you don't meet the general eligibility requirements described above, but your employment ends because of a position elimination that qualifies you for severance pay and related benefits, you may be eligible if: — You execute the release for severance pay and related benefits; — You are at least age 50 as of your termination date; and — You have at least 20 years of total service as of your termination date. You elect retiree benefits at the time of retirement or when subsidized COBRA ends (if applicable). Electing **retiree benefits cannot be deferred.**

Important Note: If you do not meet all of the criteria below to qualify for company-subsidized retiree medical coverage, you may qualify for retiree benefits including "access only" (or unsubsidized) retiree medical coverage.

For Certain Heritage JPMorgan Chase Employees Only (i.e., Heritage Chase and Heritage Morgan): Summary of Eligibility Requirements for Company Subsidized Retiree Medical Coverage	
Hire Date	• You're a heritage Chase employee hired before January 1, 1997; or • You're a heritage Morgan employee who was employed on January 31, 1989 (and you didn't incur a break in service of longer than one year since that date). AND
Age and Service as of December 31, 2005	• You were employed by JPMorgan Chase, were at least age 50, and your age plus cumulative service was equal to 60 or more as of December 31, 2005 ("Rule of 60"); or • You were employed by JPMorgan Chase and had at least 25 years of cumulative service as of December 31, 2005. AND
Age and Service When Employment with JPMorgan Chase Ends	**General eligibility requirements:** • You must be at least age 55 as of your termination date; and • You must have 15 or more years of cumulative service, of which the last five years must be continuous, as of your termination date. In addition, heritage Morgan employees who attained the "Morgan Rule of 70" (minimum age 50, with age plus years of credited service under the Retirement Plan equal to 70 or more) as of December 31, 2003, are eligible to participate in the Retiree Benefits Program with company-subsidized retiree medical coverage. OR **Alternative eligibility requirements in the event of a position elimination that qualifies for severance pay and related benefits:** • If you don't meet the general eligibility requirements described above, but your employment ends because of position elimination that qualified you for severance pay and related benefits, you may be eligible if: — You execute the release for severance pay and related benefits; — You're at least age 50 as of your termination date; and — You have at least 20 years of cumulative service as of your termination date; and You elect retiree benefits at the time of retirement or when subsidized COBRA ends (if applicable). Electing **retiree benefits cannot be deferred.**

Additional Requirements for Rehired Employees

Below are additional eligibility requirements if your employment has terminated and you're subsequently rehired by JPMorgan Chase. These provisions are applicable to the eligibility requirements for company-subsidized retiree medical coverage.

Please Note: If you're re-employed by JPMorgan Chase and are eligible for active employee benefits, your retiree medical benefits will end. When your employment with JPMorgan Chase ends, you will again be eligible for retiree benefits and your cost for coverage will be based on the cost-sharing arrangement for which you were eligible when you first retired.

Rehire Not Employed on December 31, 2005

One of the eligibility criteria to receive subsidized retiree medical coverage is that you must have been employed on December 31, 2005, and met certain age and/or cumulative service requirements as of that date. If you terminated employment with JPMorgan Chase during 2005 and were rehired after December 31, 2005, but within one year of your termination date, you will be deemed to have satisfied that portion of the eligibility criteria for subsidized retiree medical coverage if:

- You were at least age 50 on December 31, 2005, and your age as of December 31, 2005, plus your cumulative service prior to your rehire was equal to 60 or more; or
- You had at least 25 years of cumulative service prior to your rehire.

Rehire Employed on December 31, 2005

If you were employed by JPMorgan Chase on December 31, 2005, terminated employment after that date, and were rehired within one year of your termination date, you will retain your eligibility for subsidized retiree medical coverage if you meet the other requirements. If your break in service is greater than one year, you will forfeit eligibility for subsidized retiree medical coverage, but may qualify for unsubsidized coverage.

Retiree Medical Plan Options

You can choose from either the Retiree Medical Plan Option 1 or Retiree Medical Plan Option 2. If you're enrolled in the Point-of-Service (POS) High Option or Point-of-Service Low Option, or any other Retiree Medical Plan, please see "Appendix" on page 60 for details on your Plan options.

Coverage Categories

When you enroll in the Retiree Medical Plan, your coverage level is based on the dependents you enroll and includes the following categories:

- You only;
- You plus spouse/domestic partner or you plus child(ren); or
- Family (you plus spouse/domestic partner plus child(ren)).

Your Eligible Dependents

In addition to covering yourself under the Retiree Medical Plan, you can also cover your eligible pre-Medicare-eligible dependents, but generally only under the same option you choose for yourself. Under the Retiree Medical Plan, you can generally cover dependents who were part of your family on the date you retired regardless of whether they were covered under the JPMorgan Chase Medical Plan for active employees.

Please Note: You cannot defer coverage for your spouse/domestic partner once you are retired.

Your eligible dependents under the Retiree Medical Plan — 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 12 for more information); and
- Your and/or your spouse's/domestic partner's children up to the last day 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. In order to cover your domestic partner's children, you must elect coverage for your domestic partner.

An Important Note on Dependent Coverage

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

Please Note: You may continue coverage beyond age 26 for an unmarried child who is unable to support himself or herself due to 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 Plan prior to turning age 26.

If JPMorgan Chase also employs or employed your spouse, domestic partner or dependent child, he or she can be covered as a retiree or as your dependent, but not as both. If you want to cover your eligible dependent child(ren), you or your spouse/domestic partner (but not both of you) may elect to provide this coverage. If you meet the eligibility criteria but die prior to retirement, your surviving spouse will continue to be eligible for retiree benefits as if you were retired.

Important Note on Dependent Eligibility

You are responsible for understanding the dependent eligibility rules 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 designated enrollment period or within 31 days of a qualified change in status (e.g., divorce). JPMorgan Chase reserves the right to conduct eligibility verifications on 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 such as **loss of coverage for your dependents and loss of coverage under COBRA continuation.**

Spouse

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

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);
- 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); and
- Children who are alternate recipients under a Qualified Medical Child Support Order (QMCSO), as required by law.

Remember: To cover the children of your domestic partner under the JPMorgan Chase Retiree Health Care & Insurance Plans, your domestic partner must also be enrolled. If you are covering the child of a domestic partner who is not a tax dependent, imputed income for that child will be applied.

Domestic Partners

In addition to the dependents previously listed, you may also cover a domestic partner as an eligible dependent under the Retiree Medical Plan 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 Retiree Medical Plan, 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 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.

Cost of Coverage

In general, you will pay the full cost for "access only" (unsubsidized) retiree medical coverage (on an after-tax basis) at group rates. JPMorgan Chase will not subsidize any portion of the cost of this coverage. Your cost for coverage depends on the option and coverage category you select. Each year, your annual benefits enrollment materials will show the cost for each option offered under each of the coverage categories. **Please Note**: If you are eligible for subsidized coverage, your cost of coverage will be shown in your enrollment materials.

Your contributions for cost of coverage start when your coverage begins. You will receive information about your eligibility and cost for retiree medical coverage when you retire. Costs for retiree medical coverage will change periodically — generally at the beginning of each plan year (January 1).

If you elect retiree coverage, you will initially be billed on a monthly basis. You will be offered the opportunity to have the monthly cost of your retiree medical coverage deducted from your personal checking or savings account upon receipt of your signed authorization.

Please Note: If you do not pay for retiree medical coverage on a timely basis, your coverage will be canceled, you cannot enroll again anytime in the future and COBRA will not be offered.

Retiree Medical Coverage for Certain Heritage Employees

If you retired under a medical plan from a heritage organization, your cost, coverage level, covered dependents and benefits provisions for retiree medical insurance may be different than the coverage described in this Summary Plan Description. For specific details about your coverage, please refer to the materials you received when you retired or contact HR Answers.

Imputed Income for Domestic Partner Coverage

You pay the same amount to cover a domestic partner under the Retiree Medical Plan as you would to cover a spouse. However, because of Internal Revenue Code restrictions, in most cases, any amount that JPMorgan Chase contributes toward your domestic partner's or domestic partner's children's (if they are not tax dependents) coverage (if you are eligible for subsidized retiree medical) will be taxable to you as imputed income (unlike coverage for a spouse) if you are enrolled in the Retiree Medical Plan. Therefore, you may owe additional U.S. federal and state income taxes in most states, as well as Social Security (FICA) taxes.

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.

How to Enroll

Participation in the Retiree Medical Plan is optional.

If You	What You Need to Do to Enroll
Are a Current Participant	During an annual benefits enrollment, you can make your election through the Benefits Web Center on **My Health** or through HR Answers. At the beginning of each enrollment period, you'll receive instructions on how to enroll. You'll also receive information about the Plan options available to you and their costs at that time. You need to consider your choice carefully; you can't change your enrollment decision during the year unless you have a Qualified Status Change. Please see "Qualified Status Changess" on page 15 for more information.
Are Newly Eligible for Coverage	If you are enrolling for the first time, you need to make your choices through the Benefits Web Center on **My Health** or through HR Answers within 31 days of your date of retirement (or within 31 days of becoming eligible for benefits as the dependent of an individual receiving long-term disability benefits from JPMorgan Chase). **There is no deferral of coverage feature in the JPMorgan Chase Retiree Plans**. You can access your benefits enrollment materials online at the Benefits Web Center.
Have a Qualified Status Change – Pre-Medicare-Eligible Dependent of Individual Receiving Long-Term Disability Benefits from JPMorgan Chase	If you're enrolling an eligible dependent during the year because you or that dependent has had a Qualified Status Change, you'll have 31 days from the date of the change in status to make your new choices through the Benefits Web Center on **My Health** or through HR Answers. Please see "Qualified Status Changess" on page 15 for more information.

Note: You or your eligible dependent(s) must call HR Answers to enroll.

If You Do Not Enroll

If You	What You Need to Do to Enroll
Are a Current Participant	If you're already participating in the Retiree Medical Plan, are pre-Medicare-eligible, and don't cancel coverage during annual benefits enrollment, you'll generally keep the same coverage for the following plan year that you had before the annual benefits enrollment (if available) or you'll be assigned coverage by JPMorgan Chase. However, you'll be subject to any changes in the Plan and coverage costs.
Are Newly Eligible for Coverage — Retiree and Dependents of Retirees	If you're newly eligible for coverage and don't enroll before the end of the designated 31-day enrollment period, you won't be eligible for coverage from the Retiree Medical Plan anytime in the future. There is no deferral of coverage feature in the JPMorgan Chase Retiree Plans.
Are Newly Eligible for Coverage — Pre-Medicare-Eligible Dependent of an Individual Receiving Long-Term Disability Benefits from JPMorgan Chase	If you're newly eligible for coverage and don't enroll before the end of the designated 31-day enrollment period, you won't be eligible for coverage from the Retiree Medical Plan anytime in the future.

Importance of Continuous Coverage for Retirees

As a retiree, you and your covered family members must remain continuously enrolled in medical coverage either through JPMorgan Chase (for individuals not yet eligible for Medicare) or Via Benefits (for those eligible for Medicare with a medical subsidy) to be eligible for coverage in the future. You cannot elect to defer retiree medical coverage for you and/or any eligible dependents at the time you retire. **Deferral of medical coverage is not an option**.

This applies to both the former employee as well as any members of their family unit.

- It also applies if you're eligible for COBRA coverage. Generally, you must elect retiree medical coverage (pre-Medicare) or coverage through Via Benefits (Medicare-eligible) rather than COBRA coverage if you want to remain covered by JPMorgan Chase Retiree Medical Plan in the future.
- If you're retiree-eligible and receiving subsidized COBRA coverage from JPMorgan Chase due to a severance arrangement, you may continue COBRA coverage until your COBRA subsidy period expires (up to six months on COBRA coverage depending on your years of service). Once the COBRA subsidy expires, you have a one-time opportunity to elect medical coverage through JPMorgan Chase Retiree Medical Plan (if pre-Medicare) or through Via Benefits (if Medicare-eligible). If you don't, you will no longer be eligible for JPMorgan Chase retiree medical coverage (pre-Medicare) or a medical subsidy from JPMorgan Chase in the future.

When Coverage Begins

If You	What You Need to Do to Enroll
Are Currently Participating	The coverage you elect during annual benefits enrollment takes effect the beginning of the following plan year (January 1).
Are Newly Eligible for Coverage	The coverage you elect as a newly eligible individual takes effect on the first of the month following your date of eligibility. **Note to Former Employees:** If you're eligible for coverage under the Retiree Medical Plan and due to job elimination are receiving a subsidy from JPMorgan Chase toward the cost of your COBRA Medical Plan coverage, you may continue your COBRA coverage until the COBRA subsidy period expires (up to six months on COBRA coverage depending on your years of service). After your COBRA subsidy expires, you can either continue with unsubsidized COBRA coverage for the remainder of your COBRA period (generally 18 months), paying the full cost of coverage, or elect retiree coverage. If you elect to continue with COBRA, at the end of your COBRA period, you will not be able to elect retiree medical coverage through JPMorgan Chase (if pre-Medicare) or be eligible for a medical subsidy (if Medicare-eligible) at any time in the future. There is no deferral of coverage feature in the JPMorgan Chase Retiree Plans.
Have a Qualified Status Change	The coverage you elect as a result of a qualifying event will take effect as of the day of the qualifying event. Please see "Qualified Status Changes" on page 15 for more information.

Qualified Status Changes

The Retiree Medical Plan elections you make during the annual benefits enrollment will stay in effect through the following plan year (or the current plan year if you enroll during the year as a newly eligible retiree). However, you may be permitted to change your elections before the next annual benefits enrollment if you have a Qualified Status Change. If you have elected not to participate in the Retiree Medical Plan, a Qualified Status Change doesn't allow you or your dependents to re-enter the Plan. **Please Note**: Any changes you make during the year must be consistent with your Qualified Status Change.

You need to enroll through the Benefits Web Center on **My Health** or through HR Answers within 31 days of the qualifying event for coverage to be effective the date of the event. Otherwise, you will not be able to make the change in coverage until the next annual benefits enrollment.

You can also visit the Benefits Web Center on **My Health** or contact HR Answers and speak with a Service Representative, if you have questions during the year about qualifying events and what the allowed benefit changes are.

Qualified Status Changes under the Retiree Medical Plan are listed in the following table.

Retiree Medical Plan Changes for Qualified Status Changes	
Event	**Retiree Medical Plan Changes**
You and/or Your Covered Dependents Gain Other Benefits Coverage*	Cancel coverage for yourself and/or your covered dependents who have gained other coverage.
You Get Legally Separated or Divorced	Cancel coverage for your former spouse and/or children who are no longer eligible.
You End a Domestic Partner Relationship or Civil Union	Cancel coverage for your domestic partner and your domestic partner's eligible children who are no longer eligible.
A Child Is no Longer Eligible*	Cancel coverage for your child.
A Covered Family Member Dies*	Cancel coverage for your deceased dependent and any other children who are no longer eligible.
You Move out of a Retiree Medical Plan Option Service Area	Change Retiree Medical Plan option for yourself and your covered dependents. (**Please Note**: In this situation, you'll be assigned new coverage by JPMorgan Chase based on your new service area. However, you'll have the ability to change this assigned coverage within 31 days of the qualifying event.)
You or your covered dependent becomes eligible for Medicare	Retiree and/or covered dependent becomes eligible for coverage through Via Benefits. Coverage through JPMorgan Chase is terminated.

*Also applies to a domestic partner relationship.

Note for Retirees and Dependents of Retirees: Once you have cancelled coverage, you cannot enroll yourself or your dependents at any time in the future.

Option 1 and Option 2 of the Retiree Medical Plan

The JPMorgan Chase Retiree Medical Plan offers medical and prescription drug coverage under two Consumer Driven Health Plan options, Option 1 and Option 2, provided by Aetna and Cigna, the health care companies that act as claims administrators for Option 1 and Option 2. Both options offer the same coverage for medically necessary services and supplies, including prescription drugs. The key differences between the two options are that Option 1 has higher monthly contributions and lower annual deductibles and annual coinsurance maximums, while Option 2 has lower monthly contributions and higher annual deductibles and annual coinsurance maximums.

This section provides a general overview of Option 1 and Option 2 with detailed descriptions of covered services in the following pages.

Provider Directories

You can easily check which health care providers participate in the various JPMorgan Chase Retiree Medical Plan options by accessing your health care company's website via **My Health**.

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 enrollment period, 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.

Our Health Care Companies

JPMorgan Chase partners with Aetna and Cigna to administer our Retiree Medical Plan. Both are large, established companies that offer broad nationwide provider networks. They also offer strong, well-established clinical programs and provide tools and resources to help you research and understand your health treatment alternatives. You can choose which of these two health care companies you want to administer your Retiree Medical Plan, regardless of whether you choose Option 1 or Option 2.

With Option 1 and Option 2 of the Retiree Medical Plan…

- **Benefits are provided through a network of participating health care providers who have agreed to charge negotiated rates for their services.** You can visit any doctor, hospital, lab or outpatient facility, even if they're not in the network. However, because in-network providers have agreed to pre-negotiated rates, you'll save money by staying in-network for your care.
- **Eligible in-network preventive medical care and eligible preventive generic drugs are covered at 100% with no deductible or coinsurance**. Please see "Out-of-Area Network Participants" on page 21 for information about eligible preventive medical care and "Prescription Drug Coverage Under Option 1 and Option 2" on page 28 for information about eligible preventive generic drugs.
- **In-network primary care visits are covered at 90% of the negotiated cost with no deductible; you pay 10%.** Primary care doctors include family practitioners, internists*, pediatricians and OB/GYNs. Visits to convenience care clinics, such as CVS Minute Clinic®, are also considered primary care visits.
- **When you receive other medical services, you'll need to satisfy an annual deductible — a set amount that you pay out-of-pocket — before the Plan shares in the cost for care. There are separate deductibles for in- and out-of-network care and for prescription drugs.**
- **After you satisfy the annual deductible, the Plan pays a percentage (generally 80% in-network and 50% out-of-network) of the cost.** Your share — called coinsurance, the amount you and the Plan share for certain expenses — after the deductible is typically 20% of the cost of in-network care and 50% of the cost for out-of-network care. The amount of coinsurance you have to pay each year is limited by separate annual in-network and out-of-network coinsurance maximums, which act as a financial safety net. In- network charges do not apply toward the out-of-network deductible or coinsurance maximum — and vice versa.

- **After you meet the out-of-network deductible, benefits for out-of-network care are limited to R&C charges.** These charges are based on average claims data in your area and are determined by your health care company in its discretion to be appropriate fees. Out-of-network charges are typically higher than the pre-negotiated rates for in-network care. You are responsible for paying any amount above R&C charges.
- **If you see an in-network provider, you will generally not have to pay anything at the point of service and you will not have to file a claim.** Your provider will typically submit your claim electronically to your health care company using the information on your ID card.
- **Prescription drugs benefits are part of your coverage and are administered by CVS Caremark.** Prescription drug coverage has a separate deductible, copayments and coinsurance, and a separate safety net in the form of per-prescription maximums and an annual out-of-pocket maximum.

* Internists must be contracted with Aetna or Cigna as a primary care physician (PCP). Go to Aetna's or Cigna's websites through **My Health** to search for PCPs/primary care.

How Option 1 and Option 2 Pay Benefits

Option 1 and Option 2 pay the same percentage for the same covered expenses (the Plan's coinsurance rate). What differs between the two options are the monthly contributions required for each option and the deductible and coinsurance maximum values, as explained in the following sections.

Prescription drugs are also covered the same way under Option 1 and Option 2. For a description of coverage for prescription drugs, please see "Prescription Drug Coverage Under Option 1 and Option 2" on page 28.

The Annual Deductible

Under Option 1 and Option 2, certain expenses are subject to an annual deductible. The annual deductible is the amount you must pay up front each calendar year before the Plan begins to pay benefits for most covered expenses.

Under Option 1 and Option 2, eligible preventive care that is received from in-network providers is covered in full without having to satisfy the deductible and in-network primary care is covered at 90% without having to satisfy the deductible (for more information on what is considered eligible preventive care and primary care, please see "Coinsurance Paid by Option 1 and Option 2 for Covered Benefits" on page 21).

Out-of-network care has a higher deductible that is separate from the in-network deductible. Amounts in excess of reasonable and customary (R&C) charges do not count toward the out-of-network deductible. As a reminder, the Prescription Drug Plan has a separate plan design and has separate deductibles from those listed in the following table.

If you elect coverage for yourself, you must pay up front for all eligible expenses (except for preventive care and primary care) until you meet the per-person deductible. After you meet the per-person deductible, the Plan will begin to pay its coinsurance rate for covered expenses (please see "Coinsurance Paid by Option 1 and Option 2 for Covered Benefits" on page 21 for the Plan's coinsurance for various expenses).

If you cover dependents, all eligible expenses paid by you and/or your covered dependents combine to meet the deductible amount for the coverage level. However, no individual must satisfy more than the per-person deductible amount. This means that once an individual's expenses meet the per-person deductible, the Plan will begin to pay benefits for that person, even if the family has not yet met the full deductible for the coverage category. Please see "The Per-Person Deductible and Coinsurance Maximum Provision" on page 20. The following table shows the annual deductibles for the different coverage levels under each option.

Option 1 and Option 2 In- and Out-of-Network Deductible				
Coverage Level	**Option 1**		**Option 2**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
You (also functions as a per-person deductible under the other coverage levels.)	$1,750	$2,750	$2,750	$4,750
You + spouse/domestic partner or You + child(ren)	$2,625	$4,125	$4,125	$7,125
You + spouse/ domestic partner + child(ren)	$3,500	$5,500	$5,500	$9,500

The Annual Coinsurance Maximum

Under Option 1 and Option 2, the annual coinsurance maximum is the maximum amount you must pay in coinsurance in a plan year toward eligible expenses. The coinsurance maximum does not include the deductible and there are separate coinsurance maximums for in-network and out-of-network charges.

The coinsurance maximum functions as your financial safety net. It prevents you from having to pay very high health care expenses in the event of a serious medical situation. Once the coinsurance maximum is reached, the Retiree Medical Plan will pay 100% of negotiated fees for covered in-network care and 100% of reasonable and customary (R&C) charges for covered out-of-network services for the rest of the year.

Amounts that you pay toward your medical deductible and amounts above R&C charges for out-of-network care do not count toward your coinsurance maximum. In addition, prescription drug benefits are subject to a separate out-of-pocket maximum, as explained in "How Prescription Drug Coverage Works" on page 29.

The annual coinsurance maximum varies based on coverage level as shown in the table below.

Option 1 and Option 2 In- and Out-of-Network Coinsurance Maximums (Medical Only, Excludes Deductible and Prescription Drugs)				
Coverage Level	**Option 1**		**Option 2**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
You (also functions as a per-person coinsurance maximum under the other coverage levels.)	$2,250	$6,000	$3,050	$6,000
You + spouse/domestic partner or You + child(ren)	$3,375	$8,000	$4,575	$8,000
You + spouse/ domestic partner + child(ren)	$4,500	$12,000	$6,100	$12,000

The Per-Person Deductible and Coinsurance Maximum Provision

If you elect coverage for yourself, you must pay all deductible/coinsurance expenses until the per-person deductible/coinsurance maximum is met. After you meet the per-person deductible/coinsurance maximum, you will pay no further deductible/coinsurance expenses for eligible covered services for the year.

If you cover dependents, the per-person rule allows any single person (e.g., the retiree or a covered spouse/domestic partner or child) within a coverage level to reach the individual deductible or coinsurance maximum, after which the deductible or coinsurance maximum is satisfied for the year for that person.

Covered family members who have not met the deductible or coinsurance maximum may then combine to meet the remainder of the deductible or coinsurance maximum for that coverage level. If no one individual has met the individual deductible or coinsurance maximum, the expenses of all covered members can combine to meet the deductible or coinsurance maximum for that coverage level.

An Example: Amounts Applied Toward In-Network Family Coinsurance Maximum for Medical Plan Option 1 After Deductibles Were Met	
On behalf of you	$2,250
On behalf of your spouse/domestic partner	$500
On behalf of one child	$250
On behalf of a second child	$250
TOTAL	**$3,250**
In this example, one person has met the $2,250 per-person coinsurance maximum (you), and combined coinsurance costs for the family have reached $3,250. Any charges for eligible medically necessary covered services for your care would therefore be reimbursable at 100% for the remainder of the year, even though the family as a whole has not yet met the family coinsurance maximum for the tier ($4,500).	

Maximum Lifetime Benefits

There is no dollar limit on the amount Option 1 and Option 2 would pay for essential benefits during the period you and your covered dependents are enrolled in the Retiree Medical Plan.

However, there is a $10,000 lifetime infertility services maximum ($30,000 if you and/or your covered spouse/domestic partner enroll in the program and receive your care in a Center of Excellence, as explained in “Centers of Excellence (COE)” on page 27). There is also a lifetime limit of 365 days for in- or out-of-network care in a skilled nursing facility. The infertility services and skilled nursing facility lifetime maximum benefits apply to both in-network and out-of-network care.

An Important Note on the Option 1 and Option 2 Benefit Maximums

The benefit maximums for infertility services and skilled nursing facility care reflect services received across Option 1 and Option 2.

You don’t gain a new benefit maximum if you switch your coverage between options or health care companies. In addition, any benefits that were applied to a lifetime maximum provision under prior medical plans of JPMorgan Chase (such as the Point of Service High and Low Options and the Consumer Driven Health Options) and medical plans of a heritage organization that was acquired by JPMorgan Chase will also be applied to the lifetime benefit maximums of the JPMorgan Chase Retiree Medical Plan.

Choosing Between In- and Out-of-Network Care

Under Option 1 and Option 2 of the Retiree Medical Plan you can choose to see any provider, but you'll pay less when you receive your care through your health care company's network of physicians and facilities because network providers have agreed to charge negotiated discounted fees for their services. In addition, the Plan pays a higher rate of coinsurance for in-network care, so your share of charges, if any, is less for in-network care. Lastly, the deductible is lower for in-network care than it is for out-of-network care, so you have to incur less expense before the Retiree Medical Plan begins to pay coinsurance for covered expenses.

When you receive in-network care:

- You usually don't have to file any claim forms; your network provider will usually file claims for you.
- Your out-of-pocket expenses will be lower compared to your expenses for the same type of care on an out-of-network basis. In-network doctors have agreed with Aetna and Cigna to charge pre-negotiated fees that are on average lower than the fees charged by doctors outside the network. You cannot be billed for any amounts above those pre-negotiated fees.

When you receive out-of-network care:

- You may need to file a claim form to receive out-of-network benefits. Please see "Filing a Claim for Reimbursement Under Option 1 and Option 2" on page 37 for more information.
- Your out-of-pocket costs for medically necessary covered services generally will be higher than if you received in-network care.
- Covered services performed by providers not participating in the network will be reimbursed at the out-of-network level of benefits, subject to reasonable and customary (R&C) charges. These charges are based on average claims data in your area and are determined by your health care company to be appropriate fees for medical services. Out-of-network charges are typically higher than the pre-negotiated fees that are covered for in-network care. **Please Note:** You will be responsible for paying any charges above the R&C amount. Charges in excess of reasonable and customary levels are not considered a covered expense under the Plan, and they therefore do not count toward the coinsurance maximum.

Out-of-Area Network Participants

The JPMorgan Chase Medical Plan vendors, Aetna and Cigna, offer broad national networks. However, in certain extremely limited situations, participants may be in an area without access to the expected level of Aetna's or Cigna's network coverage. In those rare circumstances, and effective as of each Annual Benefits Enrollment period, participants impacted by this are offered coverage during Annual Benefits Enrollment through Cigna's "Out of Area" program and are offered participation in Option 1. Out-of-Area participants can use any provider and the services are covered as in-network. Typically, eligibility for Out-of-Area participation is determined by Cigna and is based on the number of primary care physicians and hospitals within a certain mileage radius of your home zip code. Out-of-Area eligibility can change, as determined by Cigna, as more physicians or hospitals are added in your area.

Coinsurance Paid by Option 1 and Option 2 for Covered Benefits

The table on the following pages shows the coinsurance percentage paid by the Retiree Medical Plan on an in-network and out-of-network basis for covered expenses. Please also see "What Is Covered Under Retiree Medical Plan Options" on page 39 for a more detailed list of covered expenses under the Retiree Medical Plan.

Please Note: When you visit an in-network facility for a scheduled surgery, the Retiree Medical Plan will cover care provided by radiologists, anesthesiologists and/or pathologists (RAPs) at the in-network percentage of the billed charges, even if the provider is considered an out-of-network provider.

For example, assume you visit an in-network facility for surgery and are treated by an out-of-network anesthesiologist whose charge is $500. The Plan will reimburse you 80% of $500 ($400) assuming you met the deductible; you will be responsible for payment of the remaining $100.

Fees for services provided by any other out-of-network specialists who attend to you while you're confined in an in-network facility will be paid at the out-of-network level of benefits. Services performed in an out-of-network facility will be paid at the out-of-network level of benefits.

Type of Service	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Eligible Preventive Care** **Please Note:** A medical service will only be covered at 100% if it is coded as preventive. Before receiving any service, you should check with your physician to be sure the procedure is considered, and will be submitted to your health care company, as preventive medical care rather than as a diagnostic service. Additional lab or other services performed during a preventive care visit that are not considered preventive in nature may not be covered at 100% with no deductible.		
Acupuncture Services	80% coverage after deductible	50% coverage after deductible
Fecal Occult Blood Test	100% coverage before deductible age 50 and over; one test per year	50% coverage after deductible age 50 and over; one test per year
Immunizations (routine adult and child) (includes immunizations related to travel)	100% coverage before deductible	50% coverage after deductible
Mental Health Care	80% coverage after deductible	50% coverage after deductible
Preventive Sigmoidoscopy/Colonoscopy	100% coverage before deductible age 50 and over; one baseline screening and one follow-up screening every five years	50% coverage after deductible age 50 and over; one baseline screening and one follow-up screening every five years
Routine Gynecological Exams and Pap Smears	• 100% coverage before deductible • one exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines	• 50% coverage after deductible • one exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines
Routine Mammography, Prostate Specific Antigen (PSA) Test and Digital Rectal Exam	• 100% coverage before deductible age 40 and over; one exam per year	• 50% coverage after deductible age 40 and over; one exam per year
Routine Physical Exams	• 100% coverage before deductible	• 50% coverage after deductible

Type of Service	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Routine Screenings Provided During Pregnancy (e.g., gestational diabetes and bacteriuria screenings, as well as items such as certain breast pumps)	100% coverage before deductible	50% coverage after deductible
Outpatient Services		
Home Health Care ***(may require precertification; limited to combined in-network and out-of-network maximum of 200 visits/calendar year; one visit = four hours)***	80% coverage after deductible	50% coverage after deductible
Infertility Services (Includes diagnostic procedures, in-vitro fertilization, artificial insemination, etc.) (available for employees and/or their spouse/domestic partners with a medical diagnosis of infertility, as defined by your health care company) Limited to combined in-network and out-of-network maximum of $10,000/lifetime for each covered retiree and/or spouse/domestic partner.*** $30,000 lifetime maximum if you and/or your covered spouse/domestic partner use a Center of Excellence for your treatment, as described under "Centers of Excellence (COE)" on page 27. ***Separate $10,000 prescription drug benefit.***	80% coverage after deductible; coverage requires you to contact your health care company and receive precertification before obtaining services	50% coverage after deductible; coverage requires you to contact your health care company and receive precertification before obtaining services

Type of Service	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Primary Care Office Visits (to family practitioners, internists, pediatricians, OB/GYNs and convenience care clinics) Internists must be contracted with Aetna and Cigna as a primary care physician (PCP). (Includes tests, injection drugs, supplies and other services authorized by the Plan and provided during the visit and billed by the primary care physician. Go to Aetna's or Cigna's websites through **My Health** to search for PCPs/primary care.)	90% coverage before deductible	50% coverage after deductible
Routine eye exams	Not covered	Not covered
Specialist's Office Visits (includes tests, injection drugs, supplies and other services authorized by the Plan and provided during the visit, consultations, specialist referrals and second surgical opinions)	80% coverage after deductible	50% coverage after deductible
Speech, Physical or Occupational Therapy ***(combined in-network and out-of-network limit of 60 visits/calendar year per therapy type***)***	80% coverage after deductible	50% coverage after deductible
Spinal Treatment/ Chiropractic Care ***(coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year***)***	80% coverage after deductible	50% coverage after deductible
Substance Use Disorder Services	80% coverage after deductible	50% coverage after deductible
Urgent Care Center	80% coverage after deductible	80% coverage after deductible

Type of Service	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
X-rays and Labs (When performed to diagnose a medical problem or treat an illness or injury. **Please Note:** For Cigna, X-rays and lab tests done in a physician's office are covered in the same manner as a PCP visit.)	80% coverage after deductible	50% coverage after deductible
Inpatient Services (precertification recommended)		
Acute Hospital Care (based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases)	80% coverage after deductible	50% coverage after deductible
Hospice Care	80% coverage after deductible	50% coverage after deductible
Mental Health Care	80% coverage after deductible	50% coverage after deductible
Skilled Nursing Facility (includes charges for services and supplies provided while patient is under continuous care and requires 24-hour skilled nursing care and room and board; limited to combined in-network and out-of-network maximum of 365 days/lifetime for each covered individual)***	80% coverage after deductible	50% coverage after deductible
Substance Use Disorder Services	80% coverage after deductible	50% coverage after deductible
Other Services		
Ambulance Services (for sudden and serious medical conditions approved by your health care company as required for emergency care — also see "If You Need Emergency Care" on page 27)	80% coverage after deductible	80% coverage after **in-network** deductible
Durable Medical Equipment and Prosthetics (includes glucose monitors, insulin pumps and related pump supplies)	80% coverage after deductible	50% coverage after deductible

Type of Service	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Emergency Room (for sudden and serious medical conditions approved by your health care company as required for emergency care — also see If You Need Emergency Care" on page 27) In accordance with applicable regulations, true emergency is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors.	80% coverage after deductible; 50% coverage after deductible for non-emergencies	80% coverage after deductible for true emergencies (**Note:** the in-network deductible applies, rather than the out-of-network deductible); 50% coverage after deductible for non-emergencies
Prescription Drugs	Please see "Prescription Drug Coverage Under Option 1 and Option 2" on page 28.	

* Covered out-of-network expenses are subject to R&C charges. You are responsible for paying any charges above the R&C amount.

** Your health care company determines preventive care services covered at 100% under the Plan based on guidelines and clinical recommendations for general population developed by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorgan Chase does not make this determination. For a list of preventive services that are covered at 100%, go to your health care company's website accessible via **My Health**.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to R&C charges. You are responsible for paying any charges above the R&C amount. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

Additional Plan Provisions

Prior Authorization

Prior authorization, also known as pre-certification or pre-approval, is required for many services and procedures, such as hospital stays and some surgical procedures.

In general, in-network providers are responsible for obtaining prior authorization before providing these services to you. Before receiving these services, you may want to contact your health care company to verify that the hospital, physician and other providers are in-network providers and that they have obtained the required prior authorization. In-network facilities and providers cannot bill you for services if they fail to obtain prior authorization as required.

If you are using an out-of-network provider, you are responsible for obtaining prior authorization before you receive these services. **Note:** You must obtain prior authorization when an out-of-network provider intends to admit you to an in-network facility or refers you to other in-network providers.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs.

Hospital Notification — Non-Emergency

In the case of a scheduled, non-emergency hospital stay, you, your physician or the facility should contact your health care company for prior authorization / pre-certification (see below). You, your physician or the facility should also contact your health care company if a maternity stay will exceed 48 hours for the mother and/or newborn child following a vaginal delivery, or 96 hours for the mother and/or newborn child following a cesarean section delivery. To provide notification, please contact your health care company at the number on the back of your ID card. You will not be penalized under the Plan if you do not notify the claims administrator.

In Case of:	To Obtain Precertification:
Non-emergency admission	You, your physician or the facility will need to call and request precertification at least 14 days before the date you're scheduled to be admitted.
Outpatient non-emergency medical services requiring precertification	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 180 days as long as you remain enrolled in the Plan.

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be precertified. You, your physician or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies aren't covered benefits, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision.

If You Need Emergency Care

If you have a medical emergency that's sudden, urgent and life threatening, you should call 911 or go to the nearest physician, hospital emergency room or other urgent care facility. Your emergency care will be covered at 80% (after you have met the in-network annual deductible) under both Option 1 and Option 2 as long as your health care company approves the care as being required for a true emergency.

In accordance with applicable regulations, true emergency is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors.

If your health care company determines that you did not have a true emergency, the Plan will pay benefits at 50% rather than 80% after meeting the deductible.

Centers of Excellence (COE)

Organ transplants, bariatric surgery and infertility treatment are complex procedures or treatments that require highly specialized or quality care. As a result, Option 1 and Option 2 have in-network hospitals that have been designated as Centers of Excellence because of the high quality care they consistently provide for these procedures and services.

Your infertility benefit maximum will be increased from $10,000 to $30,000 if you and/or a covered spouse/domestic partner enrolls in the program and chooses a Center of Excellence for your treatment. (**Please Note**: There is a separate prescription drug benefit for infertility services.)

Please Note: In order to receive benefits for infertility treatment services or bariatric surgery, you must contact your health care company and receive precertification before obtaining services.

To locate a Center of Excellence, visit your health care company's website at **My Health** or call your health care company (see "Questions?" on page 2 for contact information).

Nurseline

You can call Aetna and Cigna and speak to a registered nurse at any time. You can get help with health advice 24 hours a day, 7 days a week — even on weekends and holidays. There are no limitations on how many times you might use the Nurseline. Examples include:

- Recognize urgent and emergency symptoms;
- Understand medication interactions;
- Locate in-network doctors and hospitals; and
- Research treatment costs.

Contact your health care company to learn more:

- Aetna: Call (800) 486-1266 and say, "Speak with a nurse."
- Cigna: Call (800) 790-3086 and select the prompt, "24-Hour Health Information Line."

Prescription Drug Coverage Under Option 1 and Option 2

Your prescription drug coverage is the same under Option 1 and Option 2 of the Retiree Medical Plan and is administered by CVS Caremark. Prescription drug coverage has a different plan design from the other Retiree Medical Plan features, with a separate deductible, copayments and coinsurance, and a separate safety net in the form of per-prescription maximums and an annual prescription drug out-of-pocket maximum. You will receive a separate prescription drug identification (ID) card from CVS Caremark in addition to your Retiree Medical Plan ID card.

For Help with Prescription Drug Coverage

You can reach a Caremark Customer Service Representative 24 hours a day, seven days a week at (866) 209-6093. In addition, once you are enrolled, you can visit CVS Caremark's website accessible via **My Health** or directly at www.caremark.com. The site allows you to:

- View the covered and excluded JPMorgan Chase drug lists;
- View your personal prescription drug history;
- Estimate drug costs and identify prescription drug cost saving opportunities;
- Order/refill/check the status of mail order prescriptions;
- Look for network retail pharmacies;
- Research drug information;
- Set up personal email reminders for refills; and
- Print temporary CVS Caremark ID cards.

How Prescription Drug Coverage Works

Highlights of prescription drug coverage are listed below; detailed information follows.

- Free preventive generic drugs. Eligible preventive generic medications are covered at 100% with no deductible or copayments at network pharmacies.
- Separate deductibles and coinsurance maximums than the Medical Plan;
- Discounted prices that are available at network pharmacies (you'll generally pay more at an out-of-network pharmacy); if you use an out-of-network pharmacy that does not accept your prescription drug ID card, you will generally pay more and will need to file a claim for eligible reimbursement.
- Option of having maintenance prescriptions filled through a convenient mail-order program or at a pharmacy;
- Traditional (non-specialty) and specialty lists of preferred/covered and excluded drugs; the most recent lists can always be found on the CVS Caremark website; and
- Mandatory Generic Drug Program; if you fill a prescription for a brand-name medication when a generic equivalent is available, you will pay the difference in cost between the brand-name drug and generic drug, plus the generic copay.

Here is how the Plan generally pays for different types of drugs:

- Free preventive generic drugs. Eligible preventive generic medications are covered at 100% with no deductible or copayments at network pharmacies.
- 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. CVS Caremark determines which drugs are considered "preventive generic" drugs. To see a list of drugs in this category, visit CVS Caremark's website accessible via **My Health**.

Please Note: Generic prescription contraceptives are also fully covered with no deductible (as are brand-name, contraceptive drugs for which a generic is not available)

- $10 copayment for non-specialty generic drugs (up to 30-day supply). You pay $10 for non-specialty generic drugs not considered preventive purchased at a network pharmacy. Non-specialty generic drugs are not subject to a deductible. If the cost of a generic drug is less than the $10 copayment, you'll pay the lower amount.
- Annual retail deductible for brand-name and specialty generic drugs. An annual deductible of $100 per individual (with a maximum of $300 per family) applies to brand-name and specialty generic prescriptions filled at retail pharmacies. There is no deductible for non-specialty generic drugs or for 90-day supplies purchased at a CVS retail pharmacy or by mail.
- Coinsurance for brand-name and specialty generic drugs. After you satisfy the retail deductible, you and the Plan share the cost of brand-name and specialty generic drugs through coinsurance.

When a generic prescription drug is not available, there are often many different brand-name alternatives. CVS Caremark has reviewed these alternatives and determined which are clinically appropriate and cost-effective. These are called "preferred brand-name prescription drugs," and are covered at a higher level than "non-preferred brand-name drugs." To see a list of preferred drugs, visit CVS Caremark's website.

- Per-prescription maximum. The amount you pay for brand-name and specialty generic drugs each time you fill a prescription is capped by a per-prescription maximum, a safety net that protects against the cost of very expensive drugs. If the coinsurance amount is greater than the per-prescription maximum, you will pay only the amount of the maximum.
- Cost savings for long-term maintenance medications. Maintenance Choice® offers advantageous pricing when you receive 90-day supplies of maintenance medication by mail or pick up your prescription at CVS retail pharmacies, where the same discounts are available. There is no deductible for maintenance medications received through Maintenance Choice®.
- Annual out-of-pocket maximum. The annual out-of-pocket maximum is the overall "safety net" of your prescription drug coverage. The maximum caps your annual cost for covered prescriptions at $1,150 per individual (with a maximum of $2,300 per family), not including the deductible. Once an individual reaches this limit (or once the family meets the family limit), that individual (or family) does not have to pay anything further for covered drugs for the calendar year, regardless of coverage level.
- The out-of-pocket maximum covers all copayments and coinsurance for covered drugs. It does not include the annual deductible for retail prescriptions or costs for non-covered drugs. **Please Note:** The prescription drug out-of-pocket maximum is separate from the Medical Plan's out-of-pocket maximum.

A Note About Generic vs. Brand-Name Drugs

Many popular brand-name drugs are expected to have a generic version available. Shortly after generic equivalents are introduced, the equivalent brand-name drug will move from preferred to non-preferred status. If you choose to continue to take the brand name drug when the generic is available, you may be subject to a significantly higher cost. Please see "Mandatory Generic Drug Program" on page 35 for more information. You should talk to your doctor to determine whether a generic equivalent is suitable.

How Prescription Drug Benefits Are Paid Under the Retiree Medical Plan

Prescription drug coverage has a separate plan design from the other Retiree Medical Plan features, with a separate deductible, copayments, and coinsurance, and a separate "safety net" in the form of per-prescription maximums and an annual prescription drug out-of-pocket maximum.

Category	Provisions	
Preventive Generic Drugs	100% coverage (deductible does not apply)	
Non-preventive Generic Drugs (non-specialty)	30-day supply: $10 or the actual cost of the drug if less than $10; not subject to the deductible 90-day supply: You pay $20 or actual cost of the drug if less than $20; not subject to the deductible	
Annual Retail Deductible (retail pharmacy only; waived for non-specialty generic drugs)	Employee only (also serves as a per-person maximum**)	$100
	Employee + spouse/domestic partner or Employee + child(ren)	$200
	Family (employee + spouse/domestic partner + child(ren))	$300
Retail Pharmacy Benefit (up to a 30-day supply) The Retail Pharmacy benefit covers up to a 30-day supply of medication purchased from a network pharmacy.		
• Preferred brand-name and specialty generic coinsurance/per-prescription maximum*	You pay 30% after the deductible, up to a $200 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $200 maximum)	

Category	Provisions	
• Non-preferred brand-name coinsurance/per-prescription maximum*	You pay 45% after the deductible, up to a $250 maximum per-prescription payment (the Plan pays 55% coinsurance plus costs above the $250 maximum)	
Mail Order Pharmacy or CVS Retail Pharmacy/ Maintenance Choice® (up to a 90-day supply; opt-out available)* The deductible does not apply if you fill maintenance medications through Maintenance Choice®. Please see "Details About Maintenance Choice®" on page 31 for more information.		
• Preferred brand-name and specialty generic coinsurance/per-prescription maximum**	You pay 30% up to a $500 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $500 maximum)	
• Non-preferred brand-name coinsurance/per-prescription maximum**	You pay 45% up to a $625 maximum per-prescription payment (the Plan pays 55%coinsurance plus costs above the $625 maximum)	
Annual Out-of-Pocket Maximum (covers copayment/coinsurance expenses for covered eligible prescription drugs; does not include the deductible)	Employee only (also serves as a per-person maximum**)	$1,150
	Employee + spouse/domestic partner or Employee + child(ren)	$1,750
	Family (employee + spouse/domestic partner + child(ren))	$2,300
• **CVS Caremark Excluded Drugs** • (Traditional and Specialty)	Not covered; you will pay the full cost for these drugs.	
• **Non-Sedating Antihistamines** • (also known as NSAs)	Not covered; you will pay the full cost for these drugs.	

* The Maintenance Choice® program covers 90-day supplies of maintenance medication. There is no deductible for maintenance medications. Maintenance Choice® allows you to: 1) send your 90-day prescription to CVS Caremark and have your medicine delivered by mail to your home; or 2) fill your 90-day prescription at any CVS retail pharmacy. If you "opt out" out of Maintenance Choice®, your prescription will be subject to the deductible and your costs will generally be higher. Please see "Details About Maintenance Choice®" on page 31.

** CVS Caremark determines which drugs are considered "generic," "brand," "preventive generic," "preferred," "non-preferred," "maintenance," and "specialty," etc. We use CVS Caremark's lists of covered and excluded drugs. An independent committee made up of pharmacists, physicians and medical ethicists reviews and approves the drug lists (also known as formularies). These lists are subject to change quarterly by CVS Caremark. If you continue to take a noncovered drug, you will pay the full cost of the drug. To see a list of drugs in these categories, visit CVS Caremark's website at **My Health**.

*** For both the retail deductible and the annual out-of-pocket maximum, the "per person" rule allows the employee or any covered dependent(s) [for example, spouse/domestic partner or child(ren)] to reach an individual deductible or out-of-pocket maximum, after which the deductible or out-of-pocket maximum is satisfied for the year for that person. Covered individuals who have not met the deductible or out-of-pocket maximum may combine to meet the remainder of the deductible or out-of-pocket maximum for that particular coverage level. If no one person has met the individual deductible or out-of-pocket maximum, the expenses of all covered individuals can combine to meet the deductible or out-of-pocket maximum for that coverage level.

Details About Maintenance Choice®

The Maintenance Choice® program provides discounted pricing for 90-day supplies of long-term maintenance drugs. Some examples of long-term maintenance drugs are those taken for:

- Asthma;
- Diabetes;
- High blood pressure:and
- High cholesterol.

To see a list of maintenance drugs and to compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS retail network pharmacy, visit CVS Caremark's website.

With Maintenance Choice®, a 90-day supply of maintenance medicine can be delivered by mail to your home or you can fill your 90-day prescription at any CVS pharmacy, where the same discounts are available.

You may also "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy (see "Opting Out of Maintenance Choice®" in the next section).

Before filling a long-term prescription through Maintenance Choice®, you can obtain two 30-day supplies at a network pharmacy by paying retail pharmacy rates. This "trial period" gives you and your doctor the ability to confirm that the medication and dosage is right for you. After that, you will need to use Maintenance Choice® to obtain the most advantageous pricing (or you may opt out of the program, but you may pay more).

A CVS Caremark Mail Order Form is available on the CVS Caremark site. Mail your prescriptions with your completed order form to the address noted on the form

Opting Out of Maintenance Choice®

You will generally pay the lowest price for maintenance medications if you use Maintenance Choice® to obtain a 90-day supply by mail or at a CVS pharmacy. However, you may "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy. You will be subject to the annual retail deductible, and, for 90-day supplies of medication, your per-prescription maximum will be higher, as shown in the following table.

Comparing Per-prescription Maximums Under Maintenance Choice® to Opting Out of Maintenance Choice®

	Maximum per-prescription charge	
	Maintenance Choice® (obtain through mail or at a CVS retail pharmacy)	***Opt Out (obtain prescription at a non-CVS retail in-network pharmacy*)***
Generic non-specialty 90-day supply	$20	$30
Preferred brand-name and specialty generic 90-day supply	$500	$600
Non-preferred brand-name 90-day supply	$625	$750

* Or a 30-day supply at a CVS pharmacy.

To compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS Caremark network pharmacy, visit CVS Caremark's website.

To continue to fill your maintenance medication prescription at a non-CVS Caremark network pharmacy after your two 30 days' supplies at a network pharmacy, you must opt out of Maintenance Choice® by calling CVS Caremark. If you order maintenance medications through a non-CVS Caremark network pharmacy without calling CVS Caremark first, your claim will be rejected and you will pay the full cost of the medication. **Please Note:** Your "opt out" status will apply to all maintenance medications that you fill through the Plan.

Out-of-Network Pharmacy Benefits/Filing a Claim if You Do Not Show Your ID Card at a Network Pharmacy

If you purchase your prescription drugs through a non-network pharmacy or do not show your CVS Caremark ID card at a network pharmacy, you will have to pay for the prescription drug and then file a CVS Caremark Claim Form to be reimbursed for the Plan's share of the eligibile expense.

What Prescription Drugs Are Covered and Not Covered

The following charts show common prescription drugs and their coverage status. **Please Note:** This list does not show every drug covered under the Plan. For the most current information and a full list of covered medications, visit CVS Caremark's website, accessible through **My Health** or directly at www.caremark.com.

Please Note: An independent committee made up of pharmacists, physicians and medical ethicists reviews and determines the covered drug list (also known as a formulary).

Prescription Drugs Covered by the Prescription Drug Plan

Drug	Coverage Status
Allergy Serums (oral immunotherapy drugs)	Covered but requires prior authorization
Aspirin	Covered — generic aspirin (81mg only) is fully covered without a deductible as prevention medication: • after 12 weeks of gestation in women who are at high risk for preeclampsia (Age limit: 12 or older, quantity limit: 100 units per fill); • for primary prevention of cardiovascular disease and colorectal cancer (Age limit: 50 to 59 years, quantitylimit: 100 units per fill) OTC products require prescription.
Breast Cancer Drugs	Covered — generic anastrozole, exemestane, raloxifene, and tamoxifen are fully covered without a deductible as part of a treatment therapy for women at risk for breast cancer and/or diagnosed with breast cancer for age 35 or older.
Contraceptives	Covered — generic prescription contraceptives are fully covered without a deductible, as are brand-name prescription contraceptives for which a generic is not available, such as Lo Loestrin® 24 Fe.* * **Please Note:** If a generic prescription becomes available for a brand-name contraceptive, the generic form of the contraceptive will be fully covered without a deductible, while the brand-name version of the contraceptive would be covered according to the provisions for other brand-name medications.
Diabetic Supplies (includes certain glucose monitors, insulin pumps and related pump supplies)	Covered — except alcohol wipes
Diet Medications (anorexiants and anti-obesity)	Covered but requires prior authorization
Fluoride Supplements	Covered — generic fluoride supplements are fully covered without a deductible for children age 5 or younger

Drug	Coverage Status
Infertility Drugs (exclusive of treatment)	Covered up to a $10,000 lifetime maximum (combined Retail Pharmacy Benefit and Maintenance Choice® program) per person
Legend Vitamins	Covered
Male Impotency Drugs	Covered at 8 units per 30 days (24 units per 90 days through Maintenance Choice®).
Prescription Tobacco Cessation Products	Covered
Proton Pump Inhibitors (PPIs) (such as Prilosec, Tagamet, and Nexium)	Covered subject to preauthorization, as described under "Coverage for Proton Pump Inhibitors" on page 35.
Respiratory Therapy Supplies	Covered — except nebulizers.
Select Medical Devices and Artificial Saliva products	Covered but requires prior authorization.
Solaraze (Diclofenac sodium gel 3%)	Covered but requires prior authorization.
Solodyn	Covered but requires prior authorization.

Prescription Drugs Not Covered by the Prescription Drug Plan

Drug	Coverage Status
Allergy Serums (injectable)	Not covered
Blood Plasma/ Blood Transfusion Agents	Not covered
Botox and Myoblock	Not covered — for cosmetic purposes; requires prior authorization for other uses.
Bulk Powders & Topical Analgesic (compounds)	Not covered**
Cosmetic Products (such as depigmenting agents, hair growth stimulants, hair removal agents)	Not covered
Mifeprex	Not covered
Non-Sedating Antihistamines (NSAs) (such as Clarinex and Allegra)*	Not covered
Nutritional Supplements (injectable or oral)	Not covered
Over-the-Counter Drugs	Not covered (but still may be less expensive than related prescription drugs)
Renova	Not covered
Rx Devices Other Than Respiratory (such as elastic bandages and supports, GI-guostomy and irrigation supplies, other Rx devices)	Not covered
Vaccines/Toxoids	Not covered

* Although non-sedating antihistamine (NSA) drugs are not covered under the Prescription Drug Plan, you can still obtain these and other non-covered prescription drugs (versus the over-the-counter alternative) at discounted prices through Maintenance Choice®. You pay 100% of the discounted price for non-covered drugs obtained through Maintenance Choice®.

** Your physician and/or pharmacist may contact CVS Caremark to seek exception approval for specific medical reasons.

Coverage for Proton Pump Inhibitors

If you are prescribed a brand-name proton pump inhibitor (PPI) prescription medication, you must have previously tried a generic proton pump inhibitor in order to receive coverage for the brand-name PPI. You should talk to your doctor to see if a generic alternative is appropriate for you. If your physician has a medical reason for you to take a brand-name PPI prescription medication rather than a generic alternative, your physician will need to contact CVS Caremark for prior authorization and a determination will be made. If the brand-name prescription is not authorized and you opt not to obtain the generic alternative available, you will be responsible for the entire cost of the prescription under the terms of the JPMorgan Chase Retiree Prescription Drug Plan.

Additional Plan Provisions

Mandatory Generic Drug Program

The plan contains a **mandatory generic drug program,** in which generic drugs are substituted for certain brand-name* prescription drugs. If you choose to fill your prescription with a brand-name drug when a generic equivalent is available, you pay the entire cost difference plus the generic drug copay. **Please Note:** These cost differences will not be limited by per-prescription maximums or annual out-of-pocket maximum limits. Your physician can contact CVS Caremark to seek a medical exception review for possible approval for specific clinical reasons.

*For this purpose, brand drugs refer to those brand drugs with a direct generic equivalent produced by at least two manufactures.

Step Therapy Program

Step Therapy is a program that lets members get the treatment they need affordably. It also helps the Plan maintain affordable prescription drug coverage. In step therapy, medicines are grouped in categories based on treatment and cost.

- First-line medicines are the first step. First-line medicines are typically generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.
- Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who don't respond to first-line medicines. Second-line drugs are the most expensive options.

Prior Authorization

Certain medications may only be covered by the Plan under certain conditions with a prior authorization (PA) from CVS Caremark prior to purchasing the medicine. To find out if a drug requires a PA, log in to www.caremark.com and run a test claim for coverage or call CVS Caremark.

Quantity Restrictions on Covered Medications

There may be quantity limits on certain medicines. Quantity limits are based on the Food and Drug Administration's (FDA) recommended dosing guidelines for each medication and are reviewed regularly by CVS Caremark to ensure clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions.

Certain prescriptions may also be limited to less than the standard days supply, which is a 30-day supply. For specific medicine limitations, please log in to www.caremark.com or call CVS Caremark at (866) 209-6093. Quantity limits may change periodically based on updates from the FDA's recommended dosing guidelines

To determine whether your medication is subject to CVS Caremark's utilization management program such as step therapy, prior authorization or quantity limit, etc., please contact CVS Caremark.

Pharmacy Advisor

The Plan also offers **Pharmacy Advisor**, a voluntary counseling program offered through CVS Caremark to help retirees (and covered spouses/domestic partners) with certain conditions — such as diabetes or heart disease — adhere to their prescription regimen, manage their medications and make sure their medications don't conflict with each other. When you pick up your prescription at a CVS Caremark pharmacy, the pharmacist will automatically offer to provide onsite counseling.

Coverage for Specialty Drugs

Certain conditions such as asthma, growth hormone deficiency, hepatitis C, immune disorders, infertility, multiple sclerosis and rheumatoid arthritis may be treated with specialty drugs. These drugs may be oral or self-injectable, include biological drugs, often require special handling, such as refrigeration, and are generally not available at the majority of pharmacies. CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides specialty drugs directly to covered individuals along with supplies, equipment and care coordination.

Certain specialty drugs require further clinical review and prior authorization before coverage will be approved. The "CVS Specialty Drug List" can be found on CVS Caremark's website. The The CVS Caremark Specialty Guideline Management Program evaluates the appropriateness of drug therapy with specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. This clinical program helps ensure patient safety, efficacy and optimal therapeutic benefit.

If you submit a prescription for a specialty drug that requires prior authorization, CVS Caremark will undertake a review. The provider who prescribed the medication will be required to call (866) 814-5506 as part of the review process. After the review is complete, you and your physician will receive a letter confirming whether coverage has been approved (usually within 48 hours after CVS Caremark receives the information it needs).

In certain cases, a first-line specialty therapy program may be required. The program is a step therapy program that encourages the use of a preferred drug prior to the utilization of a non-preferred drug. Preferred drugs under this program are well-supported treatment options and represent the most cost-effective drug for a given condition. Before a non-preferred specialty drug is covered, an established evidence-based protocol must be met.

If coverage is approved, you'll pay your normal copay or coinsurance, after any applicable deductible, for your prescription. If coverage is not approved, you have the right to appeal (please see the *Retiree Plan Administration* document .)

You may contact CVS Caremark Specialty Customer Care at (800) 237-2767 from 6:30 a.m. to 8 p.m. Cental time, Monday through Friday, and Saturdays from 6 a.m. to 3 p.m. Central time to arrange for expedited, confidential delivery of your specialty drug to the location of your choice. You will also have access to a pharmacist-led or nurse-led CareTeam that can provide customized care, counseling on how to best manage your condition(s), patient education and evaluation to assess your progress and to discuss your concerns.

If You Had an MRA as an Active Employee

If you meet the retiree eligibility requirements defined earlier and you retire from JPMorgan Chase, you can continue to access your MRA regardless of what medical coverage you have in retirement, whether it is through COBRA, the JPMorgan Chase Retiree Medical Planor another plan not affiliated with JPMorgan Chase. If you are enrolled in COBRA or in the JPMorgan Chase Retiree Medical Plan, the MRA can be used to pay for covered out-of-pocket medical and prescription drug expenses.

Costs for Your MRA if You Are a Retiree

If you are a retiree, monthly administrative fees will be deducted from your MRA account and you will need to file an MRA and/or HCSA Claim Form for reimbursement of your covered out-of-pocket medical and prescription drug expenses (see "Filing a Claim for Reimbursement Under Option 1 and Option 2" below).

Filing a Claim for Reimbursement Under Option 1 and Option 2

When you receive in-network care, your network doctor or other provider will file the claim for you; you will generally not be asked to pay at the time of service. However, there may be instances in which you paid out-of-pocket for an expense. In these cases, you would need to file a claim form to receive reimbursement from the Retiree Medical Plan. In addition, if you utilized an out-of-network provider, you may need to file a claim form.

How to file a claim and determine which claim form to use depends on the services you received and whether you paid out-of-pocket, as detailed below. Always keep your receipt for any out-of-pocket expense for which you intend to file for reimbursement. Instructions for accessing claim forms, if necessary, and mailing addresses are in "How to Submit a Claim" on page 38.

If You Saw an In-Network Provider and Paid Out-of-Pocket

While in-network providers have been asked by Aetna and Cigna to submit claims for JPMorgan Chase participants directly to their health care companies and not to ask for payment at the time of service, occasionally an in-network provider may nevertheless ask you to pay at the time of service.

You will typically be reimbursed automatically by your health care provider. However, if reimbursement is not made automatically, you will need to call your provider when you receive your Health Statement (for Aetna participants) or Explanation of Benefits (for Cigna participants). The Explanation of Benefits (EOB)/Health Statement will show that your health care company made payment to your provider. You should explain to the provider's billing office that they have been paid twice: once by you at the time of service and again when the Plan paid them. If you need additional assistance, you can call your health care company at the number on the back of your ID card or the JPMorgan Chase Health Advocate for help in getting reimbursed for amounts paid out-of-pocket (see "If You Have Questions About a Claim" on page 39).

If You Saw an Out-of-Network Provider and Paid Out-of-Pocket

Out-of-network providers may require payment at the point of service. In these circumstances you should submit a Retiree Medical Claim Form to your health care company (see "How to Submit a Claim" on page 38) to be reimbursed for the Plan's share of the expense. Be sure not to sign the box on the Retiree Medical Claim Form that authorizes your health care company to make payment directly to your provider, as the payment should be made to you.

Your health care company will process your claim to determine your and the Plan's responsibility, based on whether you have satisfied your deductible and the amount of coinsurance applicable.

If You Paid Out-of-Pocket for a Prescription Drug

If you paid out-of-pocket for a prescription drug because you purchased your drugs through a non-network pharmacy or did not show your ID card at a network pharmacy, use the CVS Caremark Claim Form to be reimbursed for the amount owed by the Prescription Drug Plan.

How to Submit a Claim

The Retiree Medical Claim Form and the MRA \ Claim Form are available through your health care company on **My Health** or by calling the phone number on the back of your ID card.

You need to file your claim by December 31 of the year after the one in which you received the service or purchased the prescription. For example, if you incur an expense on July 1, 2020, you must file your claim for reimbursement by December 31, 2021. If you fail to meet this deadline, your claim will be denied.

Be sure to attach itemized receipts to your claim form, and keep copies for your records. Mail your claim form to the address printed on the forms.

HCSA claims must be submitted by December 31 of the year in which you retire.

If You Have MRA Funds

If you are a retiree and have leftover MRA funds available from when you were an active employee with JPMorgan Chase, you can submit a claim to the health care company you had coverage with as an active employee.

Medical Claim Forms

Medical claim forms and MRA/HCSA claim forms should be sent to your health care company (either Aetna or Cigna) at the address below:

Aetna
P.O. Box 14079
Lexington, KY 40512-4079

Customer Service: (800) 468-1266

Cigna
P.O. Box 182223
Chattanooga, TN 37422-7223

Customer Service: (800) 790-3086

Remember: If you have already paid your medical provider, be sure not to sign the box on the Medical Claim Form that authorizes your health care company to make payment directly to your provider, as the payment should go to you.

Generally, Medical Claim Forms are processed in 10-12 business days and mailed with a Health Statement (for Aetna) or an Explanation of Benefits (for Cigna). Payment (if any) is sent about two weeks after the claim is processed.

CVS Caremark Claim Forms

The CVS Caremark Claim Form is available at **My Health.** The form is also available on the CVS Caremark website. Please mail your completed claim form to:

CVS Caremark Claims Department
P.O. Box 52136
Phoenix, AZ 85072-2136

Member Services: (866) 209-6093

Generally, prescription claims are processed weekly and mailed with payment (if any) in about two to three weeks.

If You Have Questions About a Claim

You can check the status of your claim by accessing your health care option at **My Health**. You can also call your health care company at the number on the back of your ID card.

If you are experiencing difficulty with a claim, JPMorgan Chase partners with Health Advocate, Inc. to help you resolve benefit claim issues. To contact Health Advocate, Inc., call (866) 611-8298 Monday through Friday, 8 a.m. to 9 p.m. Eastern Time.

Appealing a Claim

If a claim for reimbursement is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the *Retiree Plan Administration* document.

What Is Covered Under Retiree Medical Plan Options 1 and 2

Retiree Medical Plan Option 1 and Option 2 cover a wide variety of services; as long as the services are medically necessary (please see "Defined Terms" on page 71). However, covered services under the Retiree Medical Plan may differ from the lists below and/or be subject to limits or restrictions. If you see in-network providers, they will be responsible for preauthorizations. If you see out-of-network providers, you are responsible for preauthorizations. For specific information on each the covered services under each health plan carrier, please contact your health plan company (Aetna or Cigna) directly.

Quality Providers

The Retiree Medical Plan carriers designate a select number of their participating providers to be quality providers. This is a special designation for physicians and other medical providers who have been proven to provide high-quality and cost-effective care. If you choose to use these providers, you may have better outcomes, lower medical costs, or both. Visit your health care company's website for more information.

Preventive Care Services

The preventive care services covered at 100% by the Retiree Medical Plan are determined by your health care company based on guidelines and clinical recommendations developed for the general population by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorgan Chase does not make this determination. For a list of preventive services that are covered at 100%, go to your health care company's website. Age and frequency limits apply. Please contact your health care company for further information.

These services generally include:

- Routine care including:
  - Pap smears (one per year, includes related laboratory fees);
  - Prostate exams (one exam per year);
  - Flexible sigmoidoscopy (one baseline screening, and one follow-up screening every five years;
  - Screening colonoscopy (one baseline screening and one follow-up screening every five years);
  - Fecal occult blood test (one test per year);
  - Routine physical exams (office visit with appropriate laboratory and radiology services);
  - Mammography screenings (one mammogram per year);

- Routine screenings during pregnancy (e.g. for gestational diabetes and bacteriuria);
- Breast pumps (please contact your health care company for details regarding which breast pumps are fully covered);
- Travel immunizations, and
- Well-child/adult care office visits (plus immunization and labs):
  - Birth to age 12 months: seven exams
  - Age 13-24 months: three exams
  - Age 25-36 months: three exams
  - Age 3 and over: one exam per year

This list is subject to change at any time.

Please Note: An in-network medical service will only be covered at 100% if it is coded as preventive. Before receiving any services, you should check with your physician to be sure a procedure is considered, and will be submitted to the claims administrator, as preventive medical care rather than as a diagnostic service.

Inpatient Hospital and Related Services

Option 1 and Option 2 cover medically necessary inpatient hospital admissions for an unlimited number of days. Covered services include, but are not limited to the following services, subject to any limitations or requirements of the Plan and based on medical necessity:

- Allergy testing and treatment, when provided as part of inpatient care for another covered condition;
- Anesthetics and their administration;
- Bariatric surgery, subject to claims administrator guidelines. **Please Note:** To receive benefits for bariatric surgery, you must contact your health care company before obtaining services; you will be informed of any required precertification. If you and/or your covered spouse/domestic partner use a Center of Excellence (COE) for your treatment, you may be eligible for reimbursement of travel and lodging expenses if your treatment facility is more than 50 miles (for Aetna) or 100 miles (for Cigna) away from your home, see the Travel Benefit below for more information. To locate a COE, visit your health care company's website at **My Health** or call your health care company.
- Basic metabolic examinations;
- Cosmetic surgery when needed to:
  - Reconstruct or treat a functional defect of a congenital disorder or malfunction;
  - Treat an infection or disease;
  - Treat an injury or accident; or
  - Reconstruct a breast after mastectomy. Coverage for the following services is available under the Medical Plan in a manner determined in consultation with you and your physician:
    - Reconstruction of the breast on which the mastectomy was performed;
    - Surgery and reconstruction for the other breast to produce a symmetrical appearance; and
    - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.
- Diagnostic services, including:
  - EEG, EKG and other diagnostic medical procedures;
  - Laboratory and pathology tests; and

- Radiology services.

- Electrocardiographic and physiotherapeutic equipment usage;
- Hemodialysis for kidney failure;
- Intensive care unit service;
- Maternity care, including:
  - Any required care for an illness or injury that the newborn develops either before or after birth, as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames;
  - Care required due to miscarriage or ectopic pregnancy;
  - Coverage of eligible expenses if your covered child has a baby, but not including nursery or other expenses incurred by the newborn child;
  - Delivery by a certified, registered nurse or midwife in a birthing center;
  - Drugs, medications and anesthesia;
  - Normal or cesarean section delivery;
  - Routine medical and hospital nursery care for your covered newborn child, as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames;
  - Circumcision by a licensed provider (for your covered newborn child), as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames; and
  - A semi-private room. The period of hospitalization for childbirth (for either the mother or the covered newborn child) is up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. (However, your attending physician — after consulting with the mother — may decide to discharge the mother or newborn child earlier.)

    Note: You must enroll a dependent within 31 days of birth in order for coverage to be effective retroactive to the date of birth. Please see "Your Eligible Dependents" on page 10 and "Qualified Status Changes" on page 15 for more information.
- Mental health care/substance abuse care;
- Operative and surgical procedures by a licensed provider for the treatment of a disease or injury, including pre-operative preparation and post-operative care;
- Multiple Surgical Procedure Reduction Policy: Option 1 and Option 2 limit the benefits you are eligible to receive if you have more than one surgical procedure performed at the same time. When you have multiple procedures performed at the same time, these options will pay:
  - 100% of your medical option's coinsurance percentage amount for the primary or major surgical procedure; and
  - 50% of your medical option's coinsurance percentage amount for the secondary procedure.; and
  - If more than two procedures are performed, please check with your claims administrator for coverage details.
- Organ and tissue transplants including replacing a non-functioning or damaged organ or tissue with a working organ or tissue from another person. **Please Note:** To receive benefits for transplant surgery, you must contact your health care company before obtaining services; you will be informed of any required precertification. Covered services include physician and hospital costs, donor search, tests to establish donor suitability, organ harvesting and procurement, and anti-rejection drugs. Donor expenses related to the transplant procedure are covered if the transplant recipient is a covered

member under this plan, but only to the extent that the donor expenses are not covered under another health insurance plan. If you and/or your covered spouse/domestic partner uses a Center of Excellence (COE) for your treatment, you may be eligible for reimbursement of travel and lodging expenses if your treatment facility is more than 50 miles away from your home, see the Travel Benefit below for more information. To locate a COE, visit your health care company's website at **My Health** or call your health care company.

- Pre-admission testing when completed within seven days of hospital admission;
- Semi-private room and board;
- Take-home drugs and medications; and
- Travel Benefit: The bariatric, cancer, congenital heart disease, and transplant programs offer a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The above list is subject to change at any time.

Newborns' and Mothers' Protection Act

In accordance with the Newborns' and Mothers' Health Protection Act, group medical plans and health insurance issuers may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section. Further, the Plan cannot require that any medical provider obtain authorization from the Plan or any insurance issuer for prescribing a length of stay not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Solely to the extent required under the Women's Health and Cancer Rights Act (WHCRA), the Retiree Medical Plan will provide certain benefits related to benefits received in connection with a mastectomy. The Retiree Medical Plan will include coverage for reconstructive surgery following a mastectomy.

If you or your dependent(s) (including your spouse/domestic partner) are receiving benefits under the Retiree Medical Plan in connection with a mastectomy and you or your dependent(s) (including your spouse/domestic partner) elect breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and you or your covered dependent(s) (including your spouse/domestic partner) for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Reconstructive benefits are subject to annual Plan deductibles and coinsurance provisions like other medical and surgical benefits covered under the Retiree Medical Plan

Outpatient Services

Outpatient services under Option 1 and Option 2 include, but are not limited to the following services, subject to any limitations or requirements of the Plan and based on medical necessity:

- Acupuncture, is covered when it's used:
  - as a form of pain control, or
  - for treatment of nausea because of chemotherapy, pregnancy or post-operative procedures;

  Treatment must be performed by a licensed provider (check with your claims administrator).
- Allergy testing and treatment;
- Chemotherapy and radiation treatments;
- Chiropractic care when medically necessary as determined by the claims administrator to diagnose or treat illness, injury or disease. Coverage is limited to 20 visits per year and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;

- Diagnostic services, including:
  - EEG, EKG and other medical electronic procedures;
  - Laboratory and pathology tests; and
  - Radiology services.
- Education therapy, but only for participants with a diagnosis of diabetes mellitus;
- Eye exams for patients with diabetes (covered as a specialist office visit);
- Hemodialysis provided at a free-standing facility such as a dialysis center or your home, when ordered by a licensed provider;
- Home health care, which may require precertification; limited to a maximum of 200 visits/calendar year; one visit = four hours. The attending physician must submit a detailed description of the medical necessity and scope of services provided to the claims administrator. The following are covered if ordered by the physician under the home health care plan and provided in the patient's home:
  - Medical supplies and laboratory services prescribed by a physician;
  - Nutrition counseling provided by or under the supervision of a registered dietitian;
  - Part-time or intermittent nursing care provided or supervised by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);
  - Part-time or intermittent home health services, primarily for the patient's medical care; and
  - Physical, occupational, speech, or respiratory therapy by a licensed qualified therapist.
- Licensed, general hospital emergency room use for treatment of an injury or sudden illness, including:
  - Emergency treatment rooms;
  - Laboratory and pathology tests;
  - Licensed providers' services;
  - Supplies and medicines administered during the visit; and
  - Radiology services.
- Licensed provider-prescribed respiratory therapy approved by the claims administrator;
- Mental health care/substance abuse care;
- Occupational therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year;
- Outpatient surgery and related follow-up care;
- Physical therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year;
- Podiatric care when medically necessary as determined by the claims administrator to diagnose or treat illness, injury or disease. Coverage ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
- Prenatal care;
- Speech therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year; and

- Temporomandibular joint syndrome (TMJ) medical treatment only; including exams, X-rays, injections, anesthetics, physical therapy and oral surgery up to $1,000 combined in-network and out-of-network maximum per year (appliances are not covered).

The above list is subject to change at any time.

Other Covered Services

Other covered services under Option 1 and Option 2 include, but are not limited to the following services, subject to any limitations or requirements of the Retiree Medical Plan and based on medical necessity:

- Compression stockings (two pair per calendar year for the following conditions only: diabetes, varicose veins, varicose ulcers, statis dermatitis, post-phlebitic syndrome and lymphedema);
- Coverage abroad, as follows:

Benefit Provision	Coverage under Option 1 and Option 2
Treatment for a true emergency*, e.g., sudden, serious chest pain	80% coverage after in-network deductible
Treatment for an urgent situation that is not a true emergency, e.g., severely sore throat	80% coverage after in-network deductible
All other treatment, e.g., elective surgery scheduled several months in advance	50% coverage after out-of-network deductible

If you receive treatment while traveling outside the United States, you will have to pay for the services up-front and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, please see "Filing a Claim for Reimbursement Under Option 1 and Option 2" on page 37. If you have any questions about benefits while traveling abroad, please call your health care company.

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

- Dental procedures resulting from a congenital or medical disorder or accidental injury (treatment must be received within 12 months of the accident). Includes surgical removal of wisdom teeth only if procedure is done in medical setting. **Please Note**: The charges must not be covered by the JPMorgan Chase Retiree Dental Plan or any other dental plan that you might be enrolled in.
- Diabetes services, diabetes self-management and training, and diabetic eye examinations/foot care — outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a physician and provided by appropriately licensed or registered health care professionals. Covered services also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
- Diabetic self-management items — Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under durable medical equipment (DME), and Prosthetics. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets, and lancet devices are described under the separate prescription drug plan. **Please note:** Specific insulin pumps may also be covered under the Prescription Drug benefit. Contact CVS Caremark for additional information on which insulin pumps are covered under the prescription drug plan.
- External cochlear devices and systems;

- Gender Affirmation Surgery (referred to by our healthcare providers as Gender Reassignment Surgery) to be eligible, the participant must meet certain medically established guidelines for obtaining the surgery (which may align with the WPATH Standards of Care v7), which require the participant to, among other things:
  - Be at least 18 years old;
  - Have a gender identity disorder diagnosis;
  - Have been approved for hormone therapy;
  - Have at least one year's real life experience living and working in desired gender; and
  - Have two letters endorsing surgery, including one from a mental health provider at the master's level.

  Follow-up procedures for GRS such as breast augmentation surgery, electrolysis, and facial surgery will not be covered.

  In-network surgery preauthorization is the responsibility of the in-network provider. For out-of-network surgery, you are responsible for preauthorization.
- Hearing aids: Under Option 1 and Option 2 reimbursement for up to $3,000 every 36 months; hearing aid must be prescribed by an in-network doctor and purchased from an in-network durable medical equipment vendor. Hearing aids do not need to be prescribed by or obtained from an in-network provider or from an in-network Durable Medical Equipment (DME) provider in order to be considered a covered, eligible charge. You will be subject to out-of-network pricing if you obtain your hearing aide from an out-of-network provider/DME equipment provider.
- Hearing aid evaluations and hearing tests;
- Intensive behavior therapy, such as applied behavior analysis (ABA) for autism spectrum disorder.
- Local emergency ambulance service or air ambulance to the nearest hospital if medically necessary and confirmed by a licensed provider. Non-emergency transportation is covered if it is provided by a licensed professional ambulance (either ground or air ambulance as determined appropriate) when the transport is from an out-of-network hospital to an in-network hospital; to a hospital that provides a higher level of care that was not available at the original hospital; to a more cost-effective acute care facility; or from an acute facility to a sub-acute setting;
- Medical equipment and supplies ordered or provided by a physician including blood and blood plasma (unless donated on behalf of the patient); artificial limbs (excluding replacements); artificial eyes and larynx (including fitting); heart pacemaker; surgical dressings; casts; splints; trusses; orthopedic braces; crutches; wheelchair; walker; cane; insulin pump; Athner monitor; custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot; hospital bed; ventilator; iron lung; ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers and bags; manual pump-operated enema systems and other items necessary to the treatment of an illness or injury that are not excluded under the Plan. Prior authorization or precertification may be required for coverage of some medical equipment and supplies. The claims administrator may authorize purchase of an item if more cost-effective than rental.
- Medically necessary visits to licensed physicians, surgeons and chiropractors, whether in the office or in your home;
- Nutritional support, including nutritional counseling (limited to six visits, regardless of whether preventive or non-preventive) and durable medical equipment, to treat inborn errors of metabolism and/or to function as the majority source of nutrition*, as long as each of the following conditions are met:
  - Without enteral (feeding tube) feedings, the individual is unable to obtain sufficient nutrients to maintain appropriate weight by dietary and/or oral supplements;

— The administration of enteral nutrition requires ongoing evaluation and management by a physician; and

— The individual has one of the following conditions that is expected to be permanent or of indefinite duration:

- An anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel;
- Disease of the small bowel that impairs absorption of an oral diet; or
- A central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.

* When assessing the majority source of nutrition, the following considerations apply:

— Enteral feeding constitutes over 50% of caloric nutritional intake as determined by clinical information submitted by the provider for review;

— Calories from parenteral (intravenous) nutrition should not be considered when assessing for the sole source of nutrition; i.e., transitioning to enteral feedings; and

— Parenteral feedings are covered when considered medically necessary and used when oral or enteral alone are not possible.

- Oxygen and supplies for its administration;
- Prosthetic devices and supplies, including fitting, adjustments and repairs, if ordered by a licensed provider. Please check with the claims administrator for frequency or other limitations. (**Please Note**: Dentures, bridges, etc., are not considered medical prosthetic devices.);
- Radiation, chemotherapy and kidney dialysis;
- Rental or purchase of durable medical equipment — includes cranial orthotics (helmets) custom molded, when prescribed by physician — as determined by the claims administrator and if ordered by a licensed provider. Frequency and other limitations may apply. At the claims administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear when repair costs exceed new purchase price, or when a change in the medical condition occurs sooner than the end of a three-year time frame. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouthpieces, etc., for necessary durable medical equipment are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year time line for replacement.
- Services and supplies that are part of an alternate care proposal. This is a course of treatment developed and authorized by the claims administrator as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless specified otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, copayments, and deductible will apply to these services.
- Skilled nursing facility for up to 365 days per lifetime (combined in-network and out-of-network) under Option 1 and Option 2. The lifetime maximums reflect services received across Option 1 and Option 2, and under prior medical plans of JPMorgan Chase (such as the POS High and Low Options) and the medical plans of a heritage organization that was acquired by JPMorgan Chase.
- Urgent care;
- Voluntary sterilization; and
- Wigs up to a $500 per year limit, for burns, chemotherapy or radiation, accidental injury, following a diagnosis of alopecia or for other medically necessary reasons.

The above list is subject to change at any time.

Hospice Care

If you or a covered dependent is diagnosed as terminally ill with six months or less to live, you may be eligible to receive reimbursement for hospice care services. Hospices provide care in a setting designed to make the patient comfortable while still providing professional medical attention.

To be eligible for reimbursement, a hospice facility must offer a hospice program approved by the claims administrator. It must be either a hospital or a freestanding hospice facility that provides inpatient care or an organization that provides health care services in your own home.

Hospice services include:

- Hospice room and board while the terminally ill person is an inpatient in a hospice;
- Outpatient and other customary hospice services provided by a hospice or hospice team; and
- Counseling services provided by a member of the hospice team.

These services and supplies are eligible only if the hospice operates as an integral part of a hospice care program, and the hospice team includes at least a doctor and a registered graduate nurse. Each service or supply must be ordered by the doctor directing the hospice care program and be:

- Provided under a hospice care program that meets standards set by the claims administrator. If such a program is required by federal or state law to be licensed, certified, or registered, it must meet that requirement; and
- Provided while the terminally ill person is in a hospice care program.

Hospice benefits also include eligible expenses for counseling services for the family unit, if ordered and received under the hospice care program. Benefits will be paid if:

- On the day before the terminally ill person passed away, he/she was:
  - In a hospice care program;
  - A member of the family unit; and
  - A covered participant.
- The charges are incurred within three months after the death of the terminally ill person.

The above list is subject to change at any time.

Infertility Treatment Procedures

There are special covered procedures that induce pregnancy but do not treat the underlying medical condition. They include (but are not limited to) artificial insemination and in-vitro fertilization. When you use a Center of Excellence (COE), the Retiree Medical Plan will pay $20,000 more than if you were to use a non-COE facility. Your total lifetime maximum benefit using a COE is $30,000. There is a lifetime maximum benefit of $10,000 at a non-COE facility. Lifetime maximum benefits apply to each covered individual (yourself and/or your spouse/domestic partner).

This limit applies to all benefits received under Option 1 and Option 2 and under prior medical plans of JPMorgan Chase (such as the POS High and Low Options) and the medical plans of a heritage organization that were acquired by JPMorgan Chase and it applies regardless of whether the service was received in-network or out-of-network. This limit does not apply to the diagnosis of infertility and/or its cause. All procedures and access will be governed by the health care company's protocols for determining appropriateness of care. Please also see "What Prescription Drugs Are Covered and Not Covered" on page 33 for information on a $10,000 lifetime maximum on prescription drugs related to infertility treatment. Please contact your option's claims administrator for specific details.

Please Note: In order to receive benefits for infertility services, you must contact your health care company and receive precertification before obtaining services.

Planning Treatments That May Cause Infertility

Covered individuals with a diagnosis of cancer who are planning cancer treatment, or medical treatment for any condition that is demonstrated to result in infertility, are considered to meet the definition of infertility. Planned cancer treatments include bilateral orchiectomy, bilateral oophorectomy, hysterectomy, and chemotherapy or radiation therapy that is established in the medical literature to result in infertility. In order to use infertility benefits covered under the Plan, you must notify your health care company and meet the following eligibility criteria:

- Covered individuals or their partners must not have undergone a previous elective sterilization procedure, (e.g. hysterectomy, tubal ligation, vasectomy), with or without surgical reversal, regardless of post reversal results;
- Covered individuals must have had a day 3 follicle-stimulating hormone (FSH) test in the prior 12 months if under age 35 or in the prior six months if age 35 or older;
- Day 3 FSH level of a female covered individual must not have been greater than 15 mIU/mL in any (past or current) menstrual cycle, regardless of the type of infertility services planned (Including donor egg, donor embryo or frozen embryo cycle); and
- Only those infertility services that have a reasonable likelihood of success are covered.

Coverage is limited to:

- Collection of sperm;
- Cryopreservation of sperm and eggs;
- Ovulation induction and retrieval of eggs;
- In vitro fertilization; and
- Embryo cryopreservation.

Cryopreservation costs are covered for the period of infertility treatments, which is generally one year. Long-term cryopreservation costs (anything longer than 12 months) are not covered under the Plan.

The above list is subject to change at any time.

Infertility Diagnostic Services

Diagnostic services to determine or cure the underlying medical conditions are covered in the same manner as any other medically necessary services.

Coverage Limitations

As mentioned earlier, certain covered services are limited to a specific number of visits or days of limitations, subject to applicable deductibles and coinsurance. These limitations are included in the coverage charts earlier in this section.

Please keep in mind that any benefits listed that have limitations on the number of visits or days of treatment are determined by medical necessity. In other words, the treatment must be medically necessary, even if the number of visits or days is within the prescribed limitations.

What Is Not Covered Under the Retiree Medical Plan Options 1 and 2

While Option 1 and Option 2 cover a wide variety of medically necessary services, not all expenses are covered. Benefits paid are subject to certain limitations and maximums set by the claims administrator. You are responsible for paying the cost of any optional items or services not covered by the Retiree Medical Plan.

The services and expenses listed below are not covered. This list of excluded expenses may change at any time.

- Care from a person who is a member of your family or your spouse's/domestic partner's family;
- Charges for the difference between a private and semi-private hospital room;
- Correction of weak, unstable, or flat feet; arch supports (unless prescribed by a physician); corrective shoes (unless prescribed by a physician); shoe orthotics (except for custom-molded shoe inserts prescribed to treat a condition, disease, or illness affecting the function of the foot); or treatment of corns, calluses, or chronic foot strain;
- Cosmetic surgery treatment, except to repair damage from accident or injury; treat a functional birth defect; reconstruct a breast after mastectomy and/or reconstruction of the non-affected breast to produce a symmetrical appearance; or treat an infection or disease;
- Custodial services, including custodial nursing care and group homes;
- Donor expenses with regard to infertility treatment;
- Educational therapy (except for members with a diagnosis of diabetes) and social or marital counseling;
- Expenses for which you're not obligated to pay (for example, if a licensed provider or hospital waives an expense, the Plan will not pay any benefit to you or a licensed provider);
- Expenses in excess of R&C charges for out-of-network services;
- Expenses submitted later than December 31 of the year following the year in which services were provided;
- Experimental, investigational, or unproven services, devices, or supplies (see the "experimental, investigational or unproven services" in "Defined Terms" beginning on page 71);
- Extended benefit coverage. If you are hospitalized on the date your JPMorgan Chase Medical Plan coverage terminates, Medical Plan coverage will end at midnight that day.
- Hospital admissions and other services that began before the participant's effective date of coverage under the Retiree Medical Plan;
- Inpatient private duty nursing;
- Non-medical charges for care in a nursing or convalescent home or long-term custodial care, even if prescribed by a licensed provider;
- Non-prescription contraceptive devices, unless medically necessary (prescription oral contraceptives are covered under the JPMorgan Chase Retiree Prescription Drug Plan);
- Non-surgical correction of temporomandibular joint (TMJ) syndrome, such as appliances or devices;
- Nutritional support expenses including but not limited to:
  - Regular grocery products (including over-the-counter infant formulas such as Similac, Nutramigen and Enfamil) that meet the nutritional needs of the patient;
  - Infant formula that is not specifically made to treat inborn errors of metabolism;

— Medical food products that:

- Are prescribed without a diagnosis requiring such food;
- Are used for convenience purposes;
- Have no proven therapeutic benefit without an underlying disease, condition, or disorder;
- Are used as a substitute for acceptable standard dietary interventions;
- Are used exclusively for nutritional supplementation; and
- Are required due to food allergies.

— Nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins and oral minerals.

- Personal services for comfort or convenience while in the hospital, such as television, telephone, etc.;
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments if required solely for purposes of school, sports or camp, career or employment, insurance, marriage or adoption;
- Redundant skin and skin tag removal;
- Refractive eye examinations for new lenses or the cost of eyeglasses or contacts. This does not apply to the first pair of contact lenses or the first pair of eyeglasses following either cataract surgery or a diagnosis of Keratoconus;
- Refractive eye surgery including, but not limited to, Lasik or radial keratotomy;
- Reproductive education and prevention classes;
- Reversals of sterilization;
- Routine dental care (please see the *Retiree Dental Plan* Summary Plan Description for information about covered services);
- Routine eye exams (please see the *Retiree Vision Plan* Summary Plan Description for information about covered services);
- Services, supplies or treatment for weight loss, nutritional supplements or dietary therapy;
- Sexual dysfunction;
- Sickness or loss covered by state workers' compensation law or automobile insurance;
- Sickness or loss that is later determined to be the legal responsibility of another person or company;
- Treatments, services or supplies that are not medically necessary or not approved by a licensed provider or services provided outside the scope of a provider's license;
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);
- Unbundled medical expenses — charges billed separately when considered by the claims administrator in its sole discretion to be part of a global procedure; and

If You Are Covered by More Than One Medical Plan

The JPMorgan Chase Retiree Medical Plan has a provision to ensure that payments from all of your group medical plans don't exceed the amount the JPMorgan Chase Retiree Medical Plan would pay if it were your only coverage.

The following rules apply to Option 1 and Option 2. The following rules do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

The JPMorgan Chase Retiree Medical Plan does not allow for duplication of benefits. If you and/or your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. The non-duplication provisions of the Retiree Medical Plan will ensure that, in total, you receive benefits up to what you would have received with the Retiree Medical Plan as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount. A summary of coordination rules (i.e., how JPMorgan Chase coordinates coverage with another group plan to ensure non-duplication of benefits) is provided below. If you have questions, please contact your health care company for help. See "Questions?" on page 2 for contact information.

Here's an example of how the JPMorgan Chase Retiree Medical Plan coordinates benefits with other medical plans:

Assume your spouse/domestic partner has a medically necessary covered procedure with a reasonable and customary (R&C) charge of $100 after meeting any deductible. If your spouse/domestic partner's plan (which we'll assume is primary) pays 70% for that procedure, your spouse/domestic partner will receive a $70 benefit (70% of $100). Also assume that your JPMorgan Chase Retiree Medical Plan option — Option 1 or Option 2 (which we'll assume is your spouse/domestic partner's secondary coverage and that the deductible has already been satisfied) — would pay 80% for this medically necessary procedure. In this case, your spouse/domestic partner normally would receive an $80 benefit (80% of $100) from the JPMorgan Chase Retiree Medical Plan option. Since your spouse/domestic partner already received $70 from her or his primary plan, he or she would receive the balance ($10) from the JPMorgan Chase Retiree Medical Plan. If, however, your Retiree Medical Plan (Option 1 or Option 2) considered the R&C charge to be $80, no additional benefit would be payable, as the JPMorgan Chase Retiree Medical Plan would pay 80% of $80, or $64. As that amount would have already been paid by your spouse/domestic partner's plan, no additional benefit would be payable from the JPMorgan Chase Retiree Medical Plan.

Determining Primary Coverage

To determine which medical plan pays first as the primary plan, here are some general guidelines:

- As a JPMorgan Chase retiree, the Retiree Medical Plan will be primary for you and consider claims for your medical expenses first, unless you are eligible for Medicare. Once you are Medicare-eligible, then Medicare becomes the primary payer of medical benefits and you will need to select coverage through Via Benefits, which is not coverage sponsored by JPMorgan Chase.
- If your covered dependent has a claim, the plan covering your dependent as an employee or a retiree will be considered primary to this Plan.
- If your claim is for a covered dependent child who has coverage under both parent's plans, the plan covering the parent who has the earlier birthday in a calendar year (based on month and birthday only) will be considered primary. In the event of divorce or legal separation, and in the absence of a qualified medical child support order, the plan covering the parent with court-decreed financial responsibility will be considered primary for the covered dependent child. If there is no court decree,

the plan of the parent who has custody of the covered dependent child will be considered primary for the covered dependent child. (Please see "Qualified Medical Child Support Order" on page 57 for more information.)

- If your other medical plan doesn't have a coordination of benefits provision, that plan will be considered primary and will pay first for you and your covered dependents.
- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

After it's determined which plan is primary, you'll need to submit your initial claim to that plan.

After the primary plan pays benefits (up to the limits of its coverage), you can then submit the claim to the other plan (the secondary plan). The secondary plan then considers your claim for any unpaid amounts. You'll need to include a copy of the written Explanation of Benefits (EOB) from your primary plan.

Right of Recovery

If the Retiree Medical Plan provides benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the Retiree Medical Plan has the right to recover these payments from you or from the person or company who is determined to be legally responsible. Assignment of your claim to a third party does not exempt you from your responsibility for repaying the Plan. You must notify the Plan promptly of any circumstance in which a third party may be responsible for compensating you with respect to an illness or injury that results in the Plan making payments on your behalf.

Aetna Recovery of Overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you're entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayment they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Subrogation of Benefits

The purpose of the Retiree Medical Plan is to provide benefits for eligible medical expenses that are not the responsibility of any third party. The Retiree Medical Plan has the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the Plan making payments on your behalf or on behalf of a covered dependent. This is known as subrogation of benefits.

The following rules apply to the Plan's subrogation of benefits rights:

- The Plan has first priority from any amounts recovered from a third party for the full amount of benefits it has paid on your behalf regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the Plan use this right when requested.
- In the event that you fail to help the Plan use this right when requested, the Plan may deduct the amount the Plan paid from any future benefits payable under the Plan.
- The Plan has the right to take whatever legal action it deems appropriate against any third party to recover the benefits paid under the Plan.

- If the amount you receive as a recovery from a third party is insufficient to satisfy the Plan's subrogation claim in full, the Plan's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim against the third party.
- The Plan is not responsible for any attorney fees, attorney liens, or other expenses you may incur without the Plan's prior written consent. The common fund doctrine does not apply to any amount recovered by any attorney you retain regardless of whether the funds recovered are used to repay benefits paid by the Plan.

If you receive a subrogation request and have questions, please contact your health care company (see "Questions?" on page 2 for contact information).

Right of Reimbursement

In addition to its subrogation rights, the Retiree Medical Plan is entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for medical expenses that have been paid by the Retiree Medical Plan.

The following rules apply to the Plan's right of reimbursement:

- You must reimburse the Plan in first priority from any recovery from a third party for the full amount of the benefits the Plan paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- Regardless of any allocation or designation of your recovery made in a settlement agreement or court order, the Plan shall have a right of full reimbursement, in first priority, from the recovery.
- You must hold in trust for the benefit of the Plan the gross proceeds of a recovery, to be paid to the Plan immediately upon your receipt of the recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees or other expenses. The common fund doctrine does not apply to any funds recovered by any attorney you retain regardless of whether the funds recovered are used to repay benefits paid by the Plan.
- If you fail to reimburse the Plan, the Plan may deduct any unsatisfied portion of the amount of benefits the Plan has paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the Plan.
- If you fail to disclose the amount of your recovery from a third party to the Plan, the Plan shall be entitled to deduct the full amount of the benefits the Plan paid on your behalf from any future benefits payable under the Plan.

Additional Plan Information

Your primary contact for matters relating to the Retiree Medical Plan is your health care company. Contact HR Answers for information about general administration issues such as enrollment and eligibility for the Plan.

Your benefits as a participant in the Retiree Medical Plan (and Prescription Drug component) are provided under the terms of this document and insurance contracts, if any, issued to JPMorgan Chase. If there is a discrepancy between the insurance contracts and this document, the insurance contracts will control.

Please Note: No person or group (other than the plan administrator for the JPMorgan Chase U.S. Retiree Benefits Program) has any authority to interpret the Retiree Medical Plan (or official plan documents) or to make any promises to you about them. The plan administrator for the JPMorgan Chase U.S. Retiree Benefits Program has complete authority in his or her sole and absolute discretion to construe and interpret the terms of the Retiree Medical Plan and any underlying insurance policies and/or contracts, including the eligibility to participate in the Retiree Medical Plan. All decisions of the plan administrator for the JPMorgan Chase U.S. Retiree Benefits Program are final and binding upon all affected parties.

HIPAA Privacy Rights and Protected Health Information

JPMorgan Chase is committed to maintaining the highest level of privacy and discretion regarding your personal compensation and benefits information. However, federal legislation under the Health Insurance Portability and Accountability Act (HIPAA) legally requires employers — like JPMorgan Chase — to specifically communicate how certain "protected health information" under employee and retiree health care plans may be used and disclosed, as well as how plan participants can get access to their protected health information.

What Is Protected Health Information?

Protected health information is considered to be individually identifiable health information as it relates to the:

- Past, present or future health of an individual; or
- Health care services or products provided to an individual; or
- Past, present, or future payment for health care services or products.

The information included in this section is a summary of HIPAA privacy regulations. To comply with the law, JPMorgan Chase will distribute to you once every three years, a "Privacy Notice of Protected Health Information under the JPMorgan Chase Health Care Plans" that describes in detail how your personal health information may be used and your rights with regard to this information (distributed 2017).

A copy of the privacy notice is also available at **My Health** > Privacy Notice or by contacting HR Answers at any time to request a paper copy. Under HIPAA, protected health information is confidential, personal, identifiable health information about you that is created or received by a claims administrator (like those under the JPMorgan Chase Retiree Medical Plan) and is transmitted or maintained in any form. ("Identifiable" means that a person reading the information could reasonably use it to identify an individual.)

Under HIPAA, the Retiree Medical Plan may only use and disclose participants' protected health information in connection with payment, treatment and health care operations. In addition, the Retiree Medical Plan must restrict access to and use of protected health information by all employees/groups except for those specifically involved in administering the Retiree Medical Plan, including payment and health care operations. In compliance with HIPAA, the Retiree Medical Plan agrees to:

- Not use or further disclose protected health information other than as permitted or required by law;
- Not use or disclose protected health information that is genetic information for underwriting purposes;
- Ensure that any agents (such as an outside claims administrator) to whom the Retiree Medical Plan gives protected health information agree to the same restrictions and conditions that apply to the Retiree Medical Plan with respect to this information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of JPMorgan Chase;
- Notify you in the event that a breach of your protected health information is discovered;
- Report to the JPMorgan Chase HIPAA Privacy Officer any use or disclosure of the information that is inconsistent with the designated protected health information uses or disclosures;
- Obtain your authorization for any use or disclosure of protected health information for marketing, or that is a sale of the protected health information as defined under applicable law;
- Make available protected health information in accordance with individuals' rights to review such personal information;
- Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules;

- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules;
- Make the Retiree Medical Plan's internal practices, books, and records relating to the use and disclosure of protected health information received from the claims administrators available to the Secretary of Health and Human Services for purposes of determining the Retiree Medical Plan's compliance with HIPAA;
- Return or destroy all protected health information received in any form from the claims administrators. The Retiree Medical Plan will not retain copies of protected health information once it is no longer needed for the purpose of a disclosure. An exception may apply if the return or destruction of protected health information is not feasible. However, the Retiree Medical Plan must limit further uses and disclosures of this information to those purposes that make the return or destruction of the information infeasible; and
- Request your authorization to use or disclose psychotherapy notes except as permitted by law, which would include for the purposes of carrying out the following treatment, payment or health care operations:
  - Use by the originator of psychotherapy notes for treatment;
  - Use or disclosure by the Retiree Medical Plan for its own training program; or
  - Use or disclosure by the Retiree Medical Plan to defend itself in a legal action or other proceeding brought by you.

If you believe that your rights under HIPAA have been violated, you can file a complaint with the JPMorgan Chase HIPAA Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the JPMorgan Chase HIPAA Privacy Officer, please contact the Privacy Officer for the JPMorgan Chase Health Care Plans in writing at the address shown below:

HIPAA Privacy Officer for the JPMorgan Chase Health Care Plans
JPMorgan Chase Corporate Benefits
4041 Ogletown Road, Floor 02
Newark, DE 19713-3159
Mail Code: DE6-1470

Retiree Medical Plan Notice of Nondiscrimination

The Affordable Care Act requires us to inform you that the JPMorgan Chase Retiree Medical Plan (the Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact JPMorgan Chase Benefits Delivery & Customer Service.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

JPMorgan Chase Benefits Delivery & Customer Service
Address: Floor 02, DE6-1470, 4041 Ogletown Road, Newark, DE 19713

Phone number: (877) 576-2427, option #1

Fax: (313) 429-8384

Email: **jpmc-health.and.insurance.plans@jpmchase.com**

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, JPMorgan Chase Benefits Delivery & Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue SW
Washington, D.C. 20201

(800)368-1019, (800) 537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATTENTION: If you speak languages listed below, language assistance services, free of charge, are available to you. Call (877) 576-2427 and select option #1.

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 -877-576-2427 #1.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1 -877-576-2427 #1。

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 -877-576-2427 #1

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 -877-576-2427 #1번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 -877-576-2427 #1.

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 -877-576-2427 #1.

ةيبرعلا (Arabic)

ةظوحلم: اذإ تنك تدحتت ركذا ةغلا ،فإف تامدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب. مقرب لصتا

1 -877-576-2427 #1.

Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. 1-877-576-2427 #1.

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1 -877-576-2427 #1.

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 -877-576-2427 #1.

Polski (Polish)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 -877-576-2427 #1.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 -877-576-2427 #1まで、お電話にてご連絡ください。

Italiano (Italian)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1 -877-576-2427 #1.

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 -877-576-2427 #1.

یسراف (Farsi)

هجوت: هب رگا نابز یسراف وگتفگ یم دینک، تالیهست ینابز تروصب ناگیار یارب امش مهارف یم دشاب. اب

1 -877-576-2427 # .1 دیریگب سامت

Qualified Medical Child Support Order

If the Retiree Medical Plan receives a judgment, decree or order known as a Qualified Medical Child Support Order (QMCSO) requiring the plan to provide medical coverage to your child or foster child who is your dependent, the Retiree Medical Plan will automatically change your medical benefit 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 on the date the QMSCO is processed by JPMorgan Chase. You may decrease your coverage for that child, if the court order requires the child's other parent to provide coverage and your spouse's or former spouse's plan actually provides that coverage. You also may make other corresponding changes to your benefits elections under the Retiree Medical Plan, to the extent permitted by the Internal Revenue Code (IRC) and the Retiree Medical Plan.

If Your Situation Changes

The following chart summarizes how your JPMorgan Chase Retiree Medical Plan coverage may be affected in certain situations, for example, if you have a Qualified Status Change.

If You Divorce or Become Legally Separated	If your spouse and/or dependent children lose coverage as a result of divorce/separation, they may have a right to elect COBRA for up to 36 months. (Please see the *Retiree Plan Administration* document for more information.) If you divorce or become legally separated, certain court orders could require you to provide medical benefits to covered dependent children. JPMorgan Chase is legally required to recognize qualified medical child support orders within the limits of the Retiree Medical Plan. If you're a party in a divorce settlement that involves the Retiree Medical Plan, you should have your attorney contact HR Answers to make sure the appropriate documents are filed and that the court order in question is actually a qualified medical child support order that complies with governing legislation. Please see "Qualified Medical Child Support Orders" above for more information.
If You Are Rehired at JPMorgan Chase	If you're re-employed at JPMorgan Chase and are eligible for active employee benefits, your retiree medical benefits will end. If you retire again, you must elect retiree coverage at that time. You cannot defer retiree coverage.
If You Die	If you die after retiring from JPMorgan Chase, any dependents enrolled under your Retiree Medical Plan coverage at the time of your death may choose to continue coverage. If your dependents choose not to continue coverage, they will be covered until the end of the month in which you die.
If You Become Eligible for Medicare	Medicare-eligible participants have access to individual health care coverage available through Via Benefits, a private Medicare exchange, which is not coverage sponsored by JPMorgan Chase.

When Coverage Ends

Coverage under any JPMorgan Chase Retiree Medical Plan option will end on the last day of the month in which:

- You cancel coverage due to a Qualified Status Change;
- You stop making required contributions;
- You become eligible for Medicare;
- You no longer meet the eligibility requirements of the Retiree Medical Plan;
- The Retiree Medical Plan is discontinued; or
- You die.

Coverage for your dependents also ends when they no longer meet the eligibility requirements described in "Your Eligible Dependents" on page 10. For your spouse, this is the last day of the month in which you divorce or longer in the event of your death. For a child, this means the last day of the month in which he or she:

- Turns age 26; or
- Is no longer eligible for coverage under a Qualified Medical Child Support Order (QMCSO).

Please Note: You can continue medical 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 Plan prior to turning age 26.

Coverage for a domestic partner ends on the last day of the month in which the domestic partner ceases to meet the eligibility requirements described in "Your Eligible Dependents" on page 10.

Please see "If Your Situation Changes" on page 58 for details on how coverage is affected in certain situations.

Continuing Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and as it applies to the Retiree Medical Plan, your covered dependents may have the right to continue medical coverage at their own expense for a certain period of time following the end of their JPMorgan Chase retiree medical coverage under 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 (as defined below). (For domestic partners, JPMorgan Chase may provide COBRA-like coverage if the domestic partner was covered under the JPMorgan Chase Retiree Medical Plan at the time that coverage ended.) If continuation coverage is elected, the cost is typically 102% of the Plan's total cost of providing coverage for up to 18 months. Covered dependents must make timely monthly payments for their COBRA coverage.

Prescription Drug Notice of Creditable Coverage

JPMorgan Chase will send a Notice of Creditable Coverage to participants who become eligible for Medicare. This notice states that the JPMorgan Chase Retiree Medical Plan options provide prescription drug benefits that are, on average, at least as good as the standard Medicare prescription drug plan benefits. The notice is important because it can help you avoid late enrollment penalties associated with Medicare prescription drug plans that may apply since JPMorgan Chase benefits-eligible employees would generally wait until retirement to enroll in Medicare.

If you have a dependent that is eligible for Medicare benefits and you do not receive a Notice of Creditable Coverage, you can contact the HR Answers to request one.

Privacy Information

The privacy of your health information is important to you and to JPMorgan Chase. We are committed to ensuring your personal health information is protected and secure, and that our practices comply with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). (For detailed information regarding HIPAA Privacy Rights, please see "HIPAA Privacy Rights and Protected Health Information" on page 54.) 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. Your health care company maintains the confidentiality of your information in accordance with privacy regulations such as HIPAA.

Right to Amend

JPMorgan Chase & Co. expressly reserves the right to amend, modify (including cost of coverage), reduce or curtail benefits under, or terminate the benefit plans and programs, including the Retiree Medical Plan, at any time for any reason, by act of the Benefits Executive, other authorized officers, or the Board of Directors. In addition, the plans and benefits described in this document do not represent vested benefits.

JPMorgan Chase also reserves the right to amend any of the plans and policies, to change the method of providing benefits, to curtail or reduce future benefits, or to terminate at any time for any reason, any or all of the plans and policies described in this document.

If you have any questions about this plan, please contact HR Answers.

Appendix

If you are pre-Medicare retiree and currently enrolled in Point of Service (POS) High or Low Option, the following information applies to you. **Please Note:** If you are pre-Medicare retiree and currently enrolled in a plan of a heritage company sponsored by JPMorgan Chase, the plan provisions described in this section do not apply to you. For more information about the plan provisions that apply, please see the applicable Summary of Benefits for the Plan in which you are enrolled, located on the Cigna website or available through HR Answers.

The Point-of-Service (POS) High and Low Options

The POS High and Low Options are two options previously available under the JPMorgan Chase Retiree Medical Plan to pre-Medicare retirees and/or their pre-Medicare dependents or the pre-Medicare dependents of Medicare-eligible individuals receiving long-term disability benefits from JPMorgan Chase. If you enrolled in POS coverage before December 31, 2012, and have not cancelled enrollment in that Plan after that point, you can continue your coverage in the POS High or Low Option. Once you become eligible for Medicare, you have access to individual medical and prescription drug coverage through Via Benefits, a private Medicare exchange, which is not coverage sponsored by JPMorgan Chase.

The POS High and Low Options are administered by Cigna (Choice Plus POS). See "Questions?" on page 2 for contact information.

Both the POS High and Low Options combine the advantages of traditional medical coverage with a cost-effective managed care arrangement that includes participating providers who have agreed to negotiated fees with the claims administrator. The POS High and Low Options help you manage your medical costs by giving you the flexibility to choose between in-network and out-of-network care for covered services.

Each of the network health care providers has agreed to accept negotiated rates, which are lower fees, when treating JPMorgan Chase Retiree Medical Plan participants. This means your out-of-pocket costs generally will be:

- Lower when you receive your care from in-network providers; and
- Higher when you receive your care from out-of-network providers.

High Option — If you're enrolled in this POS Option, you pay higher premiums but have lower deductibles and copayments/coinsurance for doctor's office visits and other services.

Low Option — If you're enrolled in this POS Option, you pay lower premiums but your deductibles and copayments/coinsurance for doctor's office visits and other services are higher.

During each annual benefits enrollment, if you enrolled in POS coverage before December 31, 2012, and have not cancelled your Plan enrollment after that point, you'll have access to information about the POS High and Low Options' coverage provisions, including benefits and costs. Before enrolling for coverage, please review that information so that you can compare the key features of the POS High and Low Options and your other JPMorgan Chase Retiree Medical Plan Options.

Additionally, if you enrolled in POS coverage before December 31, 2012, and have not cancelled your Plan enrollment after that point, you may enroll in the Retiree Medical Plan Option 1 or Option 2. If you choose to enroll in Retiree Medical Plan Option 1 or Option 2, you will not be able to re-elect POS coverage at any time in the future.

With the POS High and Low Options….

- Each time you need medical care, you can choose to use an in-network or out-of-network provider.
- You do not need to designate a primary care physician (PCP). However, specialist copayments are higher than PCP copayments. Generally, PCPs include internists, general practitioners, family practice doctors and pediatricians. Check with your administrator for details.
- The Plan offers 100% coverage for eligible in-network preventive medical care. **Please Note:** A service that is normally considered preventive may be classified and coded as diagnostic rather than preventive medical care by your physician in certain circumstances. A medical service will only be covered at 100% if it is coded as preventive. Before receiving any service, you should check with your physician to be sure a procedure is considered, and will be submitted to the claims administrator as a preventive medical care rather than as a diagnostic service.
- In-network physician and specialist office visits are covered after a copayment, while most other services are subject to coinsurance, after paying the annual deductible.
- Out-of-network care is subject to an annual deductible, and expenses are generally covered at a lower percentage than in-network services.
- If you use out-of-network providers, you generally need to notify your claims administrator before a hospital admission.
- Claim forms are usually required for out-of-network care.
- If you need specialist care, you may self-refer to an in-network provider and still receive a higher level of benefits.

How the POS High and Low Options Pay Benefits

The POS Options have networks of participating physicians, hospitals and other health care professionals who have agreed to a negotiated fee arrangement for covered health services. The POS Options are administered by Cigna. You may view an online provider directory for your POS option by visiting the Benefits Web Center available on **My Health.** You can also find in-network providers by contacting the POS claims administrator and requesting information from a Service Representative.

Benefit Provision	In-Network	Out-of-Network*
Annual Deductible for the POS High Option (No individual family member may satisfy more than the single deductible amount. Any amount paid toward in-network services is not applied to the out-of-network deductible.)	• $500 You • $1,000 You + spouse/ domestic partner • $1,000 You + children • $1,500 You + spouse/ domestic partner + children	• $1,000 You • $2,000 You + spouse/ domestic partner • $2,000 You + children • $3,000 You + spouse/ domestic partner + children
Annual Deductible for the POS Low Option (No individual family member may satisfy more than the single deductible amount. Any amount paid toward in-network services is not applied to the out-of-network deductible.)	• $750 You • $1,500 You + spouse/ domestic partner • $1,500 You + children • $2,250 You + spouse/ domestic partner + children	• $1,750 You • $3,500 You + spouse/ domestic partner • $3,500 You + children • $5,250 You + spouse/ domestic partner + children
Coinsurance Percentage for the POS High Option	90%	70%
Coinsurance Percentage for the POS Low Option	80%	60%
Annual Out-of-Pocket Maximum for the POS High Option** (No individual family member's out-of- pocket expenses will exceed the individual out-of-pocket maximum.)	• $1,600 You • $3,200 You + spouse/ domestic partner • $3,200 You + children • $4,800 You + spouse/ domestic partner + children	• $3,200 You • $6,400 You + spouse/ domestic partner • $6,400 You + children • $9,600 You + spouse/ domestic partner + children
Annual Out-of-Pocket Maximum for the POS Low Option** (No individual family member's out-of- pocket expenses will exceed the individual out-of-pocket maximum.)	• $2,650 You • $5,300 You + spouse/ domestic partner • $5,300 You + children • $7,950 You + spouse/ domestic partner + children	• $5,300 You • $10,600 You + spouse/ domestic partner • $10,600 You + children • $15,900 You + spouse/ domestic partner + children

* Generally, all out-of-network expenses are subject to reasonable and customary (R&C) charges.

** Excludes annual deductible and copayments.

How the POS High Option Pays Benefits

The way benefits are paid depends on whether you receive your care in-network or out-of-network.

Type of Service	In-Network Care	Out-of-Network Care*
Preventive Care		
Routine Physical exams	100% coverage	70% coverage after deductible
Routine Gynecological Exams and Pap Smears	100% coverage	70% coverage after deductible

Type of Service	In-Network Care	Out-of-Network Care*
Routine Mammography, Prostate Specific Antigen (PSA) Test, and Digital Rectal Exam	100% coverage	70% coverage after deductible
Fecal Occult Blood Test	100% coverage	70% coverage after deductible
Sigmoidoscopy/Colonoscopy	100% coverage	70% coverage after deductible
Outpatient Services		
Doctor's Office Visits (includes tests, supplies and other services authorized by the Plan and provided during the visit, consultations, specialist referrals and second surgical opinions; excludes eligible preventive care visits, which are covered 100% in-network)	100% coverage after $20 primary care office visit copayment;** $30 specialist office visit copayment	70% coverage after deductible
X-rays and Labs (When performed to diagnose a medical problem or treat an illness or injury. **Please Note:** X-rays and lab tests done in a physician's office are covered in the same manner as a PCP visit.)	90% coverage after deductible	70% coverage after deductible
Infertility Services (includes diagnostic procedures, in vitro fertilization, artificial insemination, etc.; limited to enrolled in program $10,000 lifetime maximum; enrolled in program and use Center of Excellence: $30,000 lifetime maximum for each covered individual***)	100% coverage after a $30 specialist office visit copayment; 90% coverage elsewhere after deductible (no copayment if in a facility)	70% coverage after deductible
Routine Eye Exams	Not covered	Not covered
Speech, Physical or Occupational Therapy (combined in-network and out-of-network limit of 60 visits/ calendar year per therapy type***)	100% coverage after $30 per visit copayment	70% coverage after deductible
Chiropractic Care (Must be medically necessary; coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year***)	100% coverage after $20 per visit copayment; $30 copayment for Specialist	70% coverage after deductible

Type of Service	In-Network Care	Out-of-Network Care*
Mental Health Care	100% coverage after $30 per visit copayment	70% coverage after deductible
Substance Abuse Care	100% coverage after $30 per visit copayment	70% coverage after deductible
Inpatient Services		
Acute hospital care (based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases; precertification requirements may apply)	90% coverage after $250 copayment per admission; waived if re-admitted for same or related condition within 14 days	70% coverage after deductible
Skilled Nursing Facility (must be ordered by physician as medically necessary; includes charges for services and supplies provided while patient is under continuous care and requires 24-hour skilled nursing care and room and board; limited to combined in-network and out-of-network maximum of 365 days/lifetime for each covered individual**)	90% coverage after $250 copayment per admission; waived if admitted from hospital	70% coverage after deductible
Hospice Care	90% coverage after deductible	70% coverage after deductible
Mental Health Care	90% coverage after $250 copayment per admission	70% coverage after deductible
Substance Abuse Care	90% coverage after $250 copayment per admission	70% coverage after deductible
Other Services		
Emergency Room (for sudden and serious medical conditions approved by claims administrator as required for emergency care) In accordance with applicable regulations, true emergency is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors.	100% after a $150 copayment per visit; waived if admitted; 70% coverage after deductible if not considered an emergency	100% after a $150 copayment per visit; waived if admitted; 70% coverage after deductible if not considered an emergency
Home Health Care (medically necessary only; may require precertification; limited to combined in-network and out-of-network maximum of 200 visits/calendar year; one visit = four hours**)	90% coverage after deductible	70% coverage after deductible

Type of Service	In-Network Care	Out-of-Network Care*
Durable Medical Equipment and Prosthetics	90% coverage after deductible	70% coverage after deductible
Prescription Drugs	Please see "Prescription Drug Coverage Under POS High and Low Options" on page 71.	Please see "Prescription Drug Coverage Under POS High and Low Options" on page 71.

* Generally, all out-of-network expenses are subject to reasonable and customary (R&C) charges.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with Cigna at (800) 790-3086 for details.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to R&C charges. You should note that since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

How the POS Low Option Pays Benefits

The way benefits are paid depends on whether you receive your care in-network or out-of-network.

Type of Service	In-Network Care	Out-of-Network Care*
Preventive Care		
Routine Physical exams	100% coverage	60% coverage after deductible
Routine Gynecological Exams and Pap Smears	100% coverage	60% coverage after deductible
Routine Mammography, Prostate Specific Antigen (PSA) Test, and Digital Rectal Exam	100% coverage	60% coverage after deductible
Fecal Occult Blood Test	100% coverage	60% coverage after deductible
Sigmoidoscopy/Colonoscopy	100% coverage	60% coverage after deductible
Outpatient Services		
Doctor's Office Visits (Includes tests, supplies and other services authorized by the Plan and provided during the visit, consultations, specialist referrals and second surgical opinions; excludes eligible preventive care visits, which are covered 100% in-network)	100% coverage after $40 primary care office visit copayment;** $50 specialist office visit copayment	60% coverage after deductible
X-rays and Labs (When performed to diagnose a medical problem or treat an illness or injury. **Please Note:** X-rays and lab tests done in a physician's office are covered in the same manner as a PCP visit.)	80% coverage after deductible	60% coverage after deductible

Type of Service	In-Network Care	Out-of-Network Care*
Infertility Services (includes diagnostic procedures, in vitro fertilization, artificial insemination, etc.; limited to enrolled in program $10,000 lifetime maximum; enrolled in program and use Center of Excellence: $30,000 lifetime maximum for each covered individual***)	100% coverage after a $50 specialist office visit copayment; 80% coverage elsewhere after deductible (no copayment if in a facility)	60% coverage after deductible
Routine Eye Exams	Not covered	Not covered
Speech, Physical or Occupational Therapy (combined in-network and out-of-network limit of 60 visits/ calendar year per therapy type***)	100% coverage after $50 per visit copayment	60% coverage after deductible
Chiropractic Care (must be medically necessary; coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year***)	100% coverage after $50 per visit copayment	60% coverage after deductible
Mental Health Care	100% coverage after $50 per visit copayment	60% coverage after deductible
Substance Abuse Care	100% coverage after $50 per visit copayment	60% coverage after deductible
Inpatient Services		
Acute hospital care (Based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases; precertification requirements may apply)	80% coverage after $500 copayment per admission; waived if re-admitted for same or related condition within 14 days	60% coverage after deductible
Skilled Nursing Facility (must be ordered by physician as medically necessary; includes charges for services and supplies provided while patient is under continuous care and requires 24-hour nursing care and room and board; limited to combined in-network and out-of-network maximum of 365 days/lifetime for each covered individual**)	80% coverage after $500 copayment per admission; waived if admitted from hospital	60% coverage after deductible
Hospice Care	80% coverage after deductible	60% coverage after deductible

Type of Service	In-Network Care	Out-of-Network Care*
Mental Health Care	80% coverage after $500 copayment per admission	60% coverage after deductible
Substance Abuse Care	80% coverage after $500 copayment per admission	60% coverage after deductible
Other Services		
Emergency Room (for sudden and serious medical conditions approved by claims administrator as required for emergency care) In accordance with applicable regulations, true emergency is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors.	100% after a $150 copayment per visit; waived if admitted; 60% coverage after deductible if not considered an emergency	100% after a $150 copayment per visit; waived if admitted; 60% coverage after deductible if not considered an emergency
Home Health Care (medically necessary only; may require precertification; limited to combined in-network and out-of-network maximum of 200 visits/calendar year; one visit = four hours**)	80% coverage after deductible	60% coverage after deductible
Durable Medical Equipment and Prosthetics	80% coverage after deductible	60% coverage after deductible
Prescription Drugs	Please see "Prescription Drug Coverage Under POS High and Low Options" on page 71.	Please see "Prescription Drug Coverage Under POS High and Low Options" on page 71.

* Generally, all out-of-network expenses are subject to reasonable and customary (R&C) charges.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with Cigna at (800) 790-3086 for details.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to R&C charges. You should note that since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

In-Network Benefits

The POS High and Low Options' greatest financial advantages generally occur when you receive your care from a network provider. When you receive in-network care through the POS High or Low Option:

- You are covered 100% for eligible preventive medical care for several in-network screenings.
- You pay a fixed copayment for office visits.
- You usually don't have to file any claim forms; your network provider will usually file claims for you.
- Your out-of-pocket expenses will be lower compared to your expenses for the same type of care on an out-of-network basis.
- There's no lifetime dollar maximum covered benefit limit (except infertility services and a skilled nursing facility).

Out-of-Network Benefits

Under both the POS High and Low Options, you have the option of visiting an out-of-network physician, hospital, or other provider at any time. For both options, if you choose to receive medically necessary covered services on an out-of-network basis:

- Services performed by providers not participating in the network will be reimbursed at the out-of-network level of benefits, based on R&C charges with respect to medically necessary covered services, and you must meet your deductible before out-of-network benefits are paid.
- You'll need to file a claim form to receive out-of-network benefits. See "How to Submit a Claim" on page 38.
- Your own costs for medically necessary covered services generally will be higher than if you received in- network care.
- There's no lifetime dollar maximum covered benefit limit (except infertility services and a skilled nursing facility).

Please Note: When you visit an in-network facility for a scheduled surgery, the POS High or Low Option will cover care provided by radiologists, anesthesiologists and/or pathologists (RAPs) at the in-network percentage of the R&C charge, even if the provider is considered an out-of- network provider. For example, assume you are enrolled in the POS High Option and visit an in-network facility for surgery and are treated by an out-of-network anesthesiologist whose charge is $500. If the R&C charge for the anesthesiologist's services is $400, the Plan will reimburse you 90% of $400 ($360) after the copayment is paid; you will be responsible for payment of the remaining $140. Fees for services provided by any other out-of-network specialists who attend to you while you are confined in an in-network facility will be paid at the out-of- network level of benefits. Services performed in an out-of-network facility will be paid at the out-of- network level of benefits.

Annual Deductible

Before you receive coverage for benefits from either the POS High or Low Option, you generally need to satisfy an annual deductible. Only R&C charges for medically necessary services will count toward the out-of-network deductible. Amounts above R&C charges do not count toward your deductible.

- Under the POS High and Low Options, if you elect coverage for yourself or yourself plus one dependent: Each covered person must pay all eligible expenses until the individual deductible is met. Then, eligible expenses are covered at the coinsurance indicated for that expense. Expenses for two covered individuals are not combined.
- After a covered person meets the individual deductible amount, that person will pay no further deductible.

If you elect coverage for yourself plus two or more dependents:

- All expenses incurred by you and/or your covered dependents combine to meet the appropriate total deductible (individual plus spouse/domestic partner or plus children, or individual plus spouse/domestic partner plus children).
- If no one person meets the individual deductible, but combined participant expenses meet the total deductible amount, no further deductible is required.
- After a covered person meets the individual deductible amount, that person will pay no further deductible.

The maximum deductible any one covered person must pay is equal to the individual amount. After one person meets the individual deductible, that person will pay no further deductible, but other covered persons must continue to pay deductibles until the total is satisfied.

An Example: Amounts Applied Toward POS High Option Out-of-Network Deductible	
On behalf of you	$1,000
On behalf of your spouse/domestic partner	$500
On behalf of one child	$750
On behalf of a second child	$750
TOTAL	$3,000
In this example, one person has met the POS High Option of the $1,000 individual deductible (you), and the combined costs have reached $3,000. So any R&C charges for medically necessary covered services would be reimbursable at 70% or until your out-of-pocket limit is met by the POS High Option, even if they were on behalf of a person who has not yet met the $1,000 individual deductible. No other covered family members need to meet their individual deductible for the rest of the year.	

Annual Out-of-Pocket Maximum

Under the POS High and Low Options, this is the maximum amount (excluding items such as annual deductible and copayments) you must pay in a calendar year toward each covered person's eligible expenses. Only R&C charges for medically necessary services will count toward the annual out-of-pocket maximum. Amounts above R&C charges do not count toward your annual out-of-pocket maximum.

If you elect coverage for yourself or yourself plus one dependent:

- Each covered person must pay all eligible out-of-pocket expenses until the individual maximum is met. Eligible out-of-pocket expenses are then covered at 100% for that person.
- After a covered person meets the individual out-of-pocket maximum, that person will pay no further out-of-pocket expenses for eligible expenses.

If you elect for yourself plus two or more dependents:

- All eligible out-of-pocket expenses paid by you and/or your covered dependents combine to meet the appropriate total maximum amount (individual plus spouse/domestic partner or plus children, or individual plus spouse/domestic partner plus children).
- If no one person meets the individual maximum, but combined participant out-of-pocket payments meet the total amount, eligible out-of-pocket expenses are then covered at 100%.
- After a covered person meets the individual out-of-pocket maximum, that person will pay no further out-of-pocket expenses for eligible expenses.

The maximum out-of-pocket expense any one covered person must pay is equal to the individual amount. After one person's expenses reach the individual out-of-pocket maximum, eligible out-of-pocket expenses are then covered at 100% for that person, but other covered persons must continue to pay out-of-pocket expenses until the total coverage level out-of-pocket maximum is satisfied. See the example below for more information.

An Example: Amounts Applied Toward POS Low Option Out-of-Network Family Out-Of-Pocket Maximum	
On behalf of you	$5,300
On behalf of your spouse/domestic partner	$3,500
On behalf of one child	$3,100
On behalf of a second child	$4,000
TOTAL	$15,900

An Example: Amounts Applied Toward POS Low Option Out-of-Network Family Out-Of-Pocket Maximum

In this example, one person has met the POS Low Option $5,300 individual out-of-pocket maximum (you), and the combined out-of-pocket costs have reached $15,900. So, any R&C charges for medically necessary covered services would be reimbursable at 100% by the POS Low Option, even if they were on behalf of a person who has not yet met the individual out-of-pocket maximum. No other covered family members need to meet their individual out-of-pocket maximum for the rest of the year.

Maximum Lifetime Benefits

There is a $30,000 lifetime infertility services maximum when a Center of Excellence is used. There is also a lifetime limit of 365 days for in- or out-of-network care in a skilled nursing facility. The fertility services and skilled nursing facility lifetime maximum benefits apply to both in-network and out-of-network care. In addition, all benefits you receive under the POS High or Low Option are added together for purposes of the lifetime maximums.

Important Note: Any benefits that have been applied to a lifetime maximum provision under a medical plan of your heritage organization, and as an active employee, will also be applied to the lifetime maximums of the JPMorgan Chase Retiree Medical Plan. You do not gain a new maximum if you switch your coverage between options.

Hospital Notification

You must contact the claims administrator within 48 hours before all scheduled hospital admissions. In the event of an emergency, you can make this notification within 48 hours after your admission. You must also contact the claims administrator if a maternity stay will exceed 48 hours for the mother and newborn child following a vaginal delivery, or 96 hours for the mother and newborn child following a cesarean section delivery. To provide notification, please contact your POS High or Low Option's claims administrator. See "Questions?" on page 2 for contact information.

If You Need Emergency Care

If you have a medical emergency that's sudden, urgent and life threatening, you should go to the nearest hospital emergency room. Your emergency care will be covered at 100%, after a $150 copayment, as if you received the care in-network as long as:

- You, the physician or a member of your family calls the POS High or Low Option claims administrator within 48 hours after the emergency; and
- The POS High or Low Option claims administrator approves the care.

If you don't follow these guidelines to receive approval, your benefits will be paid as if you received the care out-of-network.

Note: The determination of whether the visit was a true emergency and thus whether coverage is at the 50% or 80% level is not dependent on notification within 48 hours after the emergency care. In accordance with applicable regulations, a true emergency is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors

Hearing Aid Coverage

Under POS High and POS Low, there is reimbursement for hearing aids up to $2,500 (POS High) and $2,400 (POS Low) every 24 months; hearing aid must be prescribed by an in-network doctor and purchased from an in-network durable medical equipment vendor. Hearing aid evaluations and hearing tests are also covered.

Prescription Drug Coverage Under POS High and Low Options

If you elect coverage in the POS High or Low Option, your prescription drug coverage is provided through the Retiree Prescription Drug Plan, administered by CVS Caremark. Please see "Prescription Drug Coverage Under Option 1 and Option 2"page 28 for details on your prescription drug coverage.

Grandfathered Retiree Medical Plans

If you are Medicare-eligible retiree and currently enrolled in a grandfathered retiree medical plan sponsored by JPMorgan Chase, the plan provisions described above do not apply to you. For more information about the plan provisions that apply, please see the applicable Summary of Benefits for the Plan in which you are enrolled, located on the Cigna website or available through HR Answers.

Defined Terms

As you read this summary of the JPMorgan Chase Retiree Medical Plan, you'll come across some important terms related to this Plan. To help you better understand the Plan, many of those important terms are defined here.

Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Retiree Medical Plan. If you elect Retiree Medical Plan coverage, your claims administrator is your health care company (Aetna or Cigna).
Coinsurance	Coinsurance is the way you and the Plan share costs for certain covered health care services, generally after you pay any applicable deductible under Option 1 and Option 2 and/or Prescription Drug Plan. For medically necessary covered in-network services, Option 1 and Option 2 pay a percentage of providers' negotiated fees and you pay the remainder. For medically necessary covered out-of-network services, Option 1 and Option 2 pay a percentage of reasonable and customary (R&C) charges for services and you pay the remainder. In all the Retiree Medical Plan options you are responsible for paying any additional amount above R&C charges. The coinsurance percentage you pay depends on the type of covered service.
Coinsurance Maximum	The coinsurance maximum is a safety net that protects you from having to pay high expenses in the event of a serious medical situation. The coinsurance maximum is the most you would need to pay in a calendar year in addition to the deductible for medically necessary covered services under Option 1 and Option 2. Once the coinsurance maximum is reached, the Retiree Medical Plan will pay 100% of negotiated rates for medically necessary covered in-network care and 100% of R&C charges for medically necessary covered out-of-network services for the rest of the calendar year. Under Option 1 and Option 2, amounts that you pay toward your medical deductible, amounts above R&C charges for out-of- network care, and your deductible, copayments, and coinsurance for prescription drugs do not count toward your medical coinsurance maximum.
Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA)	A federal law that allows you and/or your covered dependents to continue Retiree Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. The *Retiree Plan Administration* document provides details on COBRA coverage.

Continuous Service (used for purposes of determining eligibility for company-subsidized retiree medical coverage)	An uninterrupted period of service with JPMorgan Chase (including service with your heritage organization at the time of the merger) from your most recent date of hire until your last day actively at work. Breaks in employment of more than 12 months are considered interruptions of continuous service. There are two exceptions: ▪ Generally, service before a break in employment (but not the break itself) as a result of position elimination counts as continuous service, as long as you were re-employed by the same employer; and ▪ Service with a company at the time of its acquisition (as opposed to a merger) may or may not count toward continuous service.
Coordination of Benefits	The rules that determine how benefits are paid when a person is covered by more than one group plan. Rules include: ▪ Which plan assumes primary liability; ▪ The obligations of the secondary claims administrator or claims payer; and ▪ How the two plans ensure that the person is not reimbursed for more than the actual charges incurred. In general, the following coordination of benefits rules apply: ▪ As a JPMorgan Chase pre-Medicare retiree, your JPMorgan Chase coverage is considered primary for you. ▪ For your spouse/domestic partner or child(ren) covered as an active employee and/or retiree of another employer, that employer's coverage is considered primary for him or her. ▪ For child(ren) covered as dependents under two plans, the primary plan is the plan of the parent whose birthday falls earlier in the year (based on month and day only, not year). Specific rules may vary, depending on whether the patient is covered by Medicare, receiving long-term disability benefits, a retiree, or a dependent of a retiree or LTD participant. These rules do not apply to any private insurance you may have.
Copay or Copayment	The fixed dollar amount you pay toward certain services under the Retiree Medical Plan when you receive your care from a medical network provider (POS High and Low Options) or receive generic prescription drugs.
Covered Expenses	The in-network negotiated fees or R&C charges for medically necessary covered services or supplies that qualify for full or partial reimbursement.
Covered Services	Medical procedures that are generally reimbursable by the JPMorgan Chase Retiree Medical Plan when they are “necessary.” (See the definition of “medically necessary” in this section). While the Plan provides coverage for numerous services and supplies, there are limitations on what's covered. For example, experimental treatments, most cosmetic surgery expenses and inpatient private duty nursing are not covered under the Retiree Medical Plan. So while a service or supply may be necessary, it may not be covered under the JPMorgan Chase Retiree Medical Plan. Please see “What Is Covered Under Retiree Medical Plan Options” on page 39 for more details.

Credited Service (applies only to a small group of heritage Morgan employees in determining alternative eligibility based on having met the rule of 70 by December 31, 2003, for company-subsidized retiree medical coverage)

This is service as defined under the 1999 Morgan Cash Balance Plan (and for service after December 31, 2001, as recognized under the 2002 JPMorgan Chase Plan) which is equal to your years and months of service as a participant accruing benefits under the plan. Participation in the 1999 Morgan Cash Balance Plan began after you completed six months of continuous service and were at least age 21 (age 22 if hired prior to July 1, 1985). If you were initially hired on or after January 1, 1987, the maximum credited service is 30 years. If you were hired before January 1, 1987, the maximum credited service is 40 years.

In general, any period of authorized absence of up to two years is not subtracted when determining your credited service. This provision includes an authorized absence for military or governmental service, provided you return to active service without loss of employment status.

If you are receiving a benefit under the Long-Term Disability (LTD) Plan, your credited service will continue until your actual retirement or your LTD benefits terminate, whichever occurs first.

Cumulative Service (used for purposes of determining eligibility for company-subsidized retiree medical coverage)

The period of service with JPMorgan Chase that may include service with predecessor heritage organizations as outlined by the following conditions:

- If employed by Manufacturers Hanover Corporation or one of its participating subsidiaries or Chemical Banking Corporation or one of its participating subsidiaries on the date of their merger (December 31, 1991), then only prior service with the specific heritage organization employing you on that merger date (December 31, 1991) will count as cumulative service. Service with the other heritage organizations will not count.
- If employed by Chemical Banking Corporation or one of its participating subsidiaries or The Chase Manhattan Corporation or one of its participating subsidiaries on the date of their merger (March 31, 1996), then only prior service with the specific heritage organization employing you on that merger date (March 31, 1996) will count as cumulative service, as follows:
  - If employed by Chemical Banking Corporation or one of its participating subsidiaries as of March 31, 1996, service recognized for pay credit purposes under the Chemical Retirement Plan on such date will count as cumulative service; or
  - If employed by The Chase Manhattan Corporation or one of its participating subsidiaries as of March 31, 1996, service recognized for benefit service purposes under the Chase Retirement Plan on such date will count as cumulative service.
- If employed by The Chase Manhattan Corporation or one of its participating subsidiaries or J.P. Morgan or one of its participating subsidiaries on the date of their merger (December 31, 2000), then only prior service with the specific heritage organization employing you on that merger date (December 31, 2000) will count as cumulative service, as follows:
  - If employed by the Chase Manhattan Corporation or one of its participating subsidiaries as of December 31, 2000, service recognized for pay credit purposes under the Chase Retirement Plan on such date will count as cumulative service; or
  - If employed by J.P. Morgan or one of its participating subsidiaries as of December 31, 2000, service recognized for vesting purposes under the J.P. Morgan Retirement Plan on such date will count as cumulative service.
- If employed by JPMorgan Chase & Co. or one of its participating subsidiaries or Bank One Corporation or one of its participating subsidiaries on the date of their merger (July 1, 2004), then only prior service with the specific heritage organization employing you on that merger date (July 1, 2004) will count as cumulative service, as follows:
  - If employed by JPMorgan Chase & Co. or one of its participating subsidiaries as of July 1, 2004, service recognized for pay credit purposes under the JPMorgan Chase Retirement Plan on such date will count as cumulative service; or
  - If employed by Bank One Corporation or one of its participating subsidiaries as of July 1, 2004, service recognized for pay credit purposes under the Bank One Personal Pension Account Plan on such date will count as cumulative service.

	If you were not employed by a heritage organization on any of the merger dates and are or have been re-employed, then your employer for purposes of the above rules will be the heritage organization that most recently employed you prior to your re-employment date, except that all service with such prior heritage organization will be recognized. Service with a company at the time of its acquisition (as opposed to a merger) may or may not count toward cumulative service, depending on the terms of the purchase agreement and the plan.
Custodial Care	Medical or non-medical services that do not seek to cure, are provided during periods when the medical condition of the patient is not changing, or do not require continued administration by medical personnel. An example of custodial care is assistance in the activities of daily living.
Deductible	The amount you pay up front each calendar year for covered expenses before Option 1 and Option 2 generally begin to pay benefits for many expenses. There are separate in-network and out-of-network deductibles. Amounts in excess of R&C charges and ineligible charges do not count toward the deductible. A separate deductible applies for the Prescription Drug Plan.
Domestic Partner	You may cover a domestic partner as an eligible dependent under the Retiree Medical Plan if you're not currently covering a spouse. 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 12 months, are currently living together, and have a serious, committed romantic relationship; 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 IRC to avoid any applicable imputed income.
Eligible Dependents	Under the Retiree Medical Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see “Your Eligible Dependents” on page 10 for more information.

Experimental, Investigational or Unproven Services	Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the claims administrator makes a determination regarding coverage in a particular case, are determined to be: ▪ Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or ▪ Subject to review and approval by any institutional review board for the proposed use; or ▪ The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or ▪ Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed. The claims administrator, in its judgment, may determine an experimental, investigational or unproven service to be covered under the Retiree Medical Plan for treating a life-threatening sickness or condition if the claims administrator determines that a service: ▪ Is safe with promising effectiveness; ▪ Is provided in a clinically controlled research setting; and ▪ Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. **Please Note**: For the purpose of this definition, the term life threatening is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. If services are denied because they are deemed to be experimental, investigational or unproven, and the service is then considered an approved service by the claims administrator within six months of the date of service, you may resubmit your claim for payment.
Explanation of Benefits (EOB)	A statement that the claims administrator prepares, which documents your claims and provides a description of benefits paid and not paid under the Retiree Medical Plan and through any related Medical Reimbursement Account that was carried over from an active employee.
Home Health Care	An alternative to inpatient hospitalization during a patient's recovery period. If the attending physician believes that part-time care will suffice in treating the sickness or injury, the physician can prescribe a schedule of services to be provided by a state-licensed home health care agency. This schedule may include administration of medication, a regimen of physical therapy, suctioning or cleansing of a surgical incision, the supervision of intravenous therapy or other skilled nursing care.
Hospice Care Program	A program that tends to the needs of a terminally ill patient as an alternative to traditional health care, while meeting medically necessary and acceptable standards of quality and sound principles of health care administration. The program must be a written plan of hospice care for a covered person, and it must be approved by the appropriate claims administrator.
Hospital	An institution legally licensed as a hospital — other than a facility owned or operated by the United States Government — that's engaged primarily in providing bed patients with diagnosis and treatment under the supervision of licensed physicians. The hospital must have 24-hour-a-day registered graduate nursing services and facilities for major surgery. Institutions that don't meet this definition don't qualify as hospitals.
Hospital Notification	Under Option 1 and Option 2 of the Retiree Medical Plan, you should notify the claims administrator in advance of a non-emergency hospital admission or if a maternity stay exceeds the guidelines. However, you will not be penalized under the Plan if you do not notify the claims administrator.
In-Network	Describes a covered service that is performed by a physician, hospital, lab, or other health care professional who is part of a health care company's network and who has agreed to pre-negotiated fees, as in Option 1 and Option 2 of the Retiree Medical Plan. When a service is performed in-network, benefits are generally paid at a higher level than they are when a service is performed out-of-network.

Medical Reimbursement Account (MRA)

Also known as a Health Reimbursement Account (HRA), the Medical Reimbursement Account (MRA) is a tax-free account established for active employees at their health care company when active employees enroll in the JPMorgan Chase Medical Plan. Employees (and their covered spouse/domestic partner) can earn Wellness Funds for their MRA by completing Initial Wellness Activities and Additional Wellness Activities.

Retirees are no longer eligible to earn Wellness Funds, but you can use remaining funds in your MRA to pay for your out-of-pocket medical and prescription drug expenses (deductibles, coinsurance and copayments).

Medically Necessary

Medical services and supplies that are determined by the claims administrator to be medically appropriate and:

- Necessary to meet the basic health needs of the covered person;
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his or her physician; and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed. or
  - Safe with promising effectiveness:
    - For treating a life-threatening sickness or condition;
    - In a clinically controlled research setting; and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Please Note: For the purpose of this definition, the term life threatening is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or condition does not mean that it is a medically necessary service or supply as defined above. The definition of medically necessary used here relates only to coverage, and may differ from the way in which a physician engaged in the practice of medicine may define medically necessary.

Finally, to be considered necessary, a service or supply cannot be educational or experimental in nature in terms of generally accepted medical standards.

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.

Multiple Surgical Procedure Reduction Policy

Under Option 1 and Option 2 of the Retiree Medical Plan, surgical procedures that are performed on the same date of service are subject to the multiple surgical procedure reduction policy. On an in-network basis, 100% of the negotiated charges are reimbursable for the primary/major procedure, 50% of negotiated charges are reimbursable for the secondary procedure, and 50% of negotiated charges are reimbursable for all subsequent procedures.

On an out-of-network basis, 100% of R&C charges are reimbursable for the primary/major procedure, 50% of R&C charges are reimbursable for the secondary procedure, and 50% of R&C charges are reimbursable for all subsequent procedures. Participants undergoing surgery are urged to discuss this policy with their health care provider.

Non-Duplication of Benefits	The Retiree Medical Plan does not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. You are entitled to receive benefits up to what you would have received under the JPMorgan Chase Retiree Medical Plan if it were your only source of coverage, but not in excess of that amount. If you have other coverage that is primary to the JPMorgan Chase Retiree Medical Plan, the claims administrator will reduce the amount of coverage that you would otherwise receive under this Plan by any amount you receive from your primary coverage. Please see the definition of Coordination of Benefits in this section for more information.
Out-of-Network	Describes a covered service that is performed by a physician, hospital, lab or other health care professional who is not part of a health care company's network and who has not agreed to pre-negotiated fees, as in Option 1 and Option 2 of the Retiree Medical Plan. When a service is performed out-of-network, benefits are generally paid at a lower level than they are when a service is performed in-network and are limited to R&C charges.
Out-of-Pocket Expense	The amount you pay for eligible expenses when you receive treatment. This includes your deductible, coinsurance and copayments.
Out-of-Pocket Maximum	Under the prescription drug coverage feature of Option 1 and Option 2, the maximum amount you would have to pay each year in copayments and coinsurance for prescription drugs. The out-of-pocket maximum does not include the deductible. After you reach the out-of-pocket maximum, the Plan would pay 100% of the cost of covered prescription drugs for the remainder of the year.
Primary Care Physician (PCP)	The network physician who provides or coordinates all the care you receive. Under Option 1 and Option 2, primary care physicians include doctors who practice family medicine, internal medicine*, obstetrics/ gynecology and pediatrics. Care provided by an in-network primary care physician is covered at 90% of the pre-negotiated fee and is not subject to the deductible. *Internists must be contracted with Aetna or Cigna as primary care physicians. (A list of doctors who are designated as primary care physicians is available on Aetna's or Cigna's websites through **My Health**.)
Primary Plan	The plan that provides initial coverage to the participant. If the participant is covered under both a JPMorgan Chase Retiree Medical Plan option and another plan, the rules of the primary plan govern when determining the coordination of benefits between the two plans. Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee) or covered by Medicare. These rules do not apply to any private insurance you may have. Please see "If You Are Covered by More Than One Medical Plan" on page 51 for more information.
Qualified Status Change	The JPMorgan Chase retiree benefits you elect during each annual benefits enrollment will generally stay in effect throughout the plan year, unless you elect otherwise due to a Qualified Status Change (such as divorce) within 31 days of the qualifying event for benefits to be effective the date of the event. **Please Note**: Any changes you make during the year must be consistent with your Qualified Status Change. Please see "Qualified Status Changes" on page 15 for more information.
Precertification or Precertify or Prior Authorization	Authorization / approval must be received in advance of certain services being provided. If the service is being provided by an in-network provider or facility, the in-network provider/facility is responsible for obtaining the precertification. If the service is being provided by an out-of-network provider/facility, you are responsible for obtaining the precertification. Please see "Prior Authorization" on page 26.

Reasonable and Customary (R&C) Charges	Also known as eligible expenses, the actual charges that are considered for payment when you receive medically necessary care for covered services from an out-of-network provider under Option 1 and Option 2. R&C means the prevailing charge for most providers in the same or a similar geographic area for the same or similar service or supply, as determined by your health care company in its discretion. These charges are subject to change at any time without notice. Reimbursement is based on the lower of this amount and the provider's actual charge. If your provider charges more than the R&C charges considered under the Options, you'll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered covered expenses. Therefore, they don't count toward your deductible, benefit limits or coinsurance maximums.
Self-Insured	JPMorgan Chase is responsible for the payment of medical claims under the Retiree Medical Plan's Option 1 and Option 2, including the Prescription Drug benefit. These Options are self-insured.
Skilled Nursing Facility	An institution that primarily provides skilled nursing care and related services for people who require medical or nursing care and that rehabilitates injured, disabled or sick people.
Split Coverage	Split coverage applies when one member of a family is Medicare-eligible and another family member is not yet eligible for Medicare. The pre-Medicare-eligible member is covered under the JPMorgan Chase Retiree Medical Plan. The Medicare-eligible member receives coverage through Via Benefits
Spouse	Any person to whom you are legally married as recognized by U.S. federal law.
Total Service (used for purposes of determining eligibility to participate in the "access only" (unsubsidized) Retiree Benefits Program)	Generally, the period beginning on your first day actively at work as an employee of JPMorgan Chase or an affiliate and ending when your employment ends. This generally includes all periods of employment with JPMorgan Chase or any of the merged companies that have become part of JPMorgan Chase. For employees who had service with heritage Bank One and who were reemployed prior to January 1, 2005, your total service will not include such prior Bank One service to the extent it would not have been recognized by the heritage Bank One Personal Pension Account Plan (PPAP) for vesting purposes. For example, if you had a break in service that began prior to being vested in the PPAP and your break exceeded five years, then service prior to the break will not be part of total service.
Visit	An encounter with a provider involving direct patient contact. Some benefit provisions limit the number of covered visits. Unless a visit is defined for a particular benefit provision (such as home health care), each procedure code billed counts as a visit toward the limit. The length of a visit may vary by procedure code.