# The Retiree Dental Plan

## *Effective 1/1/20*

*The Retiree Dental Plan is available to pre-Medicare-eligible retirees and their eligible covered pre-Medicare dependents. It is also available to pre-Medicare-eligible dependents of Medicare-eligible retirees and to pre-Medicare-eligible dependents of Medicare-eligible individuals receiving long-term disability benefits from JPMorgan Chase.*

*The Retiree Dental Plan is designed to provide pre-Medicare-eligible individuals with access to cost-effective dental care. The Plan offers you and your enrolled dependents coverage for preventive care, basic and major restorative care, and orthodontia dental services, depending on the option you choose.*

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. JPMorgan Chase or you may terminate the employment relationship at any time.

## 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.

To update your profile on My Personal Profile, visit https://mpp.jpmorganchase.com.

For help through a Dental Plan customer service representative, call:

- MetLife Preferred Dentist Program (PDP): MetLife Dental at (888) 673-9582
- Aetna, Inc. Dental Maintenance Organization (DMO) Option: Aetna at (800) 741-4781
- Cigna Dental Health Maintenance Organization (DHMO) Option: Cigna at (800) 790-3086

You can also obtain answers to general questions, enroll, or find claim forms online at **My Health** (https://myhealth.jpmorganchase.com):

- To enroll or access Dental Plan options or for provider directories, access the Benefits Web Center using Single Sign-On password: **My Health** > Benefits Web Center

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.

## About this Summary Plan Description

This document is the Dental Plan section of the summary plan descriptions for the JPMorgan Chase U.S. Retiree Benefits 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 Dental 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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# Dental Plan 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 dental option websites to find in-network provider directories, check claims status, and much more.

## Your Choices

**Preferred Dentist Program (PDP) Option:** The PDP Option, administered by MetLife, lets you choose between receiving in-network or out-of-network care each time you need dental work. You will generally pay less for your care when you use a MetLife in-network dental provider for two reasons:

- In-network care is generally covered at a higher percentage with lower annual deductibles than out-of-network care; and
- Network dentists have agreed to charge lower, negotiated fees for their services when treating JPMorgan Chase Retiree Dental Plan participants.

**Dental Maintenance Organization (DMO) Option or the Dental Health Maintenance Organization (DHMO) Option (depending on your home ZIP code)**

The DMO Option, administered by Aetna Inc., and the DHMO Option, administered by Cigna, offer you a broad range of dental services on a pre-paid basis. You'll be able to choose one or the other of these options, depending on your home ZIP code. In some ZIP codes, both the DMO and DHMO will be offered. If you enroll, you agree to receive care solely from dentists associated with the network for your option, and in return, you will have no deductibles to meet and no claim forms to file. The DMO and DHMO administrators actively work to keep dental care costs low by requiring DMO and DHMO dentists to meet strict quality standards, screening for cost-effective practice patterns, and negotiating fees charged for services.

## Your Coverage Levels

If you elect coverage, 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

Depending on the option you choose, covered services can include some or all of the following:

- Preventive care services, such as oral exams, fluoride treatment, prophylaxis, X-rays (excluding intra-oral X-rays), sealants and emergency palliative treatment.
- Basic restorative care services, such as fillings, extractions, oral surgery, anesthesia and antibiotic injections.
- Major restorative care services, such as services to replace lost teeth, and inlays, onlays, and crowns, and their repair or recementing.
- Orthodontia services.

# Participating in the Retiree Dental Plan

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

## Eligibility

Your participation in the JPMorgan Chase Retiree Dental Plan is optional. In general, you're eligible to participate if you're a retiree of JPMorgan Chase (retired at least at age 55 with 15 years of total service 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.

**Provider Directories**

You can easily check which dental providers participate in the various JPMorgan Chase Retiree Dental Plan options by using the Benefits Web Center on **My Health** or by contacting your Dental Plan customer service representative. See "Questions?" on page 2 for contact information.

**Please Note:** You should always check with your dental health care provider prior to electing coverage to ensure that he or she plans to continue participating in the network of the Dental option you choose. If your dental care provider decides to leave the network, it does not qualify as an event that allows you to change coverage during the year.

## Retiree Dental Plan Options

You can choose your dental coverage from among the following options, depending on your home ZIP code:

- Preferred Dentist Program (PDP) Option;
- Dental Maintenance Organization (DMO) Option; and
- Dental Health Maintenance Organization (DHMO) Option.

## Coverage Categories

When you enroll in the Retiree Dental Plan, your coverage level is based on the dependents you enroll and includes the following coverage 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 Dental Plan, you can also cover your eligible pre-Medicare dependents. For details about your eligible dependents, please see "Your Eligible Dependents" in the *Retiree Medical Plan* Summary Plan Description.

## Dependent Age Exceptions Under the DMO and DHMO Options

The DMO and DHMO coverage may be subject to state laws providing different eligibility rules for certain dependents. Please contact Aetna DMO or Cigna DHMO if you would like additional information.

## Cost of Coverage

You pay the full cost of coverage under each of the Retiree Dental Plan options at retiree group rates. JPMorgan Chase will not subsidize any portion of this cost for coverage. You pay for coverage with after-tax dollars. 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.

Your contributions for cost of coverage start when your coverage begins. Your contributions are billed to you on a monthly basis. You will receive information about your eligibility and cost for retiree dental coverage when you retire. JPMorgan Chase will adjust costs for retiree dental coverage periodically, generally at the beginning of each plan year (January 1). If you elect retiree dental coverage, you will initially be billed on a monthly basis. You will be offered the opportunity to have the monthly cost of your retiree dental coverage deducted from your personal checking or savings account upon receipt of your signed authorization.

**Please Note:** If you do not pay your retiree dental premiums on a timely basis, your coverage will be canceled, you will not be able to re-enroll in the future, and COBRA will not be offered.

## How to Enroll

Participation in the Retiree Dental Plan is optional.

| If You | What You Need to Do to Enroll |
|---|---|
| **Are a Current Participant** | During annual benefits enrollment, you can make your election through the Benefits Web Center on **My Health** or by contacting HR Answers. At the beginning of each enrollment period, you'll receive instructions on how to enroll.<br>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 Change" on page 9 for more information. |
| **Are Newly Eligible for Coverage** | If you're enrolling for the first time, you need to make your choices through the Benefits Web Center on **My Health** or by contacting 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**.<br>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 by contacting HR Answers. Please see "Qualified Status Change" on page 9 for more information. |

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

## If You Do Not Enroll

| If You | What Happens If You Do Not Enroll |
|---|---|
| **Are a Current Participant** | If you're already participating in the Retiree Dental Plan, are pre-Medicare-eligible, and don't cancel coverage during the annual benefits enrollment, you'll generally keep the same coverage for the following plan year that you had before 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 a 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 Dental Plan any time 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 able to make the change in coverage until the following annual benefits enrollment. |

## When Coverage Begins

| If You | When the Coverage You Elect Begins |
|---|---|
| **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.<br>**Note to former employees:** If you're eligible for coverage under the Retiree Dental Plan and due to job elimination are receiving a subsidy from JPMorgan Chase toward the cost of your COBRA Medical or Dental 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 dental coverage through JPMorgan Chase (if pre-Medicare) at any time in the future. |
| **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 Change" on page 9 for more information. |

## Qualified Status Changes

The Retiree Dental Plan elections you make during 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're a pre-Medicare retiree or dependent of a retiree and have elected not to participate in the Retiree Dental Plan, a Qualified Status Change does not 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 by contacting 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 Dental Plan are listed in the following table.

| Retiree Dental Plan Changes for Qualified Status Changes | |
|---|---|
| **Event** | **Retiree Dental 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 for Coverage*** | 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 Dental Plan Option Service Area** | Change Retiree Dental Plan option for yourself and your covered dependents. (**Please Note:** In this situation, you will be assigned new coverage by JPMorgan Chase based on your new service area. However, you will have the ability to change this assigned coverage within 31 days of the qualifying event.) |

* Also applies to a domestic partner relationship.

If you are an individual receiving long-term disability benefits from JPMorgan Chase or the pre-Medicare-eligible dependent of a Medicare-eligible individual receiving long-term disability benefit from JPMorgan Chase, other qualified status change scenarios may apply. Please contact HR Answers.

**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.

# The Preferred Dentist Program (PDP) Option

The Preferred Dentist Program (PDP) Option is one of the options available under the JPMorgan Chase Retiree Dental Plan. The PDP Option is administered by MetLife. The PDP Option lets you choose between receiving in-network or out-of-network care each time you need dental work. You will generally pay less for your care when you use a MetLife in-network dental provider for two reasons:

- In-network care is generally covered at a higher percentage with lower annual deductibles than out-of-network care; and
- Network dentists have agreed to charge lower, negotiated fees for their services.

**With the PDP Option…**

- You can receive in-network or out-of-network care at any time and still receive benefits.
- In-network preventive care is covered at 100% with no deductible.
- There's no deductible for out-of-network preventive care.
- There's no deductible for orthodontic care.
- Combined in-network and out-of-network annual limits apply to preventive and restorative care.
- Combined in-network and out-of-network lifetime limits apply to orthodontia benefits.
- Claim forms are not needed for in-network providers.

## How the PDP Option Works

The PDP Option has networks of participating dentists and other dental providers who have agreed to a negotiated fee arrangement for covered dental services when treating JPMorgan Chase participants. However, you can also choose to receive care from any other dental provider and still receive benefits.

If you're interested in enrolling in the PDP Option, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You may view an online provider directory by accessing MetLife's website (https://mybenefits.metlife.com) or the Benefits Web Center via **My Health**. You can also call MetLife at (888) 673-9582 if you need help finding a provider.

**Pre-Determination of PDP Benefits**

Under the PDP Option, you should submit an itemized list of any proposed course of treatment (including recent pre-treatment X-rays) that you expect will cost more than $300, before work has begun. A dental consultant at MetLife will review the proposed treatment before work begins and MetLife will inform you and your dentist of the amount of covered charges. That way, you'll understand the benefits that will be paid before treatment begins. Benefits will be paid according to the Plan provisions in effect when the services are actually rendered. The amount may change if the treatment changes from that which was predetermined or if frequency limits apply. Except in the case of an emergency, you may not want to begin the course of treatment until you know what amount your JPMorgan Chase Retiree Dental Plan option will pay.

## How the PDP Option Pays Benefits

**Please Note:** The way benefits are paid depends on whether you receive your care in-network or out-of-network. The following chart shows how the PDP Option pays benefits.

| Benefit Provision | In-Network | Out-of-Network |
|---|---|---|
| **Annual Deductible** | | |
| • Preventive | • None | • None |
| • Restorative | • $50 individual; $150 family | • $100 individual; $300 family |
| • Orthodontia | • None | • None |
| **Preventive (no deductible)** | 100% coverage* | 90% coverage* |
| • Oral exams | • Maximum two per calendar year | • Maximum two per calendar year |
| • Prophylaxis (cleaning) | • Maximum two per calendar year | • Maximum two per calendar year |
| • Fluoride | • Maximum one per calendar year under age 19 | • Maximum one per calendar year under age 19 |
| • Full mouth X-ray | • Maximum one every 60 months | • Maximum one every 60 months |
| • Bitewing X-ray | • Maximum one per calendar year** | • Maximum one per calendar year** |
| • Sealants | • Maximum two treatments per tooth (permanent molars only)/lifetime; under age 19 | • Maximum two treatments per tooth (permanent molars only)/lifetime; under age 19 |
| **Basic restorative** (fillings, extractions, periodontal, oral surgery, anesthesia, including non-intravenous conscious sedation when medically necessary) | 80% coverage, after deductible* | 70% coverage, after deductible* |
| **Major restorative** (dentures, inlays, onlays, crowns, bridges, root canal) | 60% coverage, after deductible* | 50% coverage, after deductible* |
| **Orthodontia *** ** | 50% coverage* | 50% coverage* |
| **Maximum Benefits** | | |
| • Combined annual for preventive and restorative | • Maximum $2,000**** | • Maximum $1,500**** |
| • Lifetime for orthodontia | • Maximum $2,500**** | • Maximum $2,000**** |

* All in-network percentages above apply to dentists' negotiated fees. All out-of-network percentages apply to reasonable and customary (R&C) charges.

** Two times per calendar year for covered participants under age 19.

*** For covered children under age 19. Please see "Orthodontic Covered Services" on page 13 for additional information.

**** Reflects a combined amount for both in-network and out-of-network; includes any benefits already applied to any lifetime maximum for orthodontia under the dental plan of a heritage organization or under the former Traditional Indemnity Option.

**Please Note:** Wherever benefits are limited to a certain number of visits, combined in-network and out-of-network visits will count toward the benefit limit. For more details on coverage limitations, see "What Is Not Covered" on page 22.

## Annual Deductible

Under the PDP Option, 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.
- 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 family deductible.
- If no one person meets the individual deductible, but combined participant expenses meet the total deductible amount, no further deductible is required.

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.

**Please Note:** There are separate deductibles (in-network and out-of-network) for restorative care.

| **An Example: Amounts Applied Toward In-Network Restorative Care Deductibles** | |
|---|---|
| On behalf of you | $50 |
| On behalf of your spouse/domestic partner | $50 |
| On behalf of child #1 | $30 |
| On behalf of child #2 | $20 |
| Total | $150 |
| In this example, four people have met the family annual deductible for in-network restorative care. So, any other covered person's in-network restorative care would be reimbursed by the Plan, even if it were on behalf of a person who has not yet met the $50 individual annual deductible. No other covered family members need to meet their in-network restorative care deductible for the rest of the year. **Please Note:** No more than $50 of expenses per individual will be applied towards the family deductible. | |

## Coinsurance

After you meet the applicable deductible, the Plan will pay a percentage of in-network dentists' negotiated fees, or, for out-of-network expenses, a percentage of the reasonable and customary (R&C) charges for eligible expenses (see "Defined Terms" beginning on page 31 for the definition of "reasonable and customary charges"). The exact percentage depends on the type of care and whether the care was received on an in-network or out-of-network basis. Please see "How the PDP Option Pays Benefits" on page 11 for the applicable coinsurance rate. You'll pay the remaining amount as coinsurance, plus any amounts above R&C charges.

## Alternate Benefit Provision

Under the PDP Option, generally benefits will be limited to the R&C charge for the least expensive method of treatment that is appropriate and that meets acceptable dental standards — as determined by MetLife, the claims administrator. Pursuant to the Plan's alternate benefit provision, if the PDP Option claims administrator determines in its sole discretion that a service less costly than the covered service the dentist performed could have been performed to treat a dental condition, the Plan will pay benefits based upon the less costly service if such service:

- Would produce a professionally acceptable result under generally accepted dental standards; and
- Would qualify as a covered service.

For example:

- When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, the PDP Option claims administrator may base the benefit determination upon the amalgam filling, which is the less costly service;
- When a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the PDP Option claims administrator may base the benefit determination upon the filling, which is the less costly service;
- When a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, PDP claims administrator may base the benefit determination upon the filling, which is the less costly service; and
- When a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the PDP Option claims administrator may base the benefit determination upon the partial denture, which is the less costly service.

If the Plan pays benefits based upon a less costly service in accordance with these provisions, the dentist may charge you or your dependent for the difference between the service that was performed and the less costly service. This is the case even if the service was performed by an in-network dentist.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes X-rays, opening of the pulp chamber, additional X-rays and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, the Plan will only pay benefits for the root canal therapy.

If a planned dental service is expected to cost more than $300, you have the option of requesting a pretreatment estimate of benefits. The dentist should submit a claim detailing the services to be performed and the amount to be charged. MetLife will provide you with an estimate of the dental insurance benefits available for the service.

## Maximum Benefits

There are limits on the benefits you can receive from the PDP Option. The maximum benefit for in-network preventive and restorative care is $2,000 per person per year, and the maximum benefit for out-of-network preventive and restorative care is $1,500 per person per year. The lifetime maximum benefit for orthodontia is $2,500 per person in-network and $2,000 per person out-of-network.
**Please Note:** These maximums reflect a *combined* amount for both in-network and out-of-network care, so out-of-network care will count against your in-network benefit maximum and vice versa.

If you were previously enrolled in the Traditional Indemnity Option, which is no longer offered, the benefits you received under that option will be added to benefits you receive under the PDP Option for purposes of determining benefits provided under the lifetime orthodontia maximum. Any benefits that have been applied to a maximum provision under a dental plan of your heritage organization will also be applied to the lifetime maximums for this Dental Plan.

## Orthodontic Covered Services

Orthodontia is covered for a child under age 19 if the orthodontic appliance is initially installed while dental coverage is in effect for the child. The orthodontic appliance is a device used for influencing tooth position and may be classified as fixed or removable, active or retaining, and intraoral or extraoral.

Orthodontic treatment generally consists of the initial placement of an appliance and periodic follow-up. It also includes other services required for the orthodontic treatment such as extractions of certain teeth.

The benefit payable for the initial placement will not exceed 20% of the amount charged by the dentist. If the initial placement was made prior to the child becoming covered under the JPMorgan Chase Retiree Dental Plan, the benefit payable will be reduced by the portion attributable to the initial placement.

The benefit payable for periodic follow-up visits will be payable on a monthly basis during the course of the orthodontic treatment if:

- Dental coverage is in effect for the child receiving the orthodontic treatment; and
- Proof is given to MetLife that the orthodontic treatment is continuing.

If the periodic follow-up visits commenced prior to the child becoming covered under the JPMorgan Chase Retiree Dental Plan:

- The number of months for which benefits are payable will be reduced by the number of months of treatment performed before the child became covered under the JPMorgan Chase Retiree Dental Plan; and
- The total amount of the benefit payable for the periodic visits will be reduced proportionately.

## An Important Note on the Lifetime Orthodontia Maximum Under the PDP Option

The most you can ever receive in orthodontia benefits under the Retiree Dental Plan for each eligible child under age 19 is $2,500. This limit includes benefits paid under the dental plans of your heritage organization and under the Traditional Indemnity Option, which was a former option under this Dental Plan.

For example, assume you received $2,000 in orthodontia benefits for one child under the prior Traditional Indemnity Option, the maximum that was payable under that option. Also assume that you now have coverage under the PDP Option. The most the PDP Option will pay toward that child's orthodontia expenses is the difference between what was paid under the Traditional Indemnity Option and the PDP's lifetime orthodontia maximums — $2,500 for in-network expenses and $2,000 for out-of-network expenses. In this case, if care is received in-network, the most the PDP Option will pay for that child's orthodontia expenses is $500 ($2,500 - $2,000 = $500). However, the PDP would not pay anything more for care received out-of-network for that child, since the lifetime orthodontia maximum had already been met under the Traditional Indemnity Option.

# The Dental Maintenance Organization (DMO)

The DMO Option offers you a broad range of dental services on a pre-paid basis. The DMO Option is available in many locations and is administered by Aetna, Inc. You agree to receive care solely from dentists associated with the DMO Option network, and in return, you will have no deductibles to meet and no claim forms to file. Aetna actively works to keep dental care costs low by requiring DMO dentists to meet strict quality standards, screening for cost-effective practice patterns, and negotiating fees charged for services.

## How the DMO Option Works

If you decide to enroll in the DMO Option for the first time or add new dependents for coverage, you must select a primary care dentist in order to receive care. **Please Note:** You can choose a different DMO dentist for yourself and each covered dependent. Changes to your primary care dentist must be made by the 15th of the month in order to be effective the first of the following month.

If you're interested in enrolling in the DMO, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You can view an online provider directory by visiting the Benefits Web Center on **My Health**. Once enrolled, you can view an online provider directory by accessing www.aetna.com. You can also call Aetna if you need help finding a provider. You should check with the dentist before scheduling an appointment or receiving services to confirm that he or she is participating in the network. See "Questions?" on page 2 for contact information.

**With the DMO Option…**

- Preventive care is covered at 100%.
- Adult and child orthodontia is covered.
- There are no annual deductibles.
- There are no claim forms to file for in-network care. In limited circumstances, out-of-network care is permitted; you are responsible for filing a claim form to receive reimbursement for DMO out-of-network services.
- There are no lifetime limits on benefits (except orthodontia and sealants).
- You only receive benefits if you use a DMO dentist; however, you can change your DMO dentist during the year. **Please Note:** Requests to change your DMO dentist must be received by the 15th of the month in order to take effect the first of the next month. You should not delay necessary dental care because you are changing your DMO dentist.
- You and your dependents can each have different DMO dentists.
- DMO Plan members can print a copy of your card off the Aetna website, pull a copy up on Aetna's mobile app, or call customer service and they will send a letter verifying coverage.

## How the DMO Option Pays Benefits

If you enroll in the DMO Option, you agree to receive care solely from dentists participating in the managed care network. Limited out-of-network coverage may be available based on state mandates or in the case of certain, out-of-area emergencies, as noted below. If you receive any out-of-network care, you must file a claim to receive benefits. Check your Aetna DMO coverage certificate or contact customer service. See "Questions?" on page 2 for contact information.

| Benefit Provision | Coverage |
|---|---|
| **Annual Deductible** | |
| • Preventive | • None |
| • Restorative | • None |
| • Orthodontia | • None |
| **Preventive** | • 100% coverage |
| • Oral exams | • Maximum two per calendar year |
| • Fluoride | • Maximum two per calendar year, and only covered for participants who are under age 19 |
| • Prophylaxis (cleaning) | • Maximum two per calendar year |
| • Full mouth X-ray | • Maximum one every 36 months |
| • Bitewing X-ray | • Maximum two per calendar year |
| • Sealants | • Maximum two treatments per tooth (permanent molars only) per lifetime and only covered for participants who are under age 19 |
| **Basic Restorative**<br>(Fillings, Extractions, Root Canal, Periodontal, Oral Surgery, Anesthesia) | 90% coverage |
| **Major Restorative**<br>(Dentures, Inlays, Onlays, Crowns, Bridges) | 60% coverage |
| **Orthodontia** | 50% coverage |
| **Maximum Benefits** | |
| • Combined annual for preventive and restorative | • No maximum |
| • Lifetime for orthodontia | • One course of treatment per individual per lifetime |
| **Out of Area Emergency Palliative Dental Care**<br>Out-of-Area Emergency Dental Care consists of necessary covered dental services given to covered persons by a non-participating (out-of-network) dental provider for the palliative (pain relieving; stabilizing) treatment of an emergency condition (if there is severe pain, swelling or bleeding). The emergency care is rendered outside of the 50-mile radius of the covered person's home address. Coverage for Out-of-Area Emergency Dental Care is subject to specific limitations described in the DMO Option. The JPMC DMO Option covers 100% of billed charges for out of area emergency care; benefits are limited to a $100 maximum and subject to R&C. | 100% coverage for reasonable and customary charges, up to a maximum benefit of $100 per incident.<br>If you receive any out-of-network care, you must file a claim to receive benefits. |

# The Dental Health Maintenance Organization (DHMO) Option

The DHMO Option offers you a broad range of dental services on a pre-paid basis. The DHMO Option is available in many locations and is administered by Cigna. You agree to receive care solely from dentists associated with the DHMO Option network, and in return, you will have no deductibles to meet and no claim forms to file. Cigna actively works to keep dental care costs low by requiring DHMO dentists to meet strict quality standards, to be screened for cost-effective practice patterns, and to charge negotiated fees for services.

## How the DHMO Option Works

If you decide to enroll in a DHMO option for the first time or add new dependents for coverage, you must select a primary care dentist in order to receive care. You only receive benefits if you use a Cigna DHMO dentist; however, you can change your dentist during the year. **Please Note:** Requests to change your DHMO dentist will take effect on the first of the month following the date the request was made. If you need assistance, prior to the first of the following month, you can call Cigna at (800) 790-3086.

If you're interested in enrolling in the DHMO, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You may view an online provider directory by visiting the Benefits Web Center on **My Health**. Once enrolled, you can view an online provider directory by accessing http://mycigna.com. You can also call Cigna if you need help finding a provider. See "Questions?" on page 2 for contact information.

**With the DHMO Option…**

- Preventive care is covered at 100%.
- Adult and child orthodontia is covered.
- There are no annual deductibles.
- There are no claim forms to file.
- There are no lifetime limits on benefits (except orthodontia).
- You only receive benefits if you use a Cigna DHMO dentist; however, you can change your dentist during the year. **Please Note:** Requests to change your DHMO dentist will take effect on the first of the month following the date the request was made.
- You and your dependents can each have different DHMO dentists.
- You and your dependents will receive a DHMO ID card following your enrollment.

## How the DHMO Option Pays Benefits

Like the DMO Option, the Cigna DHMO Option is a managed care dental option that offers access to a national network of dentists. If you enroll in this option, you agree to receive care solely from dentists participating in the network. Limited out-of-network coverage may be available based on state mandates or in the case of certain, out-of-area emergencies, as noted below. If you receive any out-of-network care, you must file a claim to receive benefits. Check your Cigna DHMO coverage certificate or contact customer service for details. See "Questions?" on page 2 for contact information.

| Benefit Provision | Coverage |
|---|---|
| **Annual Deductible** | |
| • Preventive | • None |
| • Restorative | • None |
| • Orthodontia | • None |
| **Preventive** | 100% coverage |

| Benefit Provision | Coverage |
|---|---|
| • Oral exams | Oral evaluations are limited to a combined total of four of the following evaluations during a 12 consecutive month period:<br>• Periodic oral evaluations;<br>• Comprehensive oral evaluations;<br>• Comprehensive periodontal evaluations; and<br>• Oral evaluations for patients under three years of age |
| • Fluoride | • Maximum two per calendar year<br>• Topical fluoride applications in excess of the two per calendar year are covered for a $15 copayment. |
| • Prophylaxis (cleaning) | • Maximum two per calendar year<br>• Cleanings in excess of the two per calendar year are covered for a $40 copayment for an adult and a $30 copayment for children. |
| • Full mouth X-ray | • Maximum one every three years |
| • Bitewing X-ray | • 100% coverage |
| • Sealants | • 100% coverage |
| **Basic Restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)** | 90% coverage (with the exception of certain oral surgery services covered at 50% or 60%) |
| **Major Restorative (dentures, inlays, onlays, crowns, bridges)** | 60% coverage (a few procedures, such as recementations, adjustments, tissue conditioning, and repairs are covered at 50%) |
| **Surgical Placement of Implant Body** | 90% coverage, one per year |
| **Orthodontia** | 50% coverage |
| **Maximum Benefits** | |
| • Combined annual for preventive and restorative | • No maximum |
| • Lifetime for orthodontia | • 24 months of interceptive and/or comprehensive treatment (cases beyond 24 months or atypical cases require additional payment by the patient) |

| Benefit Provision | Coverage |
|---|---|
| **Emergency Care Away From Home**<br>If you have an emergency while you are out of your service area or unable to contact your in-network general dentist, you may receive emergency covered services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your in-network general dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your patient charge schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of $100 per incident (where allowable by state law). To receive reimbursement, send appropriate mycigna.com reports and X-rays to Cigna Dental. | 100% coverage for reasonable and customary charges, up to a maximum benefit of $100 per incident.<br>If you receive any out-of-network care, you must file a claim to receive benefits. |

# What Is Covered

Each of the Retiree Dental Plan options covers a wide variety of services, as long as the services are necessary and their costs either do not exceed negotiated fees for in-network services, or are not reasonable and customary (R&C) charges for out-of-network services if allowed for under an option. (Please see "Defined Terms" beginning on page 31 for the definitions of "necessary services" and "reasonable and customary charges.") Covered services and frequency limits under each JPMorgan Chase Retiree Dental Plan option may differ. The following lists include examples of covered services, but the lists are not exhaustive and coverage remains subject to any Plan requirements or limitations. For specific information on each option's covered services and frequency limits, please contact the option's claims administrator directly, using the telephone numbers provided under "Where to Submit Claims" on page 28. The list of covered services may change at any time.

## Preventive Care Services

Covered preventive care services include the following services (please see "How the PDP Option Pays Benefits" on page 11, "How the DMO Option Pays Benefits" on page 15, and "How the DHMO Option Pays Benefits" on page 17 for age and frequency limitations):

- Oral exams;
- Bitewing X-rays;
- Fluoride treatments;
- Full mouth X-rays;
- Prophylaxis (cleaning)
- Sealants; and
- Emergency palliative treatment.

## Basic Restorative Care Services

Covered basic restorative care services include:

- Consultations (two per calendar year under the PDP and DMO; no frequency limit under the DHMO);
- Extractions;
- Fillings;
- Injections of antibiotic drugs (**Please Note:** The DMO covers injections of antibiotic drugs as a Major Restorative Care Service);
- Most periodontal or other gum disease treatment;
- Periodontal maintenance (four visits per calendar year under PDP combined with regular cleanings; under DMO and DHMO, two visits per calendar year covered only after active periodontal therapy);
- Oral surgery (except as covered by the *Retiree Medical Plan* Summary Plan Description);
- Administration of general anesthesia in conjunction with oral surgery when necessary; medically necessary (may be subject to certain limits as defined by the carrier);
- Periodontal scaling/root planing (one per quadrant per 24 months; under PDP and DMO; limited to 4 quadrants per consecutive 12 months under DHMO);
- Periodontal surgery (one per quadrant per 36 months under PDP; one per site, or per tooth, under DHMO);
  - Aetna DMO: no limitations on these services
  - Cigna DHMO: one per quadrant per 36 months;

- Repair or recementing of crowns, inlays, or onlays; dentures; or bridgework;
- Relines/rebases
  - MetLife PDP and Aetna DMO: one per denture per 36 months, after six months from installation
  - Cigna DHMO: one per denture per 36 months, within first six months after insertion; replacement limit of one every five years; and
- Root canal treatments. (**Please Note:** The Dental DMO and DHMO Options cover root canal as a Basic Care Service. The PDP Option covers root canal as a Major Restorative Care Service.)

## Major Restorative Care Services

Covered major restorative care services include:

- Crowns/inlays/onlays (one per tooth per five calendar years);
- Root canal treatments (**Please Note:** The PDP Option covers root canal as a Major Restorative Care Service. The Dental DMO and DHMO Options cover root canal as a Basic Care Service.);
- Injections of antibiotic drugs (**Please Note:** The DMO Option covers injections of antibiotic drugs as a Major Restorative Care Service. The PDP and DHMO Options cover injections of antibiotic drugs as a Basic Care Service.);
- Only appliances related to temporomandibular joint syndrome (TMJ) and only to a lifetime maximum of $500 and specific to the PDP and DMO options.
- Initial placement and replacement of dentures and bridges — if the original appliance is at least five years old and cannot be repaired;
- Services necessary to replace teeth lost while coverage is in effect;
- Treatment for harmful habits as described and determined by the claims administrator;
- Treatment for accidental injury (eligible dental expenses are covered under the Retiree Dental Plan; eligible medical expenses are covered under the Retiree Medical Plan); and
- Implant(s). Benefits may also be available for the final restoration or prosthesis (crown or partial denture) over the implant. A pre-treatment estimate should be submitted for a dental consultant to evaluate the claim to determine if any benefits are payable.

## Orthodontia

Please review the information on orthodontia in the PDP, DMO and DHMO sections:

- For the PDP, orthodontia is for covered children under age 19. Please see “How the PDP Option Pays Benefits” on page 11.
- For the DMO, orthodontia is covered at a percentage for both children and adults. Please see “How the DMO Option Pays Benefits” on page 15.
- For the DHMO, orthodontia is covered at a percentage for both children and adults. Please see “How the DHMO Option Pays Benefits” on page 17.

# What Is Not Covered

While the JPMorgan Chase Retiree Dental Plan options cover a wide range of dental services, some expenses are not covered. These include but are not limited to those listed below.

**For specific information on the PDP's, DMO's, and DHMO's coverage exclusions and limits, please contact the appropriate claims administrator (MetLife, Aetna, or Cigna) directly.** (See the contact numbers provided under "Where to Submit Claims" on page 28). The list of covered services and the list of excluded services may change at any time.

- Any of the following services:
  - A gold restoration or crown, unless:
    - It is treatment for decay or traumatic injury, and teeth can't be restored with a filling material; or
    - The tooth is an abutment to a covered partial denture or fixed bridge.
  - An appliance — or modification of one — if an impression for it was made before the person became covered.
- Any of the following services incurred more than 31 days after the date the person's coverage ends:
  - A crown, bridge, or gold restoration for which the tooth was prepared while the person was covered;
  - An appliance — or alteration of one — for which an impression was made while the person was covered; or
  - Root canal therapy for which the pulp chamber was opened while the person was covered.
- Charges in connection with:
  - A service to the extent that it is more than the usual charge made by the provider for the service when there is no insurance;
  - Appliances or restorations needed to alter vertical dimensions or restore occlusion, or for the purposes of splinting or correcting attrition, abrasion, or erosion; or
  - Replacement of lost, missing, or stolen appliances or appliances that have been damaged due to abuse, misuse, or neglect.
- Treatment for problems of the jaw joint, including:
  - Craniomandibular disorder;
  - Temporomandibular joint syndrome (TMJ), other than what is noted in "What Is Covered" on page 20, or
  - Other conditions of the joint linking the jawbone and skull, and of the complex of muscles, nerves, and other tissues related to that joint.
- Expenses submitted later than December 31 of the year following the year in which services were provided.
- Installation of prosthetic devices (including bridges and crowns) while not covered or which were installed more than 31 days after coverage ends.

- Loss — or portion of a loss — for which mandatory automobile no-fault benefits are recovered or recoverable.
- Loss — or portion of a loss — resulting from war or act of war, declared or undeclared.
- Partial or full removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth (including congenitally missing teeth) missing before the person became covered under this Plan. The exclusion does not apply if the denture, bridge, or bridgework also includes replacement of a natural tooth that:
  - Is removed while the person is covered; and
  - Was not an abutment to a partial denture, removable bridge, or fixed bridge installed during the prior five years.
- Procedures related to occupational illness or injury.
- Replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for a replacement or modification of a crown or gold restoration or inlay/onlay within five years after that denture, bridgework, crown, inlay/onlay, or gold restoration was installed.
- Expenses or charges with respect to services rendered by hospitals, clinics, laboratories (except dental X-rays are covered), or other institutions.
- Services and supplies included as covered medical expenses under:
  - Any other employer-sponsored plan that covers you, including Medicare;
  - Any other governmental health program, except Medicaid; or
  - Your JPMorgan Chase Retiree Medical Plan option.
- Services and supplies rendered in a veteran's facility or government hospital, or services furnished in whole or in part under the laws of the United States or any of its state or political subdivisions.
- Services furnished for cosmetic purposes. Facings on crowns or pontics — which are behind the second bicuspid — will always be considered cosmetic. This limitation does not apply if the service is needed as a result of accidental injuries sustained while a person is covered.
- Services that are not necessary services as determined by the claims administrator.
- Services to the extent that a benefit for those services is provided under any other program paid in full or in part, directly or indirectly, by JPMorgan Chase. This includes insured and uninsured programs. If a program provides benefits in the form of services, the cash value of each service rendered is considered the benefit provided for that charge.
- Services to the extent that the charges are above the prevailing charge in the area for dental care of a comparable nature. A charge is above the prevailing charge to the extent that it's above the range of charges generally made in the same or similar geographic area for dental care of a comparable nature. The geographic area and that range are determined by the claims administrator.
- Treatment by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, a trustee, or a similar person or group.
- Expenses in connection with services, procedures, drugs, or other supplies that are determined by the claims administrator to be experimental, or still under clinical investigation by health professionals.
- Charges for oral hygiene programs (in home care), completion of claim forms by the provider on your behalf, and broken appointments.
- Services provided by a relative or domestic partner, or for which a charge would not normally be made.
- Treatment by anyone except a licensed dentist (except for cleaning or scaling of teeth and topical application of fluoride performed by a licensed dental hygienist, if rendered under the supervision and guidance of a licensed dentist).

- Mail order orthodontics.

In addition, the DMO Option does not cover services provided to a person age five or older if that person becomes covered other than:

- As described for any period of enrollment agreed to by JPMorgan Chase and Aetna, Inc. This limitation does not apply to charges incurred:
  - After the end of the 12-month period starting on the date the person became covered;
  - As a result of accidental injuries sustained while the person was covered; or
  - Preventive service, unless listed above.
- During the first 31 days the person is eligible for this coverage.

## Other Limitations

Replacements of — or additions to — existing dentures or bridgework will be covered under the JPMorgan Chase Retiree Dental Plan only if at least one of the following conditions exists:

- The present denture or bridgework cannot be made serviceable, and it is at least five years old;
- It's necessary to replace teeth extracted after the present denture or bridgework was installed; or
- Replacement by a permanent denture is needed because the present denture is temporary, and replacement occurs within 12 months after the date the temporary denture was installed.

### Missing Tooth Exclusion for the PDP and the DMO

The missing tooth exclusion means that a charge is an ineligible charge if it is for a partial or full removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth missing before the person became covered under the Retiree Dental Plan. This exclusion does not apply if the denture, bridge, or bridgework also includes replacement of a natural tooth that:

- Is removed while the person is covered; and
- Was not an abutment to a partial denture, removable bridge, or fixed bridge installed during the previous five years.

# *If You Are Covered by More Than One Retiree Dental Plan*

The JPMorgan Chase Retiree Dental Plan has a provision to ensure that payments from all of your group dental plans don't exceed the amount the JPMorgan Chase Retiree Dental Plan would pay if it were your only coverage. The following rules do not apply to any private, personal insurance you may have. They are in addition to the maximum annual benefits for covered preventive and restorative services and the maximum lifetime benefits for covered orthodontia services, included under each option.

These rules do not apply to the Dental Maintenance Organization (DMO) and Dental Health Maintenance Organization (DHMO) plans, which have their own coordination of benefits provisions. If you are covered by a DMO or DHMO, please check with that organization to learn how it handles coordination of benefits.

## Non-Duplication of Benefits

The JPMorgan Chase Retiree Dental 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. The non-duplication provisions of the Retiree Dental Plan will ensure that, in total, you receive benefits up to what you would have received with the Retiree Dental 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 claims administrator for help. See "Questions?" on page 2 for contact information.

**An Example: How the Retiree Dental Plan Coordinates Benefits with Other Dental Plans**

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

## Determining Primary Coverage

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

- As a JPMorgan Chase retiree, the Retiree Dental Plan will be primary for you and consider claims for your dental expenses first.
- If your covered dependent has a claim, the plan covering your dependent as an employee or retiree will be considered primary to this Plan.
- If your claim is for a covered dependent child, who has coverage under both parents' plans, the plan covering the parent who has the earlier birthday in a calendar year (based on month and birth date 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 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 29 for more information.)
- If your other dental 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) to consider 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 Dental 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 Dental 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.

# Subrogation of Benefits

The purpose of the Retiree Dental Plan is to provide benefits for eligible dental expenses that are not the responsibility of any third party. The Retiree Dental 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.

# Right of Reimbursement

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

# Claiming Benefits

The following explains when and how to file claims for dental expenses under the PDP Option. If you're enrolled in the DMO or DHMO Option, you usually don't need to file a claim. For more information on your rights with respect to claims, please see the *Retiree Plan Administration* document .

## How to File Claims

Rules regarding claims depend on which Retiree Dental Plan option you're enrolled in and where you receive your care, as follows:

| Option | Claims Process |
|---|---|
| **PDP Option** | • In-Network Benefits: Generally, you do not have to file a claim form.<br>• Out-of-Network Benefits: Generally, you must file a claim form. (Some dentists may submit claims electronically on your behalf; you should check with your dentist.) Once the claims administrator has reviewed and approved your completed claim form, you'll be reimbursed for the appropriate portion of the cost. Claim forms for out-of-network benefits are available on **My Health**. |
| **Dental Maintenance Organization (DMO) Option and Dental Health Maintenance Organization (DHMO) Option** | • You do not have to file a claim form for in-network care.<br>• Claim forms for out-of-network emergency services, as defined by the Plan, are available on **My Health**. |

To have your claim considered for benefits, you need to file your claim by December 31 of the year following the year in which services were provided. If you fail to meet this deadline, your claim will be denied. Be sure to attach itemized bills or receipts to your claim form, and keep copies for your records. Separate claim forms must be submitted for each family member for whom a claim is made. After you submit a claim, you will receive a written explanation of how the benefit was paid.

If your dentist submits a paper claim, make sure he or she uses the proper claim form, and that your identification number or Social Security number and signature are included with the information provided. Payment of benefits can be made to you or your dentist. If payment is to be made to your dentist, you should specify this on your claim form by signing the form and dating the appropriate box. If you don't indicate who the payment should be made to, it will be made to you.

## Where to Submit Claims

Where you send your completed claims depends on which Retiree Dental Plan option you're enrolled in and which organization administers your claims.

The claims administrators' contact information is listed in the following table:

| Claims Administrator | Address and Telephone Number |
|---|---|
| MetLife Preferred Dentist Program (PDP) Option | MetLife Dental<br>P.O. Box 981282<br>El Paso, TX 79998-1282<br>(888) 673-9582<br>8 a.m. to 11 p.m. Eastern Time, Monday through Friday |
| Aetna, Inc. Dental Maintenance Organization (DMO) Option | Aetna, Inc.<br>P.O. Box 14094<br>Lexington, KY 40512<br>(800) 741-4781<br>8 a.m. to 6 p.m. Eastern Time, Monday through Friday |
| Cigna Dental Health Maintenance Organization (DHMO) Option | Cigna Dental Health<br>P.O. Box 188045<br>Chattanooga, TN 37422-8045<br>(800) 790-3086<br>24 hours/day; seven days/week |

## Appealing Claims

If a claim for reimbursement under the Retiree Dental Plan 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.

### Help Pursuing Claims

You may authorize someone else to pursue claim information on your behalf. If you do so, you must notify the claims administrator in writing of your choice of an authorized representative.

For the Retiree Dental Plan, your claims administrator will provide you with a HIPAA (Health Insurance Portability and Accountability Act of 1996) consent form that you must use to specify the extent to which your personal representative is authorized to act on your behalf. This form must be on file with your claims administrator prior to any action by your personal representative.

If you would like to designate an authorized representative for claims related to eligibility to participate in a plan, please contact HR Answers.

# *Additional Plan Information*

Your primary contact for all matters relating to the Retiree Dental Plan is your claims administrator (see "Where to Submit Claims" on page 28). 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 Dental Plan 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 Dental 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 Dental Plan and any underlying policies and/or contracts, including the eligibility to participate in the Retiree Dental 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. The Health Insurance Portability and Accountability Act (HIPAA) legally requires employers — like JPMorgan Chase — to specifically communicate how certain "protected health information" under retiree health care plans may be used and disclosed, as well as how plan participants can get access to their protected health information.

JPMorgan Chase may only use and disclose protected health information received from the Retiree Dental Plan claims administrator in ways that are permitted by, required by, and consistent with HIPAA privacy regulations.

For details about HIPAA privacy regulations and your rights with regard to this information, please see "HIPAA Privacy Rights and Protected Health Information" in the *Retiree Medical Plan* Summary Plan Description.

## Qualified Medical Child Support Order

If the Retiree Dental Plan receives a judgment, decree, or order known as a Qualified Medical Child Support Order (QMCSO) requiring the Plan to provide dental coverage to your child or foster child who is your dependent, the Retiree Dental Plan will automatically change your dental benefits elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin on the date the QMCSO 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 benefit elections under the Retiree Dental Plan, to the extent permitted by the Internal Revenue Code and the Retiree Dental Plan.

## If Your Situation Changes

The following chart summarizes how your JPMorgan Chase Retiree Dental Plan coverage may be affected in certain situations.

| Event | How Coverage Is Affected |
|---|---|
| **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.)<br>If you divorce or become legally separated, certain court orders could require you to provide dental benefits to covered dependent children. JPMorgan Chase is legally required to recognize qualified medical child support orders within the limits of the Retiree Dental Plan. If you're a party in a divorce settlement that involves the Retiree Dental 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 Order" on 29 for more information. |

| Event | How Coverage Is Affected |
|---|---|
| **You Are Rehired at JPMorgan Chase** | If you're re-employed at JPMorgan Chase and are eligible for active employee benefits, your retiree dental benefits will end. Please see the *Retiree Medical Plan* Summary Plan Description for more information. If you retire again, you must elect retiree coverage at that time. You cannot defer retiree coverage. |
| **You Die** | If you die after retiring from JPMorgan Chase, any dependents enrolled under your Retiree Dental Plan coverage at the time of your death may choose to continue coverage. Please see the *Retiree Medical Plan* Summary Plan Description for more information regarding length of coverage.<br>If your dependents choose not to continue coverage, they will be covered until the end of the month in which you die. |
| **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 Dental 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 Dental Plan;
- The Retiree Dental Plan is discontinued; or
- You die.

Coverage for your dependents ends when they no longer meet the eligibility requirements described in "Your Eligible Dependents" in the *Retiree Medical Plan* Summary Plan Description. 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).

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" in the *Retiree Medical Plan* Summary Plan Description.

Please see "If Your Situation Changes" on page 29 for details on how coverage is affected in certain situations.

## Continuing Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), your covered dependents have the right to continue retiree dental coverage at their own expense for a certain period of time if your JPMorgan Chase Retiree Dental coverage ends due to certain circumstances. (For domestic partners, JPMorgan Chase may provide COBRA-like coverage if the domestic partner was covered under the JPMorgan Chase Retiree Dental 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. Members must make timely monthly payments for their COBRA coverage. Please see the *Plan Administration* Summary Plan Description for more information on COBRA.

# Right to Amend

JPMorgan Chase reserves the right to amend, modify, reduce or curtail benefits under, or terminate the Retiree Dental Plan at any time for any reason by act of the Benefits Executive, other authorized officers, or the Board of Directors. In addition, the Retiree Dental Plan does not represent a vested benefit.

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

# Defined Terms

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

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| **Claims Administrator** | The companies that provide certain claims administration services for the Retiree Dental Plan. |
| **Coinsurance** | The way you share costs for certain coverage options after you pay any applicable deductible. Certain Retiree Dental Plan options pay either a percentage of reasonable and customary (R&C) charges or a percentage of the in-network dentist's negotiated fees for covered services, and you pay the remainder. The actual percentage depends on the option you've chosen and the type of covered service. |
| **Consolidated Omnibus Budget Reconciliation Act of 1985(COBRA)** | A federal law that allows you and/or your covered dependents to continue Retiree Dental 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. |
| **Coordination of Benefits** | The rules that determine how benefits are paid when a patient is covered by more than one group plan. Please see "If You Are Covered by More Than One Retiree Dental Plan" on page 24, for more information. |
| **Covered Expenses** | The in-network negotiated fees or reasonable and customary (R&C) charges for out-of-network services if allowed for under an option for necessary covered services or supplies that qualify for full or partial reimbursement under the Retiree Dental Plan. |
| **Covered Services** | Dental procedures that are generally reimbursable by the JPMorgan Chase Retiree Dental Plan when they are "necessary." (See the definition of "necessary services" in this section.) While the Plan provides coverage for numerous services and supplies, there are limitations on what's covered. So, while a service or supply may be necessary, it may not be covered under the JPMorgan Chase Retiree Dental Plan. Please see "What Is Covered" on page 20 for more details. |
| **Deductible** | The amount you pay in a calendar year for covered expenses before the Preferred Dentist Program (PDP) Option begins to pay benefits. Amounts in excess of reasonable and customary (R&C) charges do not count toward the deductible. |
| **Eligible Dependents** | Under the Retiree Dental Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see "Your Eligible Dependents" in the *Retiree Medical Plan* Summary Plan Description for more information. |
| **Explanation of Benefits (EOB)** | A statement that the claims administrator prepares, which documents your claim and provides a description of benefits paid and not paid under the Retiree Dental Plan. |

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| **Fully-Insured** | Retiree Dental Plan options for which the benefit payments are the responsibility of the insurance carrier (DMO and DHMO). |
| **In-Network/ Out-of-Network** | Terms referring to whether a covered service is performed by a dentist who is part of the network associated with the Retiree Dental Plan ("in-network") or by a dentist who is not part of the network ("out-of-network"). 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. |
| **Maximum Annual Benefit** | The most the Preferred Dentist Program (PDP) Option will pay for covered preventive and restorative services for each participant in a year. |
| **Maximum Lifetime Orthodontia Benefit** | The most the Preferred Dentist Program (PDP) Option, the Dental Maintenance Organization (DMO), and Dental Health Maintenance Organization (DHMO) Options will pay for covered orthodontia services for each participant's lifetime.<br>Any benefits that have been applied to a maximum provision under a dental plan of your heritage organization or under the former Traditional Indemnity Option will also be applied to the lifetime maximum for this Retiree Dental Plan. |
| **Necessary Services** | Services or supplies that are accepted and used by the dental community as appropriate for the condition being treated or diagnosed. The services or supplies also must be prescribed by a dentist for the diagnosis or treatment of the condition to be considered necessary. Some prescribed services may not be considered necessary and may not be covered under the JPMorgan Chase Retiree Dental Plan. The claims administrator will determine whether a service or supply is necessary.<br>Finally, to be considered necessary, a service or supply cannot be cosmetic, educational, or experimental in nature and must be in accordance with generally accepted dental standards. |
| **Non-Duplication of Benefits** | The Retiree Dental 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 Dental 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 Dental 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. |
| **Pre-Determination** | For the PDP Option, an itemization of the proposed course of treatment (including recent pre-treatment X-rays), which you should submit before work is begun, if you anticipate that charges will be more than approximately $300. A dental consultant will review the proposed treatment before work begins and the claims administrator will inform you and your dentist of the amount of covered charges. That way, you'll understand the benefits that will be paid before treatment begins. Benefits will be paid according to the Plan provisions in effect when the services are actually rendered. The amount may change if the treatment changes from that which was predetermined or if frequency limits apply. Except in the case of an emergency, you may not want to begin the course of treatment until you know what amount your JPMorgan Chase Retiree Dental Plan option will pay. |
| **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 or death) within 31 days of the qualifying event for benefits to be effective the date of the event.<br>**Please Note:** Any changes you make during the year must be consistent with your Qualified Status Change. Please see "Qualified Status Change" on page 9 for more information. |

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| **Reasonable and Customary (R&C) Charges** | The actual charges that are considered for payment when you receive medically necessary care for covered services from an out-of-network provider under the Retiree Dental Plan. 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. 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.<br>If your provider charges more than the R&C charges considered under the plans, you'll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered eligible expenses. Therefore, they don't count toward your deductible, benefit limits, or maximums. |
| **Self-Insured** | JPMorgan Chase is responsible for the payment of dental claims under the PDP Option. |