The Vision Plan

Effective 1/1/22

The Vision Plan helps you and your family pay for covered vision expenses, such as eye exams, prescription glasses (lenses and frames), and contact lenses.

This section of the Guide will provide you with a better understanding of how your Vision Plan coverage works, including how and when benefits are paid.

Be sure to see important additional information about the Plan, in the sections titled About This Guide, What Happens If… and Plan Administration.

Questions?

For questions or concerns regarding this Vision Plan, please contact the Plan's claims administrator:

EyeMed Vision Care
(833) 279-4363

Representatives are available Monday through Friday, from 7:30 a.m. to 11 p.m. Eastern Time, Saturday from 8 a.m. to 11 p.m. and Sunday, from 11 a.m. to 8 p.m. Eastern Time.

About This Summary Plan Description

This section is the summary plan description (SPD) and the plan document for the JPMorgan Chase Vision Plan. Please retain this section for your records. Other sections may also constitute the complete SPD/plan document, including the *Plan Administration* section.

This summary does not include all of the details contained in the applicable insurance contracts, if any. For plans that are funded through insurance, if there is a discrepancy between the insurance contract and the SPD/plan document, the insurance contract will control.

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

Table of Contents Page

Vision Coverage Highlights

My Health	**My Health** is your central online resource for our health care plans. From **My Health** you can easily connect to the EyeMed website to find in-network providers, check claims status, and much more.
Your Choices	The JPMorgan Chase Vision Plan lets you choose between an EyeMed network provider and a non-EyeMed network provider each time you need vision services. You will generally pay less for your eye care when you use an EyeMed network provider for two reasons: ▪ EyeMed network provider eye care is generally covered at a higher benefit level than care received through a non-EyeMed network provider; and ▪ EyeMed network providers have agreed to charge negotiated fees for their services and/or eyewear when treating JPMorgan Chase Vision Plan participants.
Your Coverage Level	Your coverage level is based on the dependents you enroll, as shown below: ▪ Yourself only; ▪ Yourself and your spouse/domestic partner, or yourself and your child(ren); or ▪ Your family (yourself, your spouse/domestic partner, and your children).
Disabled Dependents Over Age 26	If you are not enrolled in one of the Medical plans but want to continue coverage for your dependent child over age 26 for the Dental and/or Vision plan, please contact your Medical plan carrier (Aetna or Cigna) to see if they qualify for continued coverage under these plans.
Covered Services	Covered services include all of the following: ▪ Eye exams; ▪ Lenses; ▪ Frames; or ▪ Contact lenses.
Vision Exams Not Covered by JPMC Medical Coverage	Because routine eye exams are not covered under the JPMorgan Chase Medical Plan options, you will need to enroll in the Vision Plan to be covered for routine vision benefits.

Cost of Coverage

You pay the full cost of coverage under the Vision Plan — JPMorgan Chase does not pay any share of the cost. You pay for coverage in equal installments through payroll contributions with before-tax dollars.

The amount you pay via payroll contributions depends on the "coverage level" you choose (described under “Coverage Levels” in the *Health Care Participation* section).

Your contributions toward the cost of coverage start when your coverage begins. Your contributions are automatically deducted from your pay.

If you have coverage but are away from work because of an unpaid leave of absence, you will be directly billed by JPMorgan Chase for any required contributions on an after-tax basis.

Your Cost Is the Full Cost

Unlike medical and dental coverage, with vision coverage, JPMorgan Chase does not pay for part of the cost of your vision coverage. If you choose to enroll for vision coverage, the cost you pay is the full cost of that coverage.

How Vision Coverage Works

The Vision Plan covers a variety of services. The benefits the Plan provides depend on three things:

- What services or items are covered;
- When you last received benefits for the same service or item; and
- Whether you receive your eye care from an EyeMed network provider or a non-network provider.

What Is Covered

Your out-of-pocket cost depends on how much the Plan will cover for a specific item or service.

- The costs are different, depending on whether you receive your eye care from an EyeMed network provider or a non-EyeMed network provider.
- For non-network care, there may be a dollar reimbursement amount the Plan will pay for that item or service, or no coverage may be allowed. You are responsible for paying:
  - Any amount over the stated reimbursement amount or
  - The full amount if there is no coverage.

When You Last Received Care

For most care, the Plan provides benefits once per item per person per calendar year. For example, the Plan will cover one pair of eyeglasses (lenses and frames) or prescription contacts for you each calendar year, and will provide the same for each of your covered dependents. Some services are subject to different limits, and for some items, discounts are available for same-year items when the full Plan benefit is not available.

Selecting an EyeMed Provider

If you decide to enroll in the Vision Plan and want to use an EyeMed network provider, you can choose a different provider for yourself and for each covered dependent. EyeMed network providers include private practitioners, regional retail locations, online options, as well as the nation's premier retailers, LensCrafters®, Target Optical, and most Pearle Vision locations.

You can easily check which providers participate in the EyeMed network by accessing the Benefits Web Center via **My Health** or the EyeMed website (if you are enrolled in the Vision Plan).

You can also call EyeMed if you need help finding an EyeMed network provider.

What the Plan Provides

Exams

For the following exams, each covered individual is limited to one service per calendar year.

Care and Service	In-Network Cost	Non-Network Reimbursement
WellVision Exam® A complete initial vision analysis, which includes a comprehensive visual exam, including the prescription for corrective eyewear and dilation, if necessary	$0 copayment	Reimbursed up to $45

Care and Service	In-Network Cost	Non-Network Reimbursement
Retinal Imaging Screening An enhancement to the WellVision Exam®.	Up to $39 copayment	No coverage
Standard Contact Lens Fit & Follow-Up Exam* Fitting and evaluation	Copayment of up to $40	No coverage
Premium Contact Lens Fit & Follow-Up*	Copayment of up to $55	No coverage

* One Contact Fit/Follow-Up benefit per calendar year (either standard or premium).

Standard Plastic Lenses

For the following lenses, each covered individual is limited to one set of lenses per calendar year.

Care and Service	In-Network Cost	Non-Network Reimbursement
Standard Plastic Single Vision Lenses Lenses having one part that corrects for either near vision or distant vision	$10 copayment	Reimbursed up to $35
Standard Plastic Lined Bifocal Lenses Lined lenses having one part that corrects for near vision, one for distant vision	$10 copayment	Reimbursed up to $50
Standard Plastic Lined Trifocal Lenses Lined lenses having one part that corrects for near vision, one for intermediate vision, and one for distant vision	$10 copayment	Reimbursed up to $65
Standard Plastic Lenticular Lenses Lenses used to assist post-cataract surgery	$10 copayment	Reimbursed up to $100
Lens Options		
• Standard Progressive Lenses	$65	Reimbursed up to $50
• Premium Progressive Lenses	$95-$185	Reimbursed up to $50
• Standard Polycarbonate Lenses	$0 copayment	Adults: Reimbursed up to $21 Kids under 19: Reimbursed up to $11
• Tints (Solid or Gradient)	$0 copayment	Reimbursed up to $11
• Standard Plastic Scratch Coating	$0 copayment	Reimbursed up to $11
• UV Coating	$15 copayment	No coverage
• Standard Anti-Reflective Coating	$45 copayment	Reimbursed up to $5
• Premium Anti-Reflective Coating	$57-$85 copayment	Reimbursed up to $5

Frames

For frames, each covered individual is limited to one set per calendar year.

In-Network Cost	Non-Network Cost
$0 copayment; $150 allowance, 20% discount over $150	Reimbursed up to $75

Contact Lenses

Please Note: Contacts are covered in place of coverage for eyeglass lenses. If you choose contacts, you won't be eligible to receive eyeglass lenses as a covered benefit during the same **calendar year**. Contact lens benefits are limited to one set per calendar year (whether the contacts are conventional, disposable, or medically necessary).

For information on lens fittings and follow-up, please see the Contact Lens Fit & Follow-Up benefits, under "Exams" on page 211.

Care and Service	In-Network Cost	Non-Network Reimbursement
Conventional Contact Lenses	$0 copayment; $150 allowance, member pays 15% of any charge over $150	Reimbursed up to $120
Disposable Contact Lenses	$0 copayment; $150 allowance, member pays 100% of the cost above $150	Reimbursed up to $120
Medically Necessary Contacts (see details, below)	$0 copayment; paid in full	Reimbursed up to $210

Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding — 10D or +10D in meridian powers
- **Keratoconus** mild/moderate — when keratoconus is present and the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- **Keratoconus advanced/ectasia —** when keratoconus is present and one or more specified conditions are met
- **Vision Improvement**: when the member's best correctable distance vision using a standard visual acuity chart can be improved by at least two lines by the use of contact lenses compared to spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers determine that contact lenses are necessary for other eye conditions or visual improvement.

Laser Vision Correction

In-Network Cost	Non-Network Reimbursement
15% off retail price or 5% off promotional prices	Not covered

Low Vision Benefits

When you visit an EyeMed network provider, the Plan may provide certain benefits if you have severe vision problems that are not correctable with regular lenses. To receive benefits, your provider must complete and submit a Low Vision Authorization Form to EyeMed.

The following chart shows how the Vision Plan pays benefits for low vision (in-network only):

Care and Service	Benefits Paid
Low vision aids approved by the claims administrator	Preferred or Non-Preferred Provider: 25% copayment, up to a $1,000 maximum allowance every two years
Supplementary testing approved by the claims administrator (a complete low vision analysis and diagnosis which provides a comprehensive vision exam, including prescription corrective eyewear or other vision aids)	• Preferred Provider: Covered in Full • Non-Preferred Provider: Reimbursed up to $125

Diabetic Eye Care Benefit

Members who have Type 1 or Type 2 diabetes are eligible to receive supplemental coverage for additional services from their vision provider. With this benefit, you can obtain a vision evaluation every six months to monitor for signs of diabetic complications. Subject to provider determination and benefit frequency limitations, you may also receive the following diagnostic testing: Retinal imaging, extended ophthalmoscopy, gonioscopy and laser scanning. If you have questions, please contact EyeMed's Customer Care Center.

Availability of diagnostic equipment and services varies by location. Members are encouraged to call their provider to confirm availability of services.

The following chart shows how the Vision Plan pays benefits for **both** Type 1 and Type 2 diabetes.

Care and Service	In-Network Cost	Non-Network Reimbursement
Office Service Visit (Medical Follow-up Exam)	$20 copayment	$77
Retinal Imaging*	$0 copayment	$50
Extended Opthalmoscopy**	$0 copayment	$15
Gonioscopy	$0 copayment	$15
Scanning Laser	$0 copayment	$33

* Not covered if extended opthalmoscopy is provided within six months.

** Not covered if retinal imaging is provided within six months.

Additional Discounts

Under the Plan, you may receive benefits for eyeglasses (frame and lenses) or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been exhausted. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers
- View additional discounts under Special Offers through EyeMed's website

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

What Is Not *Covered*

While the JPMorgan Chase Vision Plan covers a variety of vision expenses, 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 Vision Plan.

You are also responsible for payment of any applicable sales tax.

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

General Limitations and Exclusions

- Any costs that exceed the allowance;
- Special lens coatings or laminations; and
- Special or designer frames or oversized lenses.

Specific Limitations and Exclusions

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes, or supporting structures*;
- Any eye or vision examination, or any corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Plan;
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Non-prescription lenses and non-prescription sunglasses (except for 20% discount);
- Two pairs of glasses in place of bifocals;
- Services rendered after the date an Insured Person ceases to be covered under the Plan, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
- Services or materials provided by any other group benefit plan providing vision care;
- Certain frames in which the manufacturer imposes a no discount policy; and
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next plan year, when vision benefits would again become available.

* **Please Note:** These expenses may be covered by the JPMorgan Chase Medical Plan. Refer to the *Medical Plan* section for additional information.

Contact Lens Limitation on Prescription Lenses

If you choose contact lenses, you will not be eligible to receive prescription lenses as a covered benefit during the same calendar year.

Claiming Benefits

The following explains when and how to file claims for vision expenses. For more information on your rights with respect to claims, please see the *Plan Administration* section.

How to File Claims

Rules regarding claims depend on whether you receive your eye care from an EyeMed network provider or a non-network provider, as shown below:

Provider	Claims Process
EyeMed Network Provider Benefits	When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).
Out-of-Network Provider Benefits	You must file a claim. You may file electronically through EyeMed's website or you may mail in a claim form. Claim forms are available on **My Health** or through EyeMed's website. You can receive reimbursement up to specific dollar amounts for annual exams and eyewear if you use a non-network provider. You first pay the provider the full cost for services rendered and/or eyewear purchased, and then submit a claim to EyeMed. Please see "Where to Submit Claims" on page 216 for your claim administrator's phone and address information.

To have your claim considered for benefits, you need to file your claim by December 31 of the year following the year in which the 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.

Your claim must include your receipts showing:

- An itemized listing of the services received;
- The covered member's name, address, and phone number;
- The covered member's Member ID number;
- The group name (JPMorgan Chase);
- The patient's name, date of birth, address, and phone number; and
- The patient's relationship to the covered member (such as self, spouse, child, etc.).

Separate claim forms must be submitted for each family member for whom a claim is made. After you submit a claim, you will receive an Explanation of Benefits (EOB) detailing how the benefit was paid.

Where to Submit Claims

First American Administrators (FAA) is the Vision Plan's claims administrator:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

(833) 279-4363

Representatives are available Monday through Friday from 7:30 a.m. to 11 p.m. Eastern time, Saturday from 8 a.m. to 11 p.m. and Sunday, from 11 a.m. to 8 p.m. Eastern time.

Time Frames for Processing Claims

FAA will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Appealing a Claim

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

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 Medical, Dental, and Vision Plans, 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.

Defined Terms

As you read this summary of the JPMorgan Chase Vision 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.

Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical, Dental, Vision and Spending Accounts Plans' payroll contributions are generally taken on a before-tax basis.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Plan.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue certain health plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. The *Health Care Participation* section provides details on COBRA coverage.
Coordination of Benefits	Coordination of benefits rules that determine how benefits are paid when a patient is covered by more than one group plan. If you are enrolled in the Vision Plan, EyeMed does not coordinate benefits and always acts as the primary coverage for you and your covered dependents.
Copayment	A copayment (also known as a copay) is the fixed dollar amount you pay toward certain services under the Plan when you receive your care from a network provider.
Covered Services	Covered services are services and procedures that are generally reimbursable by the Plan. While the Plan provides coverage for numerous services and supplies, there are limitations on what's covered. While a service or supply may be necessary, it may not be covered under the Plan. Please see the sections that explain what the Plan covers and what is not covered for more details.

Eligible Dependents	Under the Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see "Your Eligible Dependents" in the *Health Care Participation* section for more information.
Network Provider/Non-Network Provider	"In-network" and "out-of-network" are terms referring to whether a provider is part of the network associated with the Plan (network provider) or is not part of the network (non-network provider). When a service is performed through a network provider, benefits are paid at a higher level than they are when a service is performed through a non-network provider.

Your JPMC Benefits Guide

Effective 1/1/22

JPMorgan Chase is committed to providing a comprehensive set of benefits choices to meet different employee needs and lifestyles. In return, we ask our employees to take an active role in designing a personal strategy to help meet their short-term and long-term health care and insurance and retirement savings objectives.

This Guide provides a detailed summary of the Health Care and Insurance Plans for Active Employees of the JPMorgan Chase U.S. Benefits Program. To access the Retirement Savings Plans, you must be on the website at www.jpmcbenefitsguide.com and click on the "Retirement Savings" item in the black horizontal menu bar at the top of the web page. For the plans that are subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), this Guide serves as the summary plan description for those plans. For most of these plans, this Guide is also the plan document.

Print and Web Versions

This Guide is available as a website, at www.jpmcbenefitsguide.com.

The website includes links to PDF versions of each section, through the "Print a Section" page, in case you want to download a section to read it offline.

How This Guide Is Organized

Most of the sections of this Guide describe the details of each benefit plan. Those sections include:

- *Health Care Benefits,* which includes the *Medical*, *Dental*, and *Vision* Plans;
- *Spending Accounts;*
- *Life and Accident Insurance*;
- *Disability Coverage*, which includes the *Short-Term* and *Long-Term Disability* Plans;
- *Other Benefits*, which includes the *Health & Wellness Centers Plan*, the *Fertility Benefits Program*, the *Group Legal Services Plan*, the *Group Personal Excess Liability Plan*, the *Back-Up Child Care Plan*, the *Expatriate Medical and Dental Plans* and the *Hawaii Medical Plan*.

Other sections of the Guide cover information that applies to all or most of the benefit plans. These sections are separated from the specific plan details to minimize repetition and to keep related information together. These sections include:

- *What Happens If …*, which describes how different life events and situations can affect your benefits or provide you with opportunities to adjust your benefits coverage;
- *Plan Administration*, which provides administrative details such as plan numbers and statements of your rights, including your right to appeal, which is required by law; and
- *Contacts*, with a full list of contact details for all of the plans.

The section *About This Guide* provides additional legal information, including information about the role this Guide serves as summary plan descriptions ("SPDs") of the benefit plans.

Retirement Savings

The 401(k) Savings Plan and the Retirement (Pension) Plan summary plan descriptions are available at www.jpmcbenefitsguide.com, as PDFs. The SPDs for those plans are complete in the PDFs, and do not rely on the any of the other sections of this Guide.

Questions?

If you still have questions after reviewing this Guide, there are a number of resources that can provide answers. As a first stop, consult the *Contacts* section.

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

Table of Contents Page

About This Guide

Effective 1/1/22

This Guide serves as the summary plan description (SPD) for the following plans of the JPMorgan Chase U.S. Benefits Program, effective as of January 1, 2022:

- *The JPMorgan Chase Core Medical Plan*
- *The JPMorgan Chase Simplified Medical Plan*
- *The Kaiser HMO Plan*
- *The JPMorgan Chase Dental Plan*
- *The JPMorgan Chase Vision Plan*
- *The JPMorgan Chase Spending Accounts*
- *The JPMorgan Chase Basic Life Insurance Plan*
- *The JPMorgan Chase Supplemental Term Life Insurance Plan*
- *The JPMorgan Chase Accidental Death and Dismemberment (AD&D) Insurance Plan*
- *The JPMorgan Chase Business Travel Accident Insurance Plan*
- *The JPMorgan Chase Short-Term Disability Plan*
- *The JPMorgan Chase Long-Term Disability Plan*
- *The JPMorgan Chase Health and Wellness Centers Plan*
- *The JPMorgan Chase U.S. Fertility Benefits Program*
- *The JPMorgan Chase Group Legal Services Plan*
- *The JPMorgan Chase Group Personal Excess Liability Insurance Plan*
- *The JPMorgan Chase Back-Up Child Care Plan*
- *The JPMorgan Chase Expatriate Medical and Dental Plans*
- *The JPMorgan Chase U.S. Retiree Benefits Program (this document does not include information related to the JPMorgan Chase U.S. Retiree Benefits Program; see the PDF available at www.jpmcbenefitsguide.com for the entire SPD for the JPMorgan Chase U.S. Retiree Benefits Program)*
- *The JPMorgan Chase 401(k) Savings Plan (this document does not include information related to the JPMorgan Chase 401(k) Savings Plan; see the PDF available at www.jpmcbenefitsguide.com for the entire SPD for the JPMorgan Chase 401(k) Savings Plan)*

About This Summary

This section summarizes certain information for the health care and insurance plans. Please retain this section for your records. Other sections may be needed in addition to this section to provide a complete summary plan description (SPD) and/or plan document for a plan, including the sections that describe the benefits the plan provides.

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

An SPD is a legally required document that provides a comprehensive description of benefit plans and their provisions. The SPD includes the following sections:

- *Plan Administration*
- *What Happens If…*
- *Health Care Participation*
- *COVID-related legislative changes to the Health Care Spending Account and the Dependent Care Spending Account*

Additional Plan Information

Your primary contact for matters relating to plan benefits is each plan's claims administrator or service provider. Contact HR Answers for information about general administration issues such as enrollment and eligibility for the plans.

Your benefits as a participant in the plans 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. Benefits Program) has any authority to interpret the plans (or official plan documents) or to make any promises to you about them. The plan administrator for the JPMorgan Chase U.S. Benefits Program has complete authority in his or her absolute discretion to construe and interpret the terms of the plans and any underlying insurance policies and/or contracts, including the eligibility to participate in the plans, and to make factual determinations.

All decisions of the plan administrator for the JPMorgan Chase U.S. Benefits Program are final and binding upon all affected parties. The plan administrators delegate their discretion to interpret the plans to the claims administrators, and to decide claims and appeals, including making factual determinations, to:

- The claims administrators; and
- The Health and Income Protection Plans Appeals Committee.

No Assignment of Benefits

The plans are used exclusively to provide benefits to you and, in some cases, your survivors. Neither you nor JPMorgan Chase can assign, transfer, or attach your benefits, or use them as collateral for a loan. You may not assign your right to file actions under ERISA regarding the plans, or use power of attorney or similar arrangements for that purpose.

Please Note: You may assign certain employee life insurance benefits and may assign to a health care service provider the right to payment. Please contact HR Answers for more information.

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 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 Guide do not represent vested benefits.

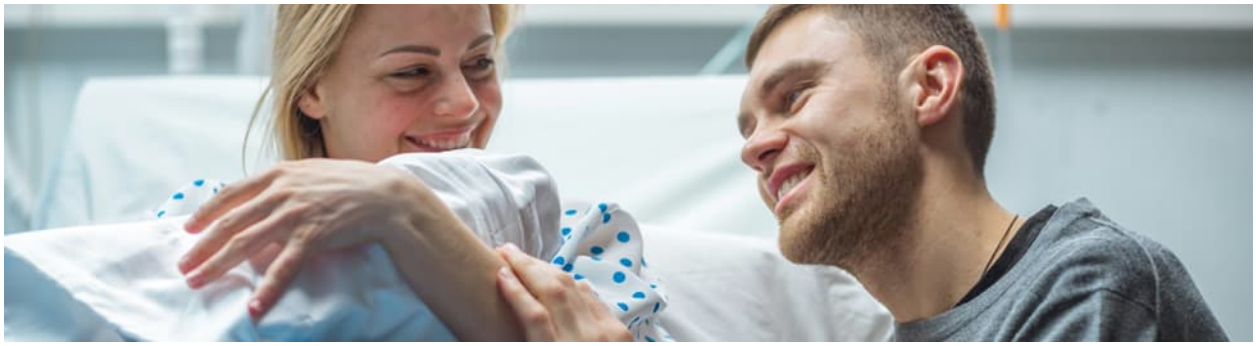
JPMorgan Chase also reserves the right to amend any of the plans and policies, to change the method of providing benefits, to curtail or reduce future benefits, or to terminate at any time for any reason, any or all of the plans and policies described in this Guide.

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

Not a Contract of Employment

Neither this Guide nor the benefits described in this Guide create a contract or a guarantee of employment between JPMorgan Chase and any employee. JPMorgan Chase or you may terminate the employment relationship at any time.

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



What Happens If …

Effective 1/1/22

This section describes the impact of certain life changes and events on your JPMorgan Chase Health Care and Insurance Plans for Active Employees benefits. Generally, you make elections once a year during Annual Benefits Enrollment, unless you have a Qualified Status Change (QSC) or other event, such as a change in work status. QSC's are generally legally defined situations. See the following information for types of changes and implications to your benefits. For more information, see the Benefits Status Change Guide on ***My Health*** *> Learn about the JPMC Benefits Program.*

New Dependents Must Be Verified

Please Note: If a QSC results in the ability to add a dependent to your coverage, that dependent is subject to the dependent verification process from JPMorgan Chase or the plans' administrators, to confirm the dependent is eligible.

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

Table of Contents

Qualified Status Changes (QSCs)

There are many changes in your situation that meet the requirements to be Qualified Status Changes (QSCs). While many of your benefits cannot be changed during the year, if you have a QSC, some benefit changes are allowed.

The following tables summarize the changes that you can make for each event. They are separated into:

- Health Benefits;
- Spending Accounts;
- Life Insurance Benefits; and
- Accident Insurance Benefits.

If You Have an Event …

If you have a QSC, or if you are unclear whether your situation is a QSC, contact HR Answers to get answers on what you can do in your situation.

31-Day Deadline

If you have a QSC, you have 31 days from the qualifying event to make benefits changes; 90 days from the qualifying event if the event is the birth or adoption of a child. The benefits you elect will be effective the date of the event if you make the elections timely. (**Please Note:** You will have 90 days from the QSC date to add any newly eligible dependents to Medical Plan coverage should that dependent pass away within this 90-day period.). Any changes you make during the year must be consistent with the status change. Be sure to take action promptly, so that you don't miss the deadline to make any benefit changes!

Retroactive Payroll Contribution Changes

If a QSC or other permitted plan change results in retroactive changes to payroll contributions, those changes will be reflected on your next administratively available pay.

QSCs for Health Benefits — Medical, Dental, Vision

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner Child
Marriage	Add	Add	Add
Domestic Partner Commitment	Add	Add	Add
Divorce, Legal Separation, or Termination of DP Commitment	Add	Drop	Drop
Death of Spouse/DP	N/A	Drop	Drop
Birth/Adoption/Legal Guardianship	Add	Add	Add
Child Gains Eligibility	Add	Add	Add

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner Child
DP's Child Becomes Eligible	Add	Add	Add
Child Gains Eligibility due to QMCSO	Add	N/A	Add
Child/DP Child no Longer Eligible	N/A	N/A	Drop
Death of Child/DP Child	N/A	N/A	Drop
You or Covered Dependent Gains Other Coverage	Drop/reduce # of dependents	Drop/reduce # of dependents	Drop/reduce # of dependents
You or Covered Dependent Loses Other Coverage	Add	Add	Add
Change in Dependent Care Provider or Fees	N/A	N/A	N/A
Move out of Provider Service Area	Change option	change option	change option

*QSCs for Spending Accounts**

QSC	Health Care Spending Account	Dependent Care Spending Account
Marriage	Begin, increase	Begin, increase, decrease, or stop
Domestic Partner Commitment	Begin, increase	Begin, increase, decrease, or stop
Divorce, Legal Separation, or Termination of DP commitment	Decrease, stop	Begin, increase, decrease, or stop
Death of Spouse/DP	Decrease, stop	Begin, increase, decrease, or stop
Birth/Adoption/Legal Guardianship	Begin, increase	Begin, increase
Child Gains Eligibility	Begin, increase	Begin, increase
DP's Child Becomes Eligible	Begin, increase	Begin, increase
Child Gains Eligibility due to QMCSO	Begin, increase	N/A
Child/DP Child no Longer Eligible	Decrease, stop	Decrease, stop
Death of Child/DP Child	Decrease, stop	Decrease, stop

QSC	Health Care Spending Account	Dependent Care Spending Account
You or Covered Dependent Gains Other Coverage	N/A	Decrease, stop
You or Covered Dependent Loses Other Coverage	Begin, increase	Begin, increase
Change in Dependent Care Provider or Fees	N/A	Begin, increase, decrease, or stop
Move out of Provider Service Area	N/A	N/A

*You can change your Transportation Spending Accounts elections at any time.

QSCs for Supplemental Term Life Insurance Benefits

QSC	Employee	Adult Dependent	Dependent Child/Domestic Partner Child
Marriage	Begin, increase, decrease, or stop	Begin, increase	Begin, increase, decrease, or stop
Domestic Partner Commitment	Begin, increase, decrease, or stop	Begin	Begin, increase, decrease, or stop
Divorce, Legal Separation, or Termination of DP Commitment	Begin, increase, decrease, or stop	Drop	Begin, increase, decrease, or stop
Death of Spouse/DP	Begin, increase, decrease, or stop	Drop	Begin, increase, decrease, or stop
Birth/Adoption/Legal Guardianship	Begin, increase	Begin, increase	Begin, increase
Child Gains Eligibility	Begin, increase	Begin, increase	Begin, increase
DP's Child Becomes Eligible	Begin, increase	Begin, increase	Begin, increase
Child Gains Eligibility due to QMCSO	Begin, increase	N/A	Begin, increase
Child/DP Child no Longer Eligible	Decrease, stop	Decrease, stop	Decrease, stop
Death of Child/DP Child	Decrease, stop	Decrease, stop	Decrease, stop
You or Covered Dependent Gains Other Coverage	Decrease, stop	Decrease, stop	Decrease, stop
You or Covered Dependent Loses Other Coverage	Begin, increase	Begin, increase	Begin, increase
Change in Dependent Care Provider or Fees	N/A	N/A	N/A
Move out of Provider Service Area	N/A	N/A	N/A

QSCs for Accidental Death and Dismemberment (AD&D) Benefits

QSC	Employee	Adult	Child
Marriage	Begin, increase, decrease, or stop	Begin, increase	Begin, increase, decrease, or stop
Domestic Partner Commitment	Begin, increase, decrease, or stop	Begin	Begin, increase, decrease, or stop
Divorce, Legal Separation, or Termination of DP Commitment	Begin, increase, decrease, or stop	Drop	Begin, increase, decrease, or stop
Death of Spouse/DP	Begin, increase, decrease, or stop	Drop	Begin, increase, decrease, or stop
Birth/Adoption/Legal Guardianship	Begin, increase	Begin, increase	Begin, increase
Child Gains Eligibility	Begin, increase	Begin, increase	Begin, increase
DP's Child Becomes Eligible	Begin, increase	Begin, increase	Begin, increase
Child Gains Eligibility due to QMCSO	Begin, increase	N/A	Begin, increase
Child/DP Child no Longer Eligible	Decrease, stop	Decrease, stop	Decrease, stop
Death of Child/DP Child	Decrease, stop	Decrease, stop	Decrease, stop
You or Covered Dependent Gains Other Coverage	Decrease, stop	Decrease, stop	Decrease, stop
You or Covered Dependent Loses Other Coverage	Begin, increase	Begin, increase	Begin, increase
Change in Dependent Care Provider or Fees	N/A	N/A	N/A
Move out of Provider Service Area	N/A	N/A	N/A

You Get Married

Getting married is a Qualified Status Change (QSC) that gives you the opportunity to adjust your coverage in ways consistent with your change in status. For example, you could enroll yourself and/or your new spouse for coverage.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections titled "Changing Your Coverage Midyear" in the plan descriptions.

If you are using the change to add a new dependent, you will be required to provide documentation of the new dependent's eligibility for coverage.

You Have or Adopt a Child or Become a Legal Guardian

Having or adopting a child or becoming a legal guardian of a child is a Qualified Status Change (QSC) that gives you the opportunity to adjust your company coverage in ways consistent with your change in status. For example, you could enroll your new child for coverage.

Any changes based on a QSC must be submitted within 31 days of the change in status, but the time available is 90 days when the qualifying event is the birth or adoption of a child. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear." You will be required to provide documentation of the new dependent's eligibility for coverage.

(You will have 90 days from the QSC to add any newly eligible dependents to the JPMC Medical Plan should that dependent pass away within this 90-day period; please contact HR Answers if this situation applies to you.)

If you are using the change to add a new dependent, you will be required to provide documentation of the new dependent's eligibility for coverage.

A Covered Dependent Becomes Ineligible

If your dependent becomes ineligible (such as when a dependent child reaches age 26, for health care coverage), the dependent's coverage will end on the last day of the month in which he or she no longer meets the eligibility requirements. For Supplemental Term Life and AD&D, once your dependent is no longer eligible, it is your responsibility to remove the dependent from your coverage, otherwise payroll deductions will continue, but coverage will not. You must contact HR Answers for assistance with removing an ineligible dependent.

Please Note: If you have multiple eligible dependent children covered under your Supplemental Term Life and/or AD&D plan, their coverage will continue.

When coverage ends, the dependent may have a right to elect COBRA for up to 36 months. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

A covered dependent becoming ineligible is a Qualified Status Change (QSC) that gives you the opportunity to adjust your coverage in ways consistent with your change in status. This means you could cancel company coverage or stop contributions to spending accounts.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear."

You and/or Your Dependents Lose Other Coverage

If you declined company coverage because you had coverage from another source and you lose that coverage, you may be eligible to enroll for company coverage because of your HIPAA Special Enrollment rights. Similarly, if you declined company coverage for an eligible dependent because he or she had coverage from another source and he or she loses that coverage, you may be eligible to enroll your eligible dependent for company coverage because of your HIPAA Special Enrollment rights. See "HIPAA Special Enrollment Rights" in the *Health Care Participation* section for more details.

Both of these situations are Qualified Status Changes (QSCs) that give you the opportunity to adjust your company coverage in ways consistent with your change in status.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear." You will be required to provide documentation of the new dependent's eligibility for coverage.

If you are using the change to add a new dependent, you will be required to provide documentation of the new dependent's eligibility for coverage.

You and/or Your Dependents Gain Other Coverage

Gaining access to other coverage is a Qualified Status Change (QSC) that gives you the opportunity to adjust your coverage in ways consistent with your change in status. This means you could decline company coverage and enroll for the newly available coverage, instead.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear."

You Move

If you move out of your Medical or Dental Plan option service area and your current option is no longer available, you can change Medical and/or 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.)

You Divorce, Separate or Terminate a Domestic Partner Relationship

Getting divorced, separated, or terminating a domestic partner relationship is a Qualified Status Change (QSC) that gives you the opportunity to adjust your coverage in ways consistent with your change in status. This means you could decline company coverage or enroll yourself and/or your dependents for coverage if you declined it in the past.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear."

If you are using the change to add a new dependent, you will be required to provide documentation of the new dependent's eligibility for coverage.

For medical, dental, and vision coverage: If your spouse and/or child(ren) lose medical, dental, or vision coverage because of divorce/separation, they may have a right to elect COBRA for up to 36 months. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

If you divorce or become legally separated, certain court orders could require you to provide health care benefits to covered child(ren). JPMorgan Chase is legally required to recognize qualified medical child support orders within the limits of the JPMorgan Chase plans. If you're a party in a divorce settlement that involves the JPMorgan Chase plans, 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" in the *Health Care Participation* section for more information.

For the spending accounts: In case of divorce or separation, you can decrease or stop contributions to the Health Care Spending Account and can start, change, or stop contributions to the Dependent Care Spending Account.

For the Life and Accident Insurance Plans: If you divorce or become legally separated, your covered spouse/domestic partner would be ineligible to continue coverage under the JPMorgan Chase Life and Accident Insurance Plans, and coverage would end as of the date of the status change. Your formerly covered spouse/domestic partner can port or convert their dependent Supplemental Term Life Insurance. Accidental Death & Dismemberment insurance may be ported. For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

For the Group Legal Services Plan: If you divorce or become legally separated, coverage for your spouse will end on the date of your divorce or legal separation.

For the Group Personal Excess Liability Plan: If you divorce or become legally separated, coverage for your spouse will end on the date of your divorce or legal separation.

You Pass Away

For medical, dental, and vision coverage, including expatriate coverage: If you pass away while actively employed at JPMorgan Chase, any dependents who were covered under your JPMorgan Chase health care coverage before your death will continue to be covered until the last day of the month in which you pass away. Covered dependents can then elect to continue coverage under COBRA and pay the active employee rate for coverage for up to 36 months of the COBRA period. Dependents must be covered under the Medical Plan at the time of your death to be eligible for COBRA coverage at JPMorgan Chase-subsidized rates. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

In addition, your dependents may be eligible to continue coverage under the Retiree Medical, Dental and/or Vision Plans if, at the time of death:

- You have already met the general eligibility requirements for retirement. (For more information, please see the **As You Leave Guide,** available on **me@jpmc**.); or
- You have already met the alternative eligibility requirements for retirement in the event of position elimination. (For more information, please see the **As You Leave Guide** as noted above.); or
- You have 25 years of total service with JPMorgan Chase.

Dependents may continue coverage under the Retiree Medical, Dental and/or Vision Plans as long as they meet the plans' requirements.

For the spending accounts: If you pass away, claims for spending accounts for expenses incurred on or before the date of death can be filed to the appropriate program administrator, please see the *Spending Accounts* section for more details and the appropriate deadlines.

For the Life and Accident Insurance Plans: If you pass away, benefits from the Life and Accident Insurance Plans are paid to the beneficiary named. If a beneficiary has not been named, then the benefits are paid according to the order listed under "Beneficiaries" in the *Life and Accident Insurance* section.

- If your dependents are enrolled for supplemental term life and accidental death and dismemberment (AD&D) insurance when you pass away, they may port their coverage by contacting MetLife, the claims administrator. Your dependents will be directly billed for this coverage. Dependents can also convert their supplemental term life insurance; however, they may not convert AD&D coverage. (Certain states have additional, specific requirements. Please refer to MetLife for state-specific rules.)

For the Group Legal Services Plan: In the event of your death while actively employed by JPMorgan Chase, your spouse has the option to continue group legal coverage by contacting MetLife Legal Plans within 31 days of the date of your death to extend coverage for an additional 12 months with direct payment to MetLife Legal Plans. Any services in progress at the time of your death will be provided, even if your spouse does not elect to continue coverage.

For the Group Personal Excess Liability Plan: In the event of your death, coverage will be provided to any surviving household member who is a covered person at the time of death, including your spouse, legal representative, or any person having proper temporary custody of your property, until the end of the policy period or policy anniversary date, whichever is sooner.

Other Events or Changes

Change in Scheduled Work Hours

This section describes how your benefits are affected if your work status changes but you are still employed by the company. The focus is on changes to your scheduled work hours. A change in work status that changes your eligibility gives you the opportunity to adjust your coverage in ways consistent with your change in status. This means you could decline company coverage or enroll for coverage if you declined it in the past, and can enroll your eligible spouse for coverage. If your spouse has children and they become your eligible dependents, you can also enroll them for coverage.

Any changes must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear."

Here's how coverage is affected if your schedule changes and you are regularly scheduled to work fewer than 20 hours per week:

- **Your JPMorgan Chase medical, dental, and vision coverage** will end on the last day of the month in which your work status changes and you are then scheduled to work fewer than 20 hours per week. Even if your coverage ends, you may be able to continue medical, dental, and/or vision coverage for a certain period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

  For expatriate coverage, COBRA continuation applies if you are a U.S. home-based expatriate or an expatriate assigned to the United States. Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for COBRA continuation coverage.

- **Your contributions to the Health Care Spending Account** will end on the last day of the month in which your work status changes and you are then scheduled to work fewer than 20 hours per week. In this case, you may continue to make contributions to the Health Care Spending Account on an after-tax basis under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if elected. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

- **Your contributions to the Dependent Care and Transportation Spending Accounts** end on the date your work status changes and you are then scheduled to work fewer than 20 hours per week.

- **For the Basic Life Insurance Plan, Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan:** Your coverage and eligibility will end on the date of your status change and you are then scheduled to work less than 20 hours per week. For more information on when you increase work hours to more than 20 hours, please see the *Life and Accident Insurance* section.

  — You can convert your basic life insurance to an individual policy within 31 days of your status change date by contacting MetLife, the claims administrator, for a conversion application.

  — You can port or convert your employee supplemental term life insurance and/or port your AD&D — up to the lesser of five times your eligible compensation or $1 million — through a direct billing arrangement with MetLife. Contact MetLife, the claims administrator, within 31 days of your change in status. If you port your coverage, you may also port dependent coverage. For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

- **For the Business Travel Accident Insurance Plan,** you remain eligible for coverage regardless of your scheduled work hours, if you are otherwise eligible for coverage.
- **Your Health & Wellness Centers Plan coverage** will end on the last day of the month in which your work status changes and you are then scheduled to work fewer than 20 hours per week. Even if your coverage ends, you may be able to continue coverage for a certain period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)
- **Your Group Legal Services Plan coverage** will end on the date your work status changes and you are then scheduled to work fewer than 20 hours per week. However, you can continue coverage for additional 12 months by contacting the MetLife Legal Group.
- **Your Group Personal Excess Liability Insurance Plan coverage** will end 60 days from the date your work status changes, and you are then scheduled to work fewer than 20 hours per week, or until the end of the policy period or policy anniversary date, whichever is sooner.

For information on becoming eligible for benefits due to a work status change, see each specific plan section (e.g., Medical).

You Go on Short-Term Disability Leave

Under the Short-Term Disability Plan, you may have the financial protection of full or partial pay for up to 25 weeks. While you are on a short-term disability leave you may continue many of your elected benefits provided you make the necessary contributions. Benefits that do not continue while you are on short-term disability leave include Business Travel Accident Insurance, the Dependent Care Spending Account, and the Transportation Spending Account.

- **For the Medical Plan, the Dental Plan, the Vision Plan, the Health & Wellness Centers Plan, the Group Legal Services Plan, and the Group Personal Excess Liability Insurance Plan:** For the approved period of your disability leave, you'll remain eligible to be covered under the Medical Plan, the Dental Plan, the Vision Plan, the Health & Wellness Centers Plan, the Group Legal Services Plan, and the Group Personal Excess Liability Insurance Plan, and you will remain eligible to participate in the Health Care Spending Account. JPMorgan Chase will deduct any required contributions for medical coverage from the pay you receive during this period on a before-tax basis for the health care plans and the Health Care Spending Account and on an after-tax basis for the Group Legal Services Plan and the Group Personal Excess Liability Insurance Plan. However, certain states require that no benefits deductions may be taken from your disability pay or state disability pay for which JPMC pays you. In these instances, impacted employees will be mailed a bill to their home address on record. Initial bills require payment within 45 days from the date on the bill and subsequent bills are due within 30 days of the bill date. If you receive a bill and do not pay it in full by the due date, all coverages reflected on the bill will be dropped. Only medical coverage, which you had in place prior to your leave, is eligible for reinstatement within 6 months following the date the coverage dropped. Employees can contact HR Answers for payment information and how to request reinstatement of dropped medical coverage.
  - This medical and dental coverage continuation includes expatriate medical and dental coverage. If you are not receiving pay via Expat Payroll during your leave, JPMorgan Chase will bill you directly for any required contributions.
- **For the Dependent Care Spending Account**, your participation is suspended during a period of paid or unpaid leave.
- **For the Transportation Spending Account**, your participation is terminated during a period of paid or unpaid leave and any unused credits in your account(s) will be forfeited if you do not return to work and reenroll in the Transportation Spending Account. If you know you will be going on a leave, you should change your contribution amount to zero approximately one month before your leave begins in order to avoid forfeiting any contributions. Expenses incurred after your leave begins will not be eligible for reimbursement or payment from your account(s). If you wish to continue participation after you return to active service, you must re-enroll. However if you participated in the "Pay Me Back" option, you have 180 days following the end of any particular benefit month you participated in the program to file claims for reimbursement from your "Pay Me Back" account.

- **For the Basic Life Insurance Plan, Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan:** For the approved period of your disability leave, you'll remain eligible to be covered under the Basic Life Insurance Plan (including Identity Theft (ID) Assistance Program, Travel Assistance and Emergency Evacuation services, funeral concierge services, and SurvivorSupport® financial counseling services), Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan.
- **For the Business Travel Accident Insurance Plan:** While you are on disability leave, your business travel accident insurance will be suspended.

You Go on Long-Term Disability

If you receive long-term disability (LTD) benefits from the JPMorgan Chase Long-Term Disability Plan (LTD Plan), you will continue to be eligible to participate in the following benefits* as long as you continue to make timely premium payments:

- Medical
- Dental
- Vision
- Group Legal
- Group Personal Excess Liability Plan
- Basic Life Insurance (fully paid by JPMC)
- Supplemental Term Life Insurance
- Accidental Death and Dismemberment Insurance

* You can also continue participation in the Health & Wellness Centers Plan.

You'll be eligible to continue these benefit plans at active employee rates for the first 24 months after going on approved LTD (that is, 30 months from the date of disability). The premiums will be converted to a monthly rate, and you will be required to pay for this coverage monthly on an after-tax basis. You will pay for this coverage on a direct-bill basis with JPMorgan Chase's administrator.

If you are an expatriate and you qualify for long-term disability (LTD) benefits from a JPMorgan Chase long-term disability plan, your expatriate assignment will end and, coincidentally, so will your eligibility for the Expatriate Medical and Dental Plan options. You must then elect coverage under your home country Medical and/or Dental Plan options, if available. If you are a U.S. home-based expatriate employee, medical coverage under one of the U.S. domestic options may continue while you are receiving LTD benefits under the U.S. LTD Plan. Be sure to consider this carefully before you decline coverage under the LTD Plan.

In certain cases, you may be temporarily approved for additional leave under another JPMorgan Chase Policy, such as the Disability and Reasonable Accommodation Policy. (For details on medical plan coverage should you become eligible for Medicare during this timeframe, please see "You Are on LTD and Become Eligible for Medicare" on page 19.)

Absent any temporary leave accommodation, your employment with JPMorgan Chase will end immediately after you have received 24 months of payments under the LTD Plan. However, you will continue to be eligible for LTD benefits provided you meet all eligibility provisions of the LTD Plan. Even if your LTD benefits end, you may be able to continue medical, dental, vision, and Health & Wellness Centers coverage for a certain period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

Please Note: If you became disabled before January 1, 2011**,** your coverage will continue at active employee rates while you receive benefits under the Long-Term Disability Plan. If you do not make the required contributions to continue your coverage, your coverage will be canceled. Reinstatement is available for only the JPMC Medical plan within 6 months of coverage termination. Impacted employees should call HR Answers for the amount owed to reinstate coverage and information about the process.

For the Health Care Spending Account, while you are receiving benefits under the JPMorgan Chase LTD Plan, you may continue to make monthly contributions to the Health Care Spending Account on an after-tax basis via direct bill. Participation in the Health Care Spending Account will cease at the end of the benefit plan year in which you start to receive LTD benefits.

For the Dependent Care Spending Account: For the Dependent Care Spending Account, you may use your account balance only for eligible expenses incurred prior to your LTD effective date and must file those claims by March 31 of the next calendar year.

For the Transportation Spending Account, your participation is suspended and any unused credits in your account(s) will be forfeited if you do not return from LTD. If you know you will be going on a leave, you should change your contribution amount to zero approximately one month before your leave begins to avoid forfeiting any contributions. Expenses incurred after your leave begins will not be eligible for reimbursement or payment from your account(s). If you wish to continue participation after you return to active service, you must re-enroll. However if you participated in the "Pay Me Back" option, you have 180 days following the end of any particular benefit month you participated in the program to file claims for reimbursement from your "Pay Me Back" account.

Your Business Travel Accident Insurance Plan coverage does not continue while you are receiving LTD benefits.

You Are on LTD and Become Eligible for Medicare

If you are receiving full long-term disability (LTD) benefits from the JPMorgan Chase Long-Term Disability Plan (LTD Plan), are not actively at work and become eligible for Medicare, Medicare becomes the primary source of your medical coverage. You will no longer be eligible for the active JPMorgan Chase medical coverage. Instead, Medicare-eligible participants have access to individual supplemental Medicare coverage available through Via Benefits, a private Medicare exchange, which is not coverage sponsored by JPMorgan Chase. For those Medicare-eligible individuals who enroll in coverage through Via Benefits and are eligible for a medical subsidy, JPMorgan Chase sponsors the Health Reimbursement Arrangement Plan associated with that coverage. For further details, contact HR Answers.

You Become Eligible for Medicare

If you are a JPMorgan Chase employee enrolled in an active JPMorgan Chase health care plan, such as the Medical Plan, Dental Plan, or Vision Plan, are actively working and you become entitled to Medicare because of your age or a qualifying disability, the JPMorgan Chase plans continue to be the primary source of your coverage. For further details on Medicare, see www.medicare.gov.

You Go on a Military Leave

Your benefits coverage may be affected if you take a military leave (paid or unpaid), as described below. For detailed information about the JPMorgan Chase Military Leave and Reserve Training Policy, please visit **me@jpmc**. In all cases, JPMorgan Chase will comply with legal requirements, including the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Paid Military Leave

If you qualify for a paid military leave, you will be provided with continuation of most benefits. **Please Note**: Certain benefits plans have exclusions for injury or illness that results from an act of war.

Benefits that do not continue while you are on a paid military leave include:

- Business Travel Accident Insurance Plan;
- Transportation Spending Account;
- Long-Term Disability Plan (after 16 weeks of paid military leave); and
- Short-Term Disability Plan.

You may resume your benefits coverage when you return to work. Some of your benefits are reinstated, but for others like the Transportation Spending Account, you must re-enroll. **Please Note:** Evidence of insurability may also be required for some plans.

Unpaid Military Leave

If you qualify for an unpaid military leave, you may continue many of your elected benefits, provided you make the necessary contributions in a timely manner. **Please Note**: Certain benefits plans have exclusions for injury or illness that results from an act of war.

Making Contributions While on Unpaid Leave

If you wish to continue certain benefits while on any unpaid leave, you must make the necessary contributions on a timely basis, even if you do not receive a bill.

Benefits that do not continue while you are on an unpaid military leave include:

- Business Travel Accident Insurance Plan;
- Dependent Care Spending Account;
- Transportation Spending Accounts;
- Long-Term Disability Plan (after 16 weeks of unpaid military leave); and
- Short-Term Disability Plan.

You may resume your benefits coverage when you return to work. Some of your benefits are reinstated, but for others like the Transportation Spending Account, you must re-enroll. **Please Note:** Evidence of insurability may also be required for some plans.

You Go on a Parental Leave

While you are on an approved parental leave, you may continue many of your elected benefits, provided you make the necessary contributions in a timely manner. Benefits that do not continue while you are on a parental leave include Business Travel Accident Insurance, the Dependent Care Spending Account, and the Transportation Spending Accounts.

Generally, if your benefits coverage ended during your leave, you may resume coverage when you return to work.

You Go on Approved Family and Medical Leave

You may continue many of your elected benefits while you are on an approved family and medical leave, provided you make the necessary contributions in a timely manner. Benefits that do not continue while you are on family leave include Business Travel Accident Insurance, the Dependent Care Spending Account, and the Transportation Spending Accounts.

Generally, if your benefits coverage ended during your leave, you may resume your benefits coverage within 31 days following your return to work.

Special Rules for Health Care Spending Account

Special rules apply to your Health Care Spending Account. When you take a leave covered under the Family and Medical Leave Policy, the entire amount you elected under your Health Care Spending Account will be available to you during your leave period, less any prior reimbursements that you have received for that plan year, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on a leave and you may not receive reimbursement for any health care expenses you incur after your coverage terminated.

If your Health Care Spending Account participation terminates during your leave, your Health Care Spending Account contributions will begin again if you return to work during the same year in which your leave began. You will not be able to submit claims for reimbursement for expenses incurred during your leave, and your contributions will increase to “make up” for the contributions you missed during your leave. The amount available for reimbursement will be the same annual amount you elected before the leave.

You may not use your Health Care Spending Account for expenses incurred during the period you did not participate.

You Go on Unpaid Leave

For medical, dental, and vision coverage: For an approved unpaid leave of absence, the Medical, Dental, and Vision Plans will still cover you, as long as you make any required contributions. You will be directly billed for any required contributions on an after-tax basis. You will also still be covered by the Health & Wellness Centers Plan.

If you do not make the required contributions to continue your coverage in a timely manner, your coverage will be canceled. However, your coverage may be reinstated when you return to work.

For the Health Care Spending and Dependent Care Spending Accounts: During an approved unpaid leave of absence, you may continue to make monthly contributions to the Health Care Spending Account on an after-tax basis, via your benefits invoice. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on a leave and you may not receive reimbursement for any health care expenses you incur after your coverage terminated. You may not make contributions to a Dependent Care Spending Account during an unpaid leave. For the Dependent Care Spending Account, you may use your account balance only for eligible expenses incurred prior to the date of your approval to go on unpaid leave, and must files those claims by March 31 of the next calendar year.

For the Transportation Spending Account, you must disenroll and any unused credits in your account(s) will be forfeited. If you know you will be going on a leave, you should change your contribution amount to zero approximately one month before your leave begins in order to avoid forfeiting any contributions. Expenses incurred after your leave begins will not be eligible for reimbursement or payment from your account(s). If you wish to continue participation after you return to active service, you must re-enroll. However if you participated in the “Pay Me Back” option, you have 180 days following the end of any particular benefit month you participated in the program to file claims for reimbursement from your “Pay Me Back” account.

For life and accident coverage: While you are on an unpaid leave, you will continue to pay your premiums for supplemental term life and AD&D insurance to JPMorgan Chase. Your basic life insurance continues at no cost to you. Your business travel accident insurance will end.

For Group Legal Services Plan coverage, you will be billed monthly to continue coverage.

For Group Personal Excess Liability Insurance Plan coverage, you will be billed monthly to continue coverage.

You Return from a Leave of Absence

If you go on a leave of absence (such as a disability, long-term disability, or paid or unpaid leave) and you return to work in a work status that makes you eligible for benefits, then:

For medical, dental, and vision coverage: The coverage that you had before your leave of absence will be reinstated.

For the Health Care Spending Account (HCSA):

- If you return to work from an unpaid leave of absence in **the same** plan year in which your leave began, before-tax contributions from your pay will automatically continue, and your total remaining amount will be prorated over the remaining pay cycles. If you return to work from a paid leave of absence in the same plan year, there is no interruption to your HCSA contributions while you are on a paid leave.
- If you return to work from **a paid or unpaid leave of absence of absence or a paid or unpaid disability leave** in **a different** plan year than the one in which your leave began, or if **you return to work from a leave in which you were receiving benefits under the JPMorgan Chase Long-Term Disability Plan**, you may enroll in the HCSA within 31 days of the date you return to work.

For the Dependent Care Spending Account (DCSA):

- If you return to work from **a leave of absence (paid or unpaid) or a disability leave (paid or unpaid)** in **the same** plan year in which your leave began, and want to participate in the DCSA, you have 31 days from your return to work date to re-elect to participate in DCSA. Contributions automatically stop when you begin your leave (of any type) and will not start automatically.
- If you return to work from **a paid or unpaid disability leave or other leave of absence** in **a different** plan year than the one in which your leave began, or if **you return to work from a leave in which you were receiving benefits under the JPMorgan Chase Long-Term Disability Plan**, you may enroll in the DCSA within 31 days of when you return from your leave.

For the Transportation Spending Account (TSA): Contributions automatically stop when you begin your leave (of any type). If you return to work from a leave and wish to participate in TSA, you must enroll in this account when you return to work. The effective date of your participation depends on the date of your enrollment. Please wait approximately ten days for your return to work information to reach WageWorks. Changes to your TSA elections become effective as of the first of the month for the following month's expenses (i.e., April deductions for May expenses).

For LTD Benefits:

- If your Total Annual Cash Compensation (TACC) is less than $60,000, you will be reinstated in LTD coverage immediately upon your return to active status.
- If your TACC is equal to or greater than $60,000, generally, you have to re-enroll for LTD coverage within 31 days of your return from your leave, and you may be required to provide evidence of insurability (EOI). Your coverage will resume on the first pay cycle after EOI is approved. If you don't re-enroll within 31-days, your next opportunity to enroll will be Annual Benefits Enrollment. Contact HR Answers for specific questions.
  - If you are on an approved medical leave, your LTD coverage remains in effect throughout your leave
  - If you are on a paid parental leave, your LTD coverage ends after 16 weeks
  - If you are on an unpaid leave, your LTD coverage ends after 16 weeks
  - If you are on any other type of nonmedical, paid or unpaid leave, coverage ends after 16 weeks

Total Annual Cash Compensation (TACC)

Total Annual Cash Compensation (TACC) is your annual rate of base salary/regular pay plus any applicable job differential pay (e.g., shift pay) as of each August 1, plus any cash earnings from any incentive plans (e.g., annual incentive, commissions, draws, overrides and special recognition payments or incentives) that are paid to or deferred by you for the previous 12-month period ending each July 31. Overtime is not included. It is recalculated as of each August 1 to take effect the following January 1 and will remain unchanged throughout the year. For most employees hired on or after August 1, it will be equal to your annual rate of base salary/regular pay plus applicable job differentials.

You Leave JPMorgan Chase

For health care coverage: If your employment with JPMorgan Chase terminates, participation in the Medical, Dental, Vision, and Health & Wellness Centers Plans for you and your covered dependents ends on the last day of the month in which you end active employment. However, you generally will be eligible to continue participation for a certain period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.) The health care plans cannot reimburse expenses incurred after the end of the month in which you leave JPMorgan Chase unless you choose to continue your participation under COBRA or under JPMorgan Chase retiree coverage. For more information, please see the **As You Leave Guide** on **me@jpmc**.

- The provisions noted above for the health care plans also apply to the expatriate medical and dental options. If you are a U.S. home-based expatriate or on expatriate assignment to the U.S., under certain circumstances, you may be eligible to continue participation for a certain period of time under COBRA. Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for COBRA continuation coverage.

For the Health Care Spending Account, if you are participating in the Health Care Spending Account when your employment with JPMorgan Chase ends, you will be covered for eligible expenses incurred in the plan year up to the end of the month in which you terminate. You then have until March 31 of the year following your termination from JPMorgan Chase to submit claims for any eligible expenses incurred during the previous year, up to the end of the month in which you terminate. Expenses incurred after the end of the month in which you leave JPMorgan Chase cannot be reimbursed by the JPMorgan Chase Health Care Spending Account unless you choose to continue your Health Care Spending Account participation under COBRA. By electing continuation coverage under COBRA, you may continue your Health Care Spending Account participation through any month up until the end of the year in which your employment ends, if you make after-tax contributions to the account. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

For the Dependent Care Spending Account, if you have a balance remaining in the Dependent Care Spending Account when your employment with JPMorgan Chase ends, you may continue to submit claims against the balance in the account for eligible expenses incurred in the plan year up to your termination date. You then have until March 31 of the year following your termination from JPMorgan Chase to submit claims for any eligible expenses incurred during the previous year, up to your termination date. Expenses incurred after your termination date cannot be reimbursed by the JPMorgan Chase Dependent Care Spending Account. You may not continue to make contributions to the Dependent Care Spending Account after your termination.

For the Transportation Spending Accounts, if you have a balance remaining in the “Pay Me Back” option of the Parking Account when you leave, you may continue to submit claims against the balance in your account for up to 180 days following the end of the benefit month (for example, expenses incurred in January must be claimed by July); otherwise, your Parking Account balance will be forfeited. You may not continue to make contributions to the Transportation Spending Accounts after your termination. If you are planning to leave the company, you should change your contribution amount to zero no later than the first day of the month preceding the month in which your employment terminates in order to avoid forfeiting any contributions. The Transportation Spending Accounts, under Section 132 of the Internal Revenue regulations, allow qualified transportation expenses to be excluded from an employee’s gross income. Under these regulations, before-tax contributions are non-refundable to the employee under any circumstances including termination of employment.

For the Life and Accident Insurance Plans, if your employment with JPMorgan Chase terminates, active participation in the Business Travel Accident, Basic Life, Supplemental Term Life and AD&D Insurance Plans generally end on the date your employment ends. For more information, please see the *Life and Accident Insurance* section.

- **For Basic Life**, upon receipt of the MetLife conversion package at your home mailing address, and within 31 days of your termination date, you may convert any portion of your Basic Life Insurance to an individual policy by contacting Metropolitan Life Insurance Company (MetLife), the plan administrator. Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will be able to address any questions on how much to convert to an individual policy. MetLife will bill you directly.

If You Port or Convert

For any policies you port or convert, you must designate beneficiaries directly with MetLife.

- **For Supplemental Term Life**, within 31 days of your termination date, you have the option to convert your employee and/or dependent life insurance coverage to an individual life policy or port that coverage following your termination of employment as follows:
  - Employee Supplemental Life Insurance:
    - You may convert the coverage to an individual policy; OR
    - You may port the lesser of your total life insurance in effect at date of termination – you can port a minimum of $10,000 or up to $2 million (in increments of $25,000)
    - You must provide MetLife evidence of insurability for the additional coverage amount
    - If you are already at the $2 million maximum you may not increase your coverage.
  - Dependent Spouse Supplemental Life Insurance:
    - You may convert the coverage to an individual policy; OR
    - You may port the minimum of $2,500 ($10,000 when porting Dependent Spouse life insurance alone) to a maximum of the lesser of your total dependent spouse life insurance in effect at date of termination, or $300,000.
  - Dependent Child Supplemental Life Insurance:
    - You may convert the coverage to an individual policy; OR
    - You may port your dependent child supplemental life insurance coverage at a minimum of $1,000 to a maximum of the lesser of the total amount in effect at the date of termination or $20,000.
- **For Accidental Death and Dismemberment (AD&D) Insurance:**
  - You may port the lesser of your total AD&D Insurance in effect on the day you elect to port or up to $2 million of your employee AD&D coverage with Metropolitan Life Insurance Company (MetLife) within 31 days of your termination date.
  - When you leave JPMorgan Chase, you may increase the amount of your portable AD&D coverage in increments of $25,000, up to a maximum of $2 million. Evidence of Insurability (EOI) may be required.
  - You may also port any dependent AD&D coverage, but only if you elect to port your employee AD&D coverage.
  - Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will also be able to address any questions on how much AD&D coverage to port for you and/or your dependents.
  - When you port your coverage(s), MetLife will bill you directly.
- **For Business Travel Accident Insurance**, you may not convert or port this coverage to an individual policy.
- For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

Porting Versus Converting Insurance Policies

When leaving the company, you may be able to either "port" or "convert" the group insurance policy to an individual policy. Both typically result in higher rates than a group policy, but there are differences.

- When you convert an insurance policy, you are not required to provide proof of insurability to receive coverage. The premium you pay is based on your age at the time of policy conversion.
- When you port a policy, you must provide proof of insurability to receive preferred, or less expensive, premiums. Also, the premiums generally change as you age.

For the Group Legal Services Plan, if your employment with JPMorgan Chase terminates, coverage for you and your covered dependents usually ends on your termination date. You have the option to continue coverage by contacting MetLife Legal Plans, the claims administrator, within 31 days of the date your coverage ends and electing to continue the Plan. Currently you can continue the Plan for an additional 12 months with direct payment to MetLife Legal Plans. Any services in progress before your termination date will be provided, even if you don't continue coverage.

For the Group Personal Excess Liability Plan, if your employment with JPMorgan Chase terminates, participation for you and your covered dependents ends 60 days from your termination date or the policy anniversary date, whichever is sooner. Marsh McLennan Agency Private Client Services can assist with securing replacement coverage. For more information, please see the **As You Leave Guide** on **me@jpmc**.

Your Expatriate Assignment Ends

If your expatriate assignment ends, your Expatriate Medical and/or Dental Plan coverage will end on the last day of the month in which your work status changes. If you remain an active JPMorgan Chase employee, you will need to elect coverage under your local/domestic, home-country medical plan and/or dental plan.

You Retire from JPMorgan Chase

For medical, dental, and vision coverage: You need to meet minimum age and service requirements at the time of retirement to be eligible for retiree medical, dental, and vision coverage.

For expatriate medical and dental coverage, you must be a U.S. home-based expatriate employee and meet minimum age and service requirements and have active medical coverage at the time of retirement to be eligible for U.S. retiree medical coverage.

- For more information, please see the **As You Leave Guide** on **me@jpmc**.
- **For the Medical Reimbursement Account (MRA)**, you may continue to use any remaining MRA funds, though you cannot earn or receive additional MRA funds.

For the Health Care Spending Account, if you are participating in the Health Care Spending Account when your employment with JPMorgan Chase ends, you will be covered for eligible expenses incurred in the plan year up to the end of the month in which you terminate. You then have until March 31 of the year following your termination from JPMorgan Chase to submit claims for any eligible expenses incurred during the previous year, up to the end of the month in which you terminate. Expenses incurred after the end of the month in which you leave JPMorgan Chase cannot be reimbursed by the JPMorgan Chase Health Care Spending Account unless you choose to continue your Health Care Spending Account participation under COBRA. By electing continuation coverage under COBRA, you may continue your Health Care Spending Account participation through any month up until the end of the year in which your employment ends, if you make after-tax contributions to the account. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

For the Dependent Care Spending Account, if you have a balance remaining in the Dependent Care Spending Account when your employment with JPMorgan Chase ends, you may continue to submit claims against the balance in the account for eligible expenses incurred in the plan year up to your termination date. You then have until March 31 of the year following your termination from JPMorgan Chase to submit claims for any eligible expenses incurred during the previous year, up to your termination date. Expenses incurred after your termination date cannot be reimbursed by the JPMorgan Chase Dependent Care Spending Account. You may not continue to make contributions to the Dependent Care Spending Account after your termination.

For the Transportation Spending Accounts, if you have a balance remaining in the "Pay Me Back" option of the Parking Account when you leave, you may continue to submit claims against the balance in your account for up to 180 days following the end of the benefit month (for example, expenses incurred in January must be claimed by July); otherwise, your Parking Account balance will be forfeited. You may not continue to make contributions to the Transportation Spending Accounts after your termination. If you are planning to leave the company, you should change your contribution amount to zero approximately one month before your departure in order to avoid forfeiting any contributions. The Transportation Spending Accounts, under Section 132 of the Internal Revenue regulations, allow qualified transportation expenses to be excluded from an employee's gross income. Under these regulations, before-tax contributions are non-refundable to the employee under any circumstances including termination of employment.

For the Life and Accident Insurance Plans, if your employment with JPMorgan Chase terminates, active participation in the Business Travel Accident, Basic Life, Supplemental Term Life and AD&D Insurance Plans generally end on the date your employment ends. For more information, please see the *Life and Accident Insurance* section.

- **Retiree Life Insurance Coverage may be available.** You need to meet minimum age and service requirements at the time of retirement to be eligible for retiree medical and dental coverage. For details on the eligibility requirements, please see the **As You Leave Guide** on **me@jpmc**.
- **For Basic Life**, upon receipt of the MetLife conversion package at your home mailing address, and within 31 days of your retirement date, you may convert any portion of your Basic Life Insurance (over the first $10,000) to an individual policy by contacting Metropolitan Life Insurance Company (MetLife), the plan administrator. Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will be able to address any questions on how much to convert to an individual policy. MetLife will bill you directly after you retire.

If You Port or Convert

For any policies you port or convert, you must designate beneficiaries directly with MetLife.

- **For Supplemental Term Life**, within 31 days of your retirement date, you have the option to convert your employee and/or dependent life insurance coverage to an individual life policy or port that coverage following your retirement as follows:
  - Employee Supplemental Life Insurance: You may port up to $2 million of your employee Supplemental Term Life Insurance with MetLife within 31 days of your retirement date.
  - When you retire from JPMorgan Chase, you may increase the amount of your portable employee supplemental life insurance coverage in increments of $25,000, up to a maximum of $2 million. You must provide evidence of insurability for the additional coverage amount. If you are already carrying the maximum amount of coverage, you may not increase your coverage.
  - You have two options for Dependent Supplemental Life Insurance:
    1. If you elect to port your employee supplemental life insurance, you also have the opportunity to port your dependent supplemental life insurance
    2. If you do not elect to port your employee supplemental life coverage but want to continue coverage for your dependents, you must convert your dependent supplemental life insurance to an individual whole life policy

- **For Accidental Death and Dismemberment (AD&D) Insurance:**
  - When you retire from JPMorgan Chase, you may port up to $2 million of your employee AD&D coverage with Metropolitan Life Insurance Company (MetLife) within 31 days of your retirement date.
  - When you leave JPMorgan Chase, you may increase the amount of your portable AD&D coverage in increments of $25,000, up to a maximum of $2 million. You must provide evidence of insurability for the additional coverage amount.
    - If you're age 80 or older, your benefit will be limited to $100,000.
  - You may also port any dependent AD&D coverage, but only if you elect to port your employee AD&D coverage.
  - Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will also be able to address any questions on how much AD&D coverage to port for you and/or your dependents.
  - When you port your coverage(s), MetLife will bill you directly.
- **For Business Travel Accident Insurance**, you may not convert or port this coverage to an individual policy.
- For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

For the Health & Wellness Centers Plan, if you retire from JPMorgan Chase, your Health & Wellness Centers Plan coverage will end on the last day of the month in which you retire. However, you generally will be eligible to continue participation for a certain period of time under COBRA, if elected. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.) For more information, please see the **As You Leave Guide** on **me@jpmc**.

For the Group Legal Services Plan, if you retire from JPMorgan Chase, coverage for you and your covered dependents ends on your retirement date. Any services in progress before your termination date will be provided, even if you don't continue coverage. For more information, please see the **As You Leave Guide** on **me@jpmc**.

For the Group Personal Excess Liability Insurance Plan, if you retire from JPMorgan Chase, coverage for you and your covered dependents ends 60 days from your retirement date, or the policy anniversary date, whichever is sooner. For more information, please see the **As You Leave Guide** on **me@jpmc**.

You Work Past Age 65

For medical, dental, and vision coverage and Healthcare Spending Accounts: If you continue to work for JPMorgan Chase after you reach age 65, you can continue participating in these plans, as long as you meet all the other eligibility requirements to participate.

For Life and Accident Insurance Plans: If you continue to work for JPMorgan Chase after you reach age 65, you may continue to participate in the Life and Accident Insurance Plans, as long as you are actively employed and meet all eligibility requirements.

- If you continue working after age 75, AD&D coverage is limited to no more than $200,000 beginning the January 1 after the year in which you reach age 75, and is reduced to a maximum of $100,000 beginning the January 1 after the year in which you reach age 80. This limitation also applies to your spouse/domestic partner.

For the Health & Wellness Centers Plan: If you continue to work for JPMorgan Chase after you reach age 65, you may continue to participate in the Health & Wellness Centers Plan, as long as you are actively employed and meet all eligibility requirements.

For the Group Legal Services Plan: If you continue to work for JPMorgan Chase after you reach age 65, you and your covered dependents can continue to be covered under the Group Legal Services Plan.

For the Group Personal Excess Liability Plan: If you continue to work for JPMorgan Chase after you reach age 65, you may continue to participate in the Plan, as long as you are actively employed and meet all eligibility requirements.

Health Care Benefits

Effective 1/1/22

Your health is important to you and to JPMorgan Chase . That's why the company provides you and your family with access to high-quality, cost-effective health care coverage and to the resources you need to stay healthy.

Our health benefit plans are built on the principle of a shared commitment to health.

- *JPMorgan Chase provides valuable benefits, funding, and a suite of features designed to help you get and pay for the care you need, manage your health care expenses, and, most importantly, take care of yourself and your family.*
- *Your role is to take responsibility for the controllable aspects of your health and your spending on health care. You can do this by staying informed about healthy lifestyle choices, getting preventive care, carefully selecting your doctors and hospitals, and understanding your treatment options and their costs before receiving services.*

How This Section Is Organized

This *Health Care Benefits* section has separate subsections for:

- The Medical Plan (including prescription drugs, the Medical Reimbursement Account (MRA), the U.S. Fertility Benefits Program, and wellness benefits);
  - For eligible employees in the United States, the plan has two options: the Simplified Medical Plan for employees in Arizona and Ohio and the Core Medical Plan for all other U.S. employees. Employees in Hawaii have a different option, and employees in California have an additional option, and these options are described in documents separate from this Guide.
- The Dental Plan; and
- The Vision Plan.

Because these three plans have the same rules about who is eligible, how you enroll, what happens when coverage ends, and COBRA information there is a separate subsection called *Health Care Participation* that covers those rules.

COBRA Continuation

The health plans described in this section are subject to special rules that can offer you an opportunity to continue coverage under JPMorgan Chase 's plans even when coverage for you or a dependent would otherwise end. See "Continuing Coverage Under COBRA" in the *Health Care Participation* section for details.

Health Care Participation

Effective 1/1/22

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

Be Sure to See *What Happens If …*

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

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

About This Summary

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

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

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

Table of Contents Page

Who's Eligible?

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

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

Who's Not Eligible

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

Examples of such individuals include an:

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

When You Become Eligible

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

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

Eligible Dependents

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

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

- Your spouse or domestic partner (see "Domestic Partners" on page 33 for more information); and
- Your and/or your spouse's/domestic partner's children up to the last day of the month in which they reach age 26*, regardless of student or marital status, financial dependence on parents, residency with parents, or eligibility for coverage under another health plan. To cover your domestic partner's children, you must elect coverage for your domestic partner.

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

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

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

Important Note on Dependent Eligibility

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

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

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

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

Spouse

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

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

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

Children

"Children" include the following:

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

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

Domestic Partners

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

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

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

OR

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

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

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

Qualified Medical Child Support Orders

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

Enrolling

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

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

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

Medical and Dental Plan Options

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

Core Medical Plan

Dental

Elections a la Carte!

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

Coverage Levels

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

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

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

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

An Important Note on Dependent Coverage

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

Tax Treatment of Domestic Partner Coverage

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

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

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

Enrolling a Domestic Partner

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

How to Enroll

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

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

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

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

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

Enrolling if You Are an Employee

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

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

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

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

Enrolling if You Are a Newly Hired Employee

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

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

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

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

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

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

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

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

If You Do *Not* Enroll

Coverage if You Do Not Enroll and You Are an Employee

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

Re-enrollment May Differ for Other Plans

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

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

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

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

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

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

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

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

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

When Coverage Begins

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

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

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

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

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

When Payroll Contributions Begin

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

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

Retroactive Contributions as Necessary

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

Changing Your Coverage Midyear

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

Important Note About Providers Leaving Networks

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

Qualified Events

Qualified Status Changes (QSCs) include:

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

Making the Changes

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

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

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

Allowable Changes

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

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

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

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

* Call HR Answers

HIPAA Special Enrollment Rights

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

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

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

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

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

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

When Coverage Ends

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

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

When Dependent Coverage Ends

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

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

Continuing Health Coverage Under COBRA

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

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

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

COBRA coverage applies to the:

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

What's Included with COBRA Medical Plan Coverage

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

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

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

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

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

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

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

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

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

Qualified Beneficiary

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

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

Qualifying Events

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

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

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

Continuation Coverage for a Domestic Partner Dependent

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

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

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

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

Giving Notice of a COBRA Qualifying Event

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

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

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

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

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

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

Updating Your Personal Contact Information

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

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

Choosing COBRA Coverage

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

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

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

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

Premium Due Dates

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

Coverage During the Continuation Period

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

COBRA Coverage Costs

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

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

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

Company-Subsidized COBRA Coverage

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

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

How Continued Coverage Could End

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

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

The MRA and COBRA

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

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

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

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

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

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

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

Special Rule for Health Care Spending Account Participants

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

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

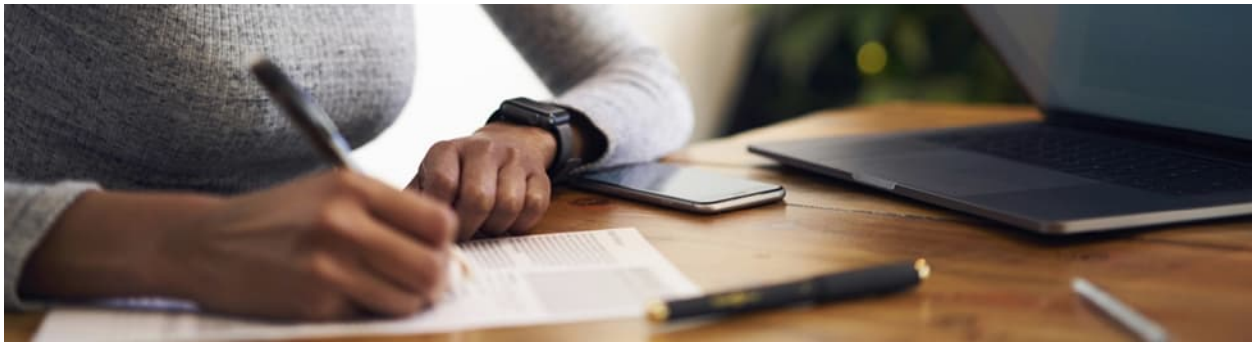
Additional Questions About COBRA Coverage

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

Defined Terms

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

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



Plan Administration

Effective 1/1/22

This section of the Guide provides you with important information as required by the Employee Retirement Income Security Act of 1974 (ERISA) about the JPMorgan Chase Health Care and Insurance Plans for Active Employees. While ERISA doesn't require JPMorgan Chase to provide you with benefits, by choosing to do so, ERISA mandates that JPMorgan Chase clearly communicate to you how the plans subject to the provisions of ERISA operate and what rights you have under the law regarding plan benefits. This section is part of the summary plan description of each of your JPMorgan Chase Health Care and Insurance Plans for Active Employees governed by ERISA. This section of the Guide also provides important information about certain benefits plans that are not governed by ERISA, such as the Group Personal Excess Liability Plan.

While the U.S. Fertility Benefits Program is a benefit offered under the Medical Plan, the section describing the Fertility Benefits Program includes the information that is included in this Plan Administration section for most other plans.

For most plans, the summary plan description and the plan document are the same document. For plans where this is not the case, copies of the plan documents are filed with the plan administrator and are available upon request. For plans that are funded through insurance, if there is a discrepancy between the insurance policy and the SPD, the insurance policy will govern.

About This Section

This section summarizes administrative information and rights for the Health Care and Insurance Plans for Active Employees. Please retain this section for your records. Other sections may be needed in addition to this section to provide a complete summary plan description (SPD) and/or plan document for a plan, including the sections that describe the benefits the plan provides.

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

Questions?

Please see the *Contacts* section as well as the "Questions?" box at the start of each section of this Guide for details on where to call and how to access the appropriate web center for each benefit plan. Each section of the Guide also includes a subsection titled "Claims Administrators' Contact Information."

For questions about eligibility and plan operations, 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 – Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays.

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

Table of Contents Page

General Information

The following summarizes important administrative information about the JPMorgan Chase Health Care and Insurance Plans for Active Employees governed by ERISA. **Please Note**: Each plan can be identified by a specific plan number, which is on file with the U.S. Department of Labor. Please see "Plan Administrative Information" on page 361 for a listing of official plan names and numbers.

Keep Your Information Current

Update your contact information (home address and phone numbers) on **me@JPMC** To access My Personal Profile while actively employed, go to **me@JPMC** – Personal Information – Contact Information.

Plan Sponsor

JPMorgan Chase Bank, NA
545 Washington Boulevard
12th Floor
Mail Code: NY1-G120
Jersey City, NJ 07310

(Certain participating companies have adopted some or all of the plans for their eligible employees. See "Participating Companies" on page 362 for a list of participating companies.)

Plan Year

January 1 – December 31

Plan Administrator

For all plans described in this Guide except for the Business Travel Accident Insurance and the Short-Term Disability Plan:

JPMorgan Chase U.S. Benefits Executive
c/o JPMorgan Chase Benefits Administration
545 Washington Boulevard
12th Floor
Mail Code: NY1-G120
Jersey City, NJ 07310

For the Business Travel Accident Insurance Plan:

JPMorgan Chase Corporate Insurance Services
JPMorgan Chase & Co.
8181 Communications Pkwy Bldg B, Floor 03
Mail Code TXW-3305
Plano, TX 75024-0239, United States

For Short-Term Disability Plan (Not applicable to the JPMorgan Chase Long-Term Disability Plan):

JPMorgan Chase Employee Relations Executive
JPMorgan Chase & Co.
201 N Walnut Street DE1-1053
Wilmington, DE 19801

Claims Administrator

The contact information for claims administrators for the various benefits plans can be found under “Contacting the Claims Administrator” on page 371 and “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 496.

COBRA Administrator

COBRA questions should be directed to JPMorgan Chase HR Answers.

COBRA payments should be directed to:

COBRA Payments JPMorgan Chase
P.O. Box 27524
New York, NY 10087-7524

(877) 576-2427

Benefits Fiduciaries

Please see “About Plan Fiduciaries” on page 363 for information on benefits fiduciaries.

Agent for Service of Legal Process

RCO Centralized Mail
Mail Code: LA4-7100
700 Kansas Lane
Monroe, LA 71203-4774

Service of legal process may also be made upon a plan trustee or the plan administrator.

Employer Identification Number

13-4994650

Plan Administrative Information

The following chart shows the information that varies by plan. All of the following plans are governed by ERISA. (The Dependent Care Spending Account, Transportation Spending Accounts, and the Group Personal Excess Liability Insurance Plan are not governed by ERISA and are not listed here. For more information, see "Contacting the Claims Administrators: Plans Not Subject to ERISA" on page 496.) In no event will any of these Administrators pay, on behalf of the JPMorgan Chase benefit programs, any benefit that may be illegal under the law of the State in which the benefit is provided or performed.

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Medical Plan/502	Aetna and Cigna See “Contacting the Claims Administrator” on page 371 for names, addresses, and telephone numbers for the Medical Plan and the Prescription Drug Plan.	See “Contacting the Claims Administrator” on page 371 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug Plan.	Self-Insured/Trustee

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Medical Plan/502	Kaiser HMO	See "Contacting the Claims Administrator" on page 371 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug Plan.	Fully-Insured
The JPMorgan Chase Medical Plan/502	Hawaii Medical	See "Contacting the Claims Administrator" on page 371 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug Plan.	Fully-Insured
The JPMorgan Chase Dental Plan/502	See "Contacting the Claims Administrator" on page 371 for names and addresses for the Preferred Dentist Program (PDP) Option, the Dental Maintenance Organization (DMO) Option, the Dental Health Maintenance Organization (DHMO) Option, and the Expatriate Dental Option.	See "Contacting the Claims Administrator" on page 371 for names, addresses, and telephone numbers for the PDP Option, the DMO Option, the DHMO Option, and the Expatriate Dental Option.	Self-Insured/Trustee: PDP Option and Expatriate Dental Option Fully Insured: DMO Option and DHMO Option
The JPMorgan Chase Vision Plan/502 (Group 1018009)	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111	Fully Insured
The JPMorgan Chase Basic Life Insurance Plan/502*	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured
The JPMorgan Chase Supplemental Term Life Insurance Plan/502*	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Accidental Death and Dismemberment (AD&D) Insurance Plan/502	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured
The JPMorgan Chase Long-Term Disability Plan's Group (LTD)/502	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176	Fully Insured
The JPMorgan Chase Long-Term Disability Plan's Individual Disability Insurance (IDI)/502	Unum 1 Fountain Square Chattanooga, TN 37402	Unum The Benefits Center P.O. Box 100262 Columbia, SC 29202-3262	Fully-Insured
The JPMorgan Chase Group Legal Services Plan/502	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114	Fully Insured
The JPMorgan Chase Employee Assistance Program (EAP)/502	Administrator: Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152	Administrator: Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152	Fully-Insured (CA & NV—clinical component only) Pre-Paid Service (all other)
The JPMorgan Chase Back-up Child Care Plan/502	N/A	Bright Horizons Children's Centers LLC 2 Wells Avenue Newton, MA 02459	Self-Insured
The JPMorgan Chase Business Travel Accident (BTA) Insurance Plan/506	AIG — National Union Fire Insurance Company of Pittsburgh, PA 17200 West 119 St. Shawnee Mission, KS 66225	AIG — National Union Fire Insurance Company of Pittsburgh, PA 17200 West 119 St. Shawnee Mission, KS 66225	Fully Insured

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Health Care Spending Account Plan/510	N/A	See "Contacting the Claims Administrator" on page 371 for names, addresses, and telephone numbers for the Health Care Spending Account Plan	Salary Reduction/ Paid from the general assets of the employer
The JPMorgan Chase Short-Term Disability Plan/548	N/A	Sedgwick Claims Management Services JPMorgan Chase Leave of Absence Service Center P.O. Box 14648 Lexington, KY 40512-4648	Self-Insured
The JPMorgan Chase Health & Wellness Centers Plan/559	N/A	JPMorgan Chase Medical Director JPMorgan Chase & Co. 270 Park Avenue, 11th Floor Mail Code: NY1-K318 New York, NY 10017-2014	Self-Insured

* The JPMorgan Chase Basic Life Insurance Plan and the JPMorgan Chase Supplemental Term Life Insurance Plan are collectively referred to as the "Life Insurance Plan" in this SPD.

Participating Companies

In some cases, affiliates or subsidiaries of JPMorgan Chase have decided to participate in the JPMorgan Chase benefits plans and offer the benefits described in this Guide. These affiliates or subsidiaries are referred to here as "participating companies." The list may change from time to time, and any company may end its participation in a plan at any time.

- Bear Stearns Asset Management, Inc.
- Campbell Global, LLC
- Connexions Loyalty Acquisitions, LLC
- eCAST Settlement Corporation
- FNBC Leasing Corporation
- Highbridge Capital Management, LLC
- InstaMed Communications, LLC
- The Infatuation Inc.
- JPMorgan Chase & Co.
- J.P. Morgan Alternative Asset Management, Inc.
- J.P. Morgan Chase Custody Services, Inc.
- J.P. Morgan Electronic Financial Services, Inc.
- J.P. Morgan Institutional Investments, Inc.
- J.P. Morgan Invest Holdings LLC
- J.P. Morgan Investment Management Inc.

- J.P. Morgan Securities, LLC
- J.P. Morgan Trust Company of Delaware
- JPMorgan Chase Bank, National Association
- JPMorgan Chase Holdings LLC
- JPMorgan Distribution Services, Inc.
- Neovest, Inc.
- Open Invest Co.
- Paymentech, LLC
- Security Capital Research & Management, Incorporated
- WePay, Inc.
- 55i, LLC

Your Rights Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) gives you certain rights and protections while you are a participant in the JPMorgan Chase employee benefits plans described in this Guide. It is unlikely you will need to exercise these rights, but it is important that you be aware of what they are.

ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the office of the plan administrator, all plan documents including insurance contracts and copies of all documents filed by the plans with the U.S. Department of Labor, such as detailed annual reports (Form 5500 Series).
- Obtain, upon written request to the plan administrator, copies of all plan documents and other plan information (for example, insurance contracts, Form 5500 Series, and updated summary plan descriptions). The plan administrator may require reasonable charges for the copies.
- Receive a summary of the plans' annual financial reports. (The plan administrator is required by law to furnish each participant with a copy of such reports.)
- Continue health care coverage for yourself, your spouse, or your eligible dependents if there is a loss of coverage under the plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

An Important Note

The Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan are not subject to the provisions of ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision free of charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of the plans' documents or the latest annual report from the plan administrator and do not receive it within 30 days, you may file suit in a U.S. federal court. In such a case, the court may require the plan administrator to provide the information and pay up to $110 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the plan administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a U.S. state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

Keep Your Contact Information Current

Active participants are required to update their personal contact information, including mailing address, to receive benefits-related information and correspondence. You can make changes online via **me@JPMC** – Personal Information – Contact Information. You can also contact HR Answers. See the *Contacts* section.

- If it should happen that the plans' fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a U.S. federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

About Plan Fiduciaries

The plan "fiduciary" is the individual or organization responsible for plan administration, claims administration, and managing plan assets. The plan fiduciary has a duty to administer the plan prudently and in the best interest of all plan members and beneficiaries.

Prudent Actions by Plan Fiduciaries

In addition to establishing the rights of plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefits plans. Certain individuals who are responsible for the plans are called "fiduciaries," and they have a duty to administer the plans prudently and in the interest of you, other plan members, and beneficiaries. While participation in these plans does not guarantee your right to continued employment, no one — including your employer or any other person — may terminate you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

Health Care and Insurance Plans for Active Employees

For each of the following plans that are governed by ERISA, the plan administrators delegate fiduciary responsibility for claims and appeals to the claims administrators, and to the Health Care and Insurance Plans Appeals Committee, where that committee is authorized to decide appeals as described in this Guide:

- Medical Plan;
- Prescription Drug Plan;
- Fertility Benefits Program;
- Dental Plan;
- Health Care Spending Account Plan;
- Vision Plan;
- Health & Wellness Centers Plan;
- Life and AD&D Insurance Plans;
- Business Travel Accident Insurance Plan;
- Long-Term Disability Plan, including Group LTD and Individual Disability Insurance;
- Short-Term Disability Plan;
- Employee Assistance Program;
- Group Legal Services Plan; and
- Back-Up Child Care Plan.

Assistance with Your Questions

If you have any questions about the JPMorgan Chase Health Care and Insurance Plans for Active Employees, you should contact HR Answers. (See the *Contacts* section.) If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Regional Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by visiting www.dol.gov/ebsa via the Internet.

You should also contact the Department of Labor if you need further assistance or information about your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with respect to health benefits that are offered through a group health plan, as well as the remedies available if a claim is denied in whole or in part.

Privacy Information

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

If you are enrolled in the Medical Plan, your health care company will have access to your individual health care and prescription claims data, in addition to the results of your Wellness Screening and Wellness Assessment. A medical professional at your health care company will review the results and may contact you to discuss ways to improve your health. Your health care company maintains the confidentiality of your information in accordance with privacy regulations such as HIPAA.

Similarly, if you have waived coverage under the JPMorgan Chase Medical Plan and you participate in the Wellness Screening and Wellness Assessment, a medical professional at Cigna will review the results and may contact you to discuss ways to improve your health. Cigna will maintain the confidentiality of your information in accordance with privacy regulations such as HIPAA.

If you use a JPMorgan Chase Health & Wellness Center, your personal health information is likewise kept confidential. While the JPMorgan Chase Health & Wellness Centers are staffed with nurses and some doctors who are employed by JPMorgan Chase, they are medical professionals and do not disclose your personal health information to anyone outside the Center without your permission. If you choose to visit one of our onsite Health & Wellness Centers, and/or share your Wellness Screening results or any other health information with staff in the Centers, that information will be kept private and will not be shared with management, Human Resources, or any other individual or group within JPMorgan Chase. For more information, go to **My Health** > Benefits Enrollment > Benefits Resources > Privacy Notice.

Privacy Notice

JPMorgan Chase is committed to maintaining the highest level of privacy and discretion about 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.

You can access the Privacy Notice at **My Health** 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 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 Medical Plan may only use and disclose participants' protected health information in connection with payment, treatment, and health care operations. In addition, the Medical Plan must restrict access to and use of protected health information by all employees/groups except for those specifically involved in administering the Medical Plan, including payment and health care operations. In compliance with HIPAA, the 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 Medical Plan gives protected health information agree to the same restrictions and conditions that apply to the 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 if 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 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 Medical Plan's compliance with HIPAA;
- Return or destroy all protected health information received in any form from the claims administrators. The 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 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 Medical Plan for its own training program; or
  - Use or disclosure by the 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 this address:

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

Claims Related to Eligibility to Participate in the Plans and Plan Operations

This section provides information about the claims and appeals process for questions relating to eligibility to participate in the plans, such as whether you meet the requirements of employees/dependents/beneficiaries who are allowed to obtain benefits under the plans, and whether you are eligible for Medical Reimbursement Account (MRA) funds. In addition, if, with respect to the plans subject to ERISA, you have a type of claim that is not otherwise described in this Guide, including claims related to general plan operations or Section 510 of ERISA, you must file your claim in accordance with this section. For information on filing claims for benefits, please see "Claiming Benefits" beginning on page 367.

In addition, for appeals relating to eligibility to participate in the Short-Term Disability Plan, the plan administrator delegates responsibility to decide the appeals to the Short-Term Disability Plan Appeals Committee.

Help Pursuing Claims for Eligibility

You may authorize someone else to pursue claim information on your behalf. If you would like to designate an authorized representative for claims related to eligibility to participate in a plan, please contact HR Answers.

How to File This Type of Claim and What You Can Expect

For questions about eligibility to participate in the Health Care and Insurance Plans for Active Employees and to receive benefits or about general plan operations, please contact HR Answers. (See the *Contacts* section.)

For the plans that are subject to ERISA, if you are not satisfied with the response, you may file a written claim with the appropriate plan administrator at the address provided in "General Information" on page 360. The plan administrator will assign your claim for a determination. You must file your claim within 90 days after the day you knew, or reasonably should have known, that you have a dispute with the plan regarding the matter that you wish to have revised or addressed. You will receive a written decision within 90 days of receipt of your claim. Under certain circumstances, this 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your request. In this situation, you will receive written notice of the extension and the reasons for it, as well as the date by which a decision is expected to be made, before the end of the initial 90-day period. If the extension is required because of your failure to submit information necessary to decide the claim, the period for making the determination will begin as of the date you submit the additional information, assuming it is provided in a timely fashion.

If Your Claim Is Denied

If you receive a notice that your claim has been denied, either in full or in part, the notice will explain the reason for the denial, including references to specific plan provisions on which the denial was based. If your claim was denied because you did not furnish complete information or documentation, the notice will state the additional materials needed to support your claim. The notice will also tell you how to request a review of the denied claim and the time limits applicable to those procedures.

To appeal a denial of the type of claims described in this section for any of the Health Care and Insurance Plans for Active Employees, you must submit a written request for appeal of your claim to the appropriate plan administrator within 60 days after receiving the notice of denial. In connection with your appeal, you may submit written comments, documents, records, or other information relevant to your claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to your claim. The plan administrator for the Business Travel Accident Insurance Plan will decide your appeal under that plan. The plan administrator for the Short Term Disability Plan will decide appeals under that plan. The Health Care and Insurance Plans Appeals Committee is delegated responsibility for deciding appeals under all other Health Care and Insurance Plans for Active Employees. For appeals regarding general plan operations that are not otherwise described in this plan description, including claims related to general plan operations or Section 510 of ERISA, the appeal will be decided by the Plan Administrator or its delegate.

In most cases, a decision will be made within 60 days after you file your appeal. But if special circumstances require an extension of time for processing, and you are notified that there will be a delay and the reasons for needing more time, there will be an extension of up to 60 days for deciding your appeal. If an extension is necessary because you did not submit enough information to decide your appeal, the timing for making a decision about your appeal is stopped from the date the plan administrator sends you an extension notification until the date that you respond to the request for additional information, assuming your response comes within a reasonable time frame.

Once a decision is reached, you will be notified in writing of the outcome. If an adverse benefit determination is made on review, the notice will include the specific reasons for the decision, with references to specific plan provisions on which it is based.

If you would like to file a court action after your appeal, please see "Filing a Court Action" on page 371, which sets forth the rules that will apply.

Claiming Benefits: Plans Subject to ERISA

An Important Reminder

The Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan are not subject to the provisions of ERISA described in this section. For information about those plans, please see "Contacting the Claims Administrators: Plans Not Subject to ERISA" beginning on page 496.

This section explains the benefits claims and appeals process for the benefits of the JPMorgan Chase Health Care and Insurance Plans for Active Employees that are subject to the Employee Retirement Income Security Act of 1974 (ERISA). It includes detailed information about what happens at each step in the process and includes important timing requirements. This section also includes information about each plan's "fiduciary" and contact information. See "About Plan Fiduciaries" on page 363 and "Contacting the Claims Administrator" on page 371. For claims relating to eligibility questions or plan operations, please see "Claims Related to Eligibility to Participate in the Plans and Plan Operations" on page 483.

Please Note: Any claims or appeals that are related to a disability will be handled in accordance with the Department of Labor regulations found in Code 29 Section 2560. This section of the Code provides certain procedural protections and safeguards for disability benefit claims. For example, the regulations require that disability claimants receive a clear explanation of why their claim was denied and of their rights to appeal a claim denial. It also allows claimants to review and respond during the course of an appeal to any new or additional evidence that the Plan relied on in connections with the claim.

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 Medical, Dental, and Vision Plans, 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.

Steps in the Benefits Claims and Appeals Process

Step 1: Filing Your Initial Claim for Benefits

In general, when you file a claim for benefits, it is paid according to the provisions of the specific benefits plan. There are different timing requirements for different plans, as outlined in the following table. For all initial benefits claims, please contact the appropriate claims administrator for the plan. See "Contacting the Claims Administrator" on page 371.

Plan/Option	Appropriate Claims Administrator	Timing for Filing Your Initial Claim
Medical Plan*, including the Medical Reimbursement Account	Claims administrator for your Medical Plan option	No later than December 31 of the year after the year in which services were provided. Please contact your claims administrator for more information.
Prescription Drug Plan	CVS Caremark	
Dental Plan*	Claims administrator for your Dental Plan option	
Vision Plan*	FAA/EyeMed Vision Care	

Plan/Option	Appropriate Claims Administrator	Timing for Filing Your Initial Claim
Fertility Benefits Program	WINFertility	Your initial claims must be filed no later than six months of when the expenses are incurred. Generally, in-network claims filing is performed by the physician or care provider.
Health Care Spending Account	Claims administrator for your Health Care Spending Account	March 31 of the year following the year for which the expense is incurred.
Life Insurance Plan	Metropolitan Life Insurance Company (MetLife)**	There is no time limit to file a claim after a covered individual passes away.
AD&D Insurance Plan	Metropolitan Life Insurance Company (MetLife)**	Notification of a loss must be made 20 days from the date of loss. Proof must be provided to MetLife within 90 days following the date of an employee's loss.
Business Travel Accident Insurance Plan	AIG-National Union Fire Insurance Company of Pittsburgh, PA	Within 20 days after an employee's loss, or as soon as reasonably possible thereafter.
Group Long-Term Disability	The Prudential Insurance Company of America	Within 272 days (nine months) following the start of the disability***.
Individual Disability Insurance	Unum	Within 30 days following the start of the disability.
Short-Term Disability Plan	Sedgwick	Within 30 days of first day of absence from work.
Group Legal Services Plan**	MetLife Legal Plans, Inc.	No later than December 31 of the year following the year in which services were provided.
Employee Assistance Program	Cigna Behavioral Health, Inc. Insured (CA & NV residents): Cigna Health and Life Insurance Company	Within 90 days from date of service.
Health & Wellness Centers Plan***	JPMorgan Chase & Co. Health Services Dept. 277 Park Ave, 1st Floor Mail Code: NY1-L085 New York, NY 10172 (212) 270-5555	No later than December 31 of the year following the year in which services were provided.
Back-up Child Care Plan	Bright Horizons Children's Centers LLC 2 Wells Avenue Newton, MA 02459 (888) 701-2235	Within 60 days from the date of service.

* Generally, in-network claims filing is performed by the physician or care provider.

** Notification of a death must be reported to JPMorgan Chase HR Answers; Bereavement Services within HR Answers will notify MetLife of the death on your behalf, allowing you to initiate the claims process. Please note that MetLife has sole responsibility and discretion to resolve any issues regarding beneficiary designations.

*** In certain circumstances, the time limit to file a claim may be up to 637 days (one year and nine months) following the start of the disability. The time limit may be even longer if the employee lacks legal capacity to file a claim earlier.

**** Generally, in-network services are filed by the Group Legal plan attorney.

******The Corporate Medical Director will assign your claim for a determination.

Life Insurance Claims & Appeals

Life insurance claims and appeals are divided between two parties.

- The plan administrator handles all eligibility and other administrative decisions concerning your life insurance benefits.
- MetLife is primarily responsible for determining your beneficiaries. If you submit a claim/appeal regarding a beneficiary designation to the plan administrator, it will be re-rerouted to MetLife.

Step 2: Receiving Notification from the Claims Administrator/Plan Administrator if an Initial Claim for Benefits Is Denied

If an initial claim for benefits is denied, the claims administrator or plan administrator will notify you within a "reasonable" period, not to exceed the time frames outlined in the following table.

Under certain circumstances, the claims administrator or plan administrator, as applicable, is allowed an extension of time to notify you of a denied benefit.

Please Note: If an extension is necessary because you did not submit necessary information needed to process your health care claim or life and AD&D insurance claim, the timing for making a decision about your claim is stopped from the date the claims administrator or plan administrator sends you an extension notification until the date that you respond to the request for additional information. You generally have 45 days from the date you receive the extension notice to send the requested information to the claims administrator or plan administrator.

What Qualifies as a "Denied Benefit"?

A "denied benefit" is any denial, reduction, or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit. In addition, a benefit may be denied if you didn't include enough information with your initial claim.

Plan/Option	Timing for Notification of a Denial of Benefits Claim
Medical Plan, Prescription Drug Plan, Fertility Benefits Program, Dental Plan, Vision Plan, Health Care Spending Account, Employee Assistance Program, and Health & Wellness Centers	• As soon as reasonably possible but no more than 72 hours for claims involving urgent care, where the life of a claimant could be jeopardized (may be oral, with written confirmation within three days). **Please Note**: You must be notified if your claim is approved or denied. • 15 days for pre-service claims, where approval is required before receiving benefits, plus one 15-day extension because of matters beyond the plan's control. • 30 days for post-service claims, where the claim is made after care is received, plus one 15-day extension because of matters beyond the plan's control.
Life Insurance Plan	60 days to make a determination once all claim information has been submitted, plus one extension
AD&D Insurance Plan	45 days, plus one 45-day extension for matters beyond the plan's control.
Business Travel Accident Insurance Plan	90 days, plus one 90-day extension for matters beyond the plan's control
Group Long-Term Disability	45 days, plus two 30-day extensions for matters beyond the plan's control.
Individual Disability Insurance	45 days
Short-Term Disability Plan	45 days, with 2-day extensions
Group Legal Services Plan	30 days, with no extensions
Back-up Child Care Plan	90 days, plus one 90-day extension for matters beyond the plan's control

Please Note: Concurrent care claims are claims for which the plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments. Concurrent care claims may fall under any of the other steps in the claims appeal process, depending on when the appeal is made. However, the plan must give you sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

The Explanation You'll Receive from the Claims Administrator/Plan Administrator in the Case of a Denied Benefit

If your initial claim is denied, the claims administrator or plan administrator is legally required to provide an explanation for the denial, which will include the following:

- The specific reason(s) for the denial;
- References to the specific plan provisions on which the denial is based;
- A description of any additional material or information needed to process your claim and an explanation of why that material or information is necessary; and
- A description of the plan's appeal procedures and time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA after, and if, your appeal is denied.

If your claim is for the Medical Plan, the explanation must also include:

- If the benefit was denied based on a medical necessity, an experimental or unproven treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge upon request. This requirement also applies to denials under the Short-Term Disability Plan and the Long-Term Disability Plan, including the Individual Disability Insurance Plan.

Step 3: Filing an Appeal to the Claims Administrator/Plan Administrator if an Initial Claim for Benefits Is Denied

If you have filed a claim for benefits and your claim is denied, you have the right to appeal the decision. JPMorgan Chase is not involved in deciding appeals for any denied benefit claim under the:

- Medical Plan, including Prescription Drug Plan and Fertility Benefits Program;
- Preferred Dentist Program (PDP); Dental Maintenance Organization (DMO) Option; and Dental Health Maintenance Organization (DHMO) Option;
- Vision Plan;
- Health Care Spending Account;
- Long-Term Disability Plan, including Group LTD and Individual Disability Insurance;
- Short-Term Disability Plan;
- Life and AD&D Insurance Plans;
- Business Travel Accident Insurance Plan;
- Back-Up Child Care Plan
- Group Legal Services Plan; and
- Employee Assistance Program.

The plan administrators delegate all fiduciary responsibility and decisions about a claim for a denied benefit under these plans to the applicable claims administrator.

Appeals related to denied claims under the Health & Wellness Centers Plan are determined by the Corporate Medical Director.

Under certain plans, final appeals for denied claims will be heard by a review panel that is independent of both the company and the Medical Plan claims administrators. The independent review panel will hear appeals for the following plans:

- Medical Plan;
- Prescription Drug Plan;
- Fertility Benefits Program; and
- Health & Wellness Centers Plan.

Please Note: Appeals related to denied claims under the Short-Term Disability Plan are determined by Sedgwick. Employees who work in New Jersey have the right to appeal to the Division of Temporary Disability Insurance for the State Temporary Disability Insurance portion of the JPMorgan Chase Short Term Disability Plan. You have one year from the date your disability began to file this appeal.

Send your written appeal to:

Division of Temporary Disability Insurance Private Plan Operations
Claims Review Unit
P.O. Box 957
Trenton, NJ 08625-0957

Telephone: (609) 292-6135

If your initial claim for benefits is denied, you — or your authorized representative — may file an appeal of the decision with the applicable claims administrator or plan administrator within the time frames indicated below, after receipt of the claim denial.

Plan	Timing for Filing an Appeal of a Denial of Benefits Claim
Medical Plan and Prescription Drug Plan	180 days
Fertility Benefits Program	
Dental Plan	
Vision Plan	
Health Care Spending Account	
Long-Term Disability, including Individual Disability Insurance	
Short-Term Disability Plan	
Business Travel Accident Insurance Plan	
Employee Assistance Program	
Health & Wellness Centers Plan	
Life and AD&D Insurance Plans	60 days
Group Legal Services Plan	
Back-up Child Care Plan	180 days

In your appeal, you have the right to:

- Submit written comments, documents, records, and other information relating to your claim.
- Request, free of charge, reasonable access to, and copies of, all documents, records, and other information that:
  - Was relied upon in denying the benefit.
  - Was submitted, considered, or generated in the course of denying the benefit, regardless of whether it was relied on in making this decision.
  - Demonstrates compliance with the administrative processes and safeguards required in denying the benefit.
  - For health care: constitutes a policy statement or plan guideline concerning the denied benefit regardless of whether the policy or guideline was relied on in denying the benefit.

If your appeal is for health care, you also have the right to receive:

- A review that does not defer to the initial benefit denial and that is conducted by someone other than the person who made the denial or that person's subordinate.
- For a denied benefit based on medical judgment (including whether a particular treatment, drug, or other item is experimental or unproven), a review in which the plan fiduciary/claims administrator consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was not consulted in connection with the initial benefits denial, nor the subordinate of this person.
- The identification of medical or vocational experts whose advice was obtained in connection with denying the benefit, regardless of whether the advice was relied on in making this decision.
- In the case of an urgent care claim where the life of a claimant could be jeopardized, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of a denied benefit.
  - All necessary information, including the decision on your appeal, will be transmitted between the plan fiduciary/claims administrator and you by telephone, facsimile, or other available similarly prompt method.

Step 4: Receiving Notification from the Claims Administrator/Plan Administrator if Your Appeal Is Denied

If your appeal is subsequently denied, the claims administrator, plan administrator, or Short-Term Disability Plan Appeals Committee is legally required to notify you in writing of this decision within a "reasonable" period of time according to the time frames outlined in the following table.

Plan/Option	Timing for Notification of a Denial of Benefits Claim
Medical Plan, Prescription Drug Plan, Fertility Benefits Program, Dental Plan, Vision Plan, Health Care Spending Account, Employee Assistance Program, and Health & Wellness Centers	• As soon as reasonably possible but no more than 72 hours for claims where the life of a claimant could be jeopardized (urgent care) • 15 days where approval is required before receiving benefits (pre-service claims) • 30 days where the claim is made after care is received (post-service claims)
Group Long-Term Disability	• **45 days**, plus **one 45-day** extension for matters beyond the plan's control.
Individual Disability Insurance	• **45 days**, plus **one 45-day** extension for matters beyond the plan's control.

Plan/Option	Timing for Notification of a Denial of Benefits Claim
Short-Term Disability Plan	• **45 days**, plus **one 45-day** extension for matters beyond the plan's control.
Life Insurance Plan	• 60 days to review and make a determination once all the information has been submitted plus one extension
AD&D Insurance Plan	45 days, plus one 45-day extension for matters beyond the plan's control
Business Travel Accident Insurance Plan	The decision on appeal will be made on the date of the next meeting of the claims administrator's appeal committee, subject to extensions permitted by law
Group Legal Services Plan	60 days
Back-up Child Care Plan	45 days, plus one 60-day extension for matters beyond the plan's control

Except in the case of urgent care claims related to health, the claims administrator or the plan administrator is allowed to take an extension to notify you of a denied appeal under certain circumstances. If an extension is necessary, the claims administrator or plan administrator will notify you before the end of the original notification period. This notification will include the reason(s) for the extension and the date the claims administrator or the plan administrator expects to provide a decision on your appeal for the denied benefit. **Please Note**: If an extension is necessary because you did not submit enough information to decide your appeal, the time frame for decisions is stopped from the date the claims administrator or the plan administrator sends you an extension notification until the date that you respond to the request for additional information.

The Explanation You'll Receive from the Claims Administrator/Plan Administrator in the Case of a Denied Benefit

If an appeal is denied, the claims administrator or plan administrator is legally required to provide an explanation for the denial, which will include the following:

- The specific reason(s) for the denial;
- References to the specific plan provisions on which the denial is based;
- A statement that you're entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement describing any appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring a civil action under ERISA.

If your appeal is for Medical Plan, the explanation must also include:

- If the benefit was denied based on a medical necessity, experimental, or unproven treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A description of the expedited review process for urgent care claims in the Medical Plan, where the life of the claimant could be jeopardized.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge upon request in the Medical Plan.

The health care plans generally require two levels of appeal, which you must complete if you would like to pursue your claim further.

The Group Long Term Disability coverage under the LTD Plan permits a voluntary second appeal. You must file the voluntary second appeal within 180 days after the denial of the first appeal. The insurer of the coverage, Prudential Insurance Company, can provide additional information about the voluntary second appeal.

Step 5: Receiving a Final Appeal by an Independent Review Panel

If your appeal of a benefits claim is denied, your final appeal for coverage will be heard by a review panel that is independent of both the company and the claims administrators. The independent review panel will hear appeals for the following plans:

- Medical Plan;
- Prescription Drug Plan;
- Fertility Benefits Program; and
- Health & Wellness Centers Plan.

The independent review panel hears only appeals that involve medical judgment, a rescission of coverage or determinations involving whether a plan or health insurance issuer is complying with surprise billing and cost-sharing protections; the panel does not hear appeals about eligibility to participate in a plan or legal interpretation of a plan that does not involve medical judgment.

You are not required to file an appeal with the independent review panel before filing a court action. This level of appeal is voluntary.

Filing a Court Action

If an appeal under a plan subject to ERISA is denied (in whole or in part), you may file suit in a U.S. federal court. If you are successful, the court may order the defending person or organization to pay your related legal fees. If you lose, the court may order you to pay these fees (for example, if the court finds your claim frivolous). You may contact the U.S. Department of Labor or your state insurance regulatory agency for information about other available options.

If you bring a civil action under ERISA, you first must follow the procedures described above regarding filing a claim and up to two levels of internal appeals with the claims administrator. You must start the court action by the earlier of: (i) one year after the date of the denial of your final appeal; or (ii) three years after the date when your initial claim should have been filed, regardless of any state of federal statutes relating to limitations of actions. If, however, the applicable state or federal law relating to limitations of actions would result in a shorter limitations period within which to start the action, the shorter limitations period will apply. For the health plans, you cannot file a suit unless you have completed two appeals, if required by the claims administrators.

If you are subject to binding arbitration, any such claim, dispute or breach arising out of or in any way related to the Plan shall be settled by such binding arbitration, to which the Plan hereby expressly consents.

Contacting the Claims Administrators: Plans Subject to ERISA

This section provides specific contact information for each benefit plan covered by ERISA.

For contact information for the plans that are not subject to ERISA (which include the Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan), please see “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 496

Generally for all health care and insurance plans, questions related to general plan administration and eligibility to participate in the plans can be addressed by HR Answers. (See the *Contacts* section.)

For questions related to plan interpretation, filing initial claim, benefit provision under the plan, payment of benefits, or denial of benefits, please refer to the appropriate claims administrator for each benefit plan, as listed below.

Medical Plan Claims Administrators	
Medical Plan	
Aetna	Aetna P.O. Box 14079 Lexington, KY 40512-4079 (800) 468-1266
Cigna	Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 790-3086
Hawaii Medical Plan	**Medical appeals:** Cigna Appeals Unit P.O. Box 188011 Chattanooga, TN 37422-8011 **Medical paper claims:** P.O. Box 182223 Chattanooga, TN 37422-7223
Kaiser HMO Plan	**CALIFORNIA – SCAL** Claim Address: P.O. Box 7004 Downey, CA 90242-7004 Member Services: (800) 464-4000 **CALIFORNIA – NCAL** Claim Address: P.O. Box 12923 Oakland, CA 94604-2923 Member Services: (800) 464-4000
Prescription Drug Plan*	CVS Caremark Attention: Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196 866-209-6093
WINFertility	WINFertility, Inc. Greenwich American Center One American Lane Terrace Level Greenwich, CT 06831 (833) 439-1517
Expatriate Medical Option*	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050 (800) 390-7183 (302) 797-3644 (if calling from outside the U.S.)

* Options marked with an asterisk are self-insured. All other options are fully insured.

Dental Plan Claims Administrators	
Preferred Dentist Program (PDP)*	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 (888) 673-9582
Dental Maintenance Organization (DMO) Option	Aetna, Inc. P.O. Box 14094 Lexington, KY 40512 (800) 843-3661
Dental Health Maintenance Organization (DHMO) Option	Cigna Dental Health P.O. Box 188045 Chattanooga, TN 37422-8045 (800) 790-3086
Expatriate Dental Option*	Cigna International JPMorgan Chase Dedicated Service Center P.O. Box 15050 Wilmington, DE 19850-5050 (800) 390-7183 (302) 797-3644 (if calling from outside the U.S.)

* Options marked with an asterisk are self-insured. All other options are fully insured.

Other Health Care and Insurance Plans Subject to ERISA	
Plan	**Contact**
Vision Plan	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111 (833) 279-4363
Health Care Spending Accounts	Refer to the same provider that you selected for your Medical Plan coverage. If you do not enroll in the Medical Plan coverage, contact Cigna. Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 790-3086 Payflex, an Aetna company Payflex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 (888) 678-8242
Back-Up Child Care Plan	Bright Horizons Children's Centers LLC. 2 Wells Ave. Newton, MA 02459 (888) 701-2235

Other Health Care and Insurance Plans Subject to ERISA	
Plan	**Contact**
Health & Wellness Centers Plan	JPMorgan Chase & Co. Health Services Dept. 277 Park Ave, 1st Floor Mail Code: NY1-L085 New York, NY 10172 (212) 270-5555
Group Long-Term Disability	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176 (877) 361-4778
Individual Disability Insurance	Unum The Benefits Center P.O. Box 100262 Columbia, SC 29202-3262 (888) 226-7959
Short-Term Disability Plan*	Sedgwick Claims Management Services JPMorgan Chase Leave of Absence Service Center P.O. Box 14648 Lexington, KY 40512-4648 (888) 931-3100
Life and AD&D Insurance Plans	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017 (888) 673-9582
Business Travel Accident Insurance Plan	JPMorgan Chase Corporate Insurance Services JPMorgan Chase & Co. 8181 Communications Pkwy Bldg B, Floor 03 Mail Code TXW-3305 Plano, TX, 75024-0239, United States
Group Legal Services Plan	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114 (800) 821-6400
Employee Assistance Program	Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152 (877) 576-2007

* Options marked with an asterisk are self-insured. All other options are fully insured.

Contacting the Claims Administrators: Plans Not Subject to ERISA

Plans that are not subject to ERISA include the Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan.

Although these plans are not subject to the claims process described under "Claiming Benefits" on page 367, you can always contact the claims administrator listed for each plan with questions about the eligibility of an expense for reimbursement, payment of benefits, or denial of plan benefits. For claims relating to questions of eligibility for benefits under the plans and how the plans operate, please see "Claims Related to Eligibility to Participate in the Plans and Plan Operations" on page 483.

For questions related to plan interpretation, filing initial claim, benefit provisions under the plan, payment of benefits, or denial of benefits, please refer to the appropriate claims administrator for the benefit plan, as listed below.

Plan	Contact
Dependent Care Spending Accounts	Refer to the same provider that you selected for your Medical Plan coverage. If you do not enroll in the Medical Plan coverage, contact Cigna. Cigna P.O. Box 188061 Chattanooga, TN 37422-8061 (800) 790-3086 Payflex, an Aetna company Payflex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 (888) 678-8242
Transportation Spending Accounts	Health Equity P.O. Box 14053 Lexington, KY 40511 (877) 924-3967
Group Personal Excess Liability Insurance Plan	Marsh McLennan Agency Private Client Services 7201 W. Lake Mead #400 Las Vegas, NV 89128 (855) 426-1380

If You Are Covered by More Than One Health Care Plan

The JPMorgan Chase medical and dental plans (including the plans for expatriates) all have provisions to ensure that payments from all of your group health care plans don't exceed the amount the JPMorgan Chase plans would pay if they were your only coverage.

The rules described here apply to the JPMorgan Chase plans. The following rules do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

The JPMorgan Chase health care plans do 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 JPMorgan Chase health care plans will ensure that, in total, you receive benefits up to what you would have received with the JPMorgan Chase plans 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 (that is, how JPMorgan Chase coordinates coverage with another group plan to ensure non-duplication of benefits) follows. If you have questions, please contact your health care company for help. (Please see contact information in the *Contacts* section.)

Here's an example of how the JPMorgan Chase health care plans coordinate benefits with other group health care 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/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 health care plan (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 necessary procedure. In this case, your spouse/domestic partner normally would receive an $80 benefit (80% of $100) from the JPMorgan Chase plan.
- 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 plan.
- If, however, your JPMorgan Chase plan considered the R&C charge to be $80, no additional benefit would be payable, as the JPMorgan Chase 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 plan.

Determining Primary Coverage

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

- If you are enrolled in the JPMorgan Chase plan and another plan and your other health care plan doesn't have a coordination of benefits provision, that plan will be considered primary, and it will pay first for you and your covered dependents.
- 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 child who is enrolled in coverage under both parents' plans, the plan covering the parent who has the earlier birthday in a calendar year (based on the month and date of birthday only, not the year) 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 child will be considered primary for the covered child. (Please see "Qualified Medical Child Support Orders" in the *Health Care Participation* section.)
- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

After it is 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 from your primary plan.

Coordination with Medicare

Medicare is a national health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). It generally provides coverage for Americans ages 65 and older. It also provides coverage to younger people with a qualifying disability. As long as you remain an active employee with JPMorgan Chase, your JPMorgan Chase coverage will be primary, and any Medicare coverage for you will be secondary. Additionally, any covered dependents who become eligible for Medicare, while you remain an active employee, will also have JPMorgan Chase coverage as primary.

- While you remain an active JPMorgan Chase employee, the JPMorgan Chase health care plans will be primary for you and your covered dependents unless those dependents have primary coverage elsewhere. If your covered dependents have primary coverage elsewhere, those claims will be considered by that primary coverage first, JPMC coverage will be secondary and Medicare will consider claims for those health care expenses tertiary (third) Even if you work past age 65 and you and/or a covered spouse/domestic partner enroll in Medicare, the JPMorgan Chase plans will consider claims for your health care expenses before Medicare while you are an active employee.
- When you are no longer an active JPMC employee or are receiving LTD benefits, Medicare coverage will be primary for the Medicare enrolled individual. JPMC coverage will be terminated upon Medicare eligibility and coverage in Medicare plans is available from Via Benefits. Please see “You Work Past Age 65” in the *What Happens If ...* section.

Right of Recovery

If the JPMorgan Chase plan provides benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the JPMorgan Chase plans have 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 JPMorgan Chase 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 JPMorgan Chase plan making payments on your behalf.

If the Plan makes a payment for benefits that is in excess of amounts payable under the terms of the Plan, whether due to error (including, for example, clerical error) or for any other reason, the Plan has the right to recover the overpayment from you, plus interest and costs, through whatever means necessary, including, without limitation, legal action or by offsetting future benefit payments to you, your beneficiary or your or your beneficiary’s heirs, assigns or estate.

By accepting benefits from this Plan, you agree that an equitable lien in favor of the Plan automatically attaches against any overpayment made by the Plan at the time the overpayment is made. You also agree that, due to the existence of the equitable lien, you must hold the overpayment amount in a constructive trust and that the Plan has a right to obtain repayment from you whether or not you subsequently spend or commingle the funds.

Subrogation of Benefits

The purpose of the JPMorgan Chase health care plans is to provide benefits for eligible health care expenses that are not the responsibility of any third party. The JPMorgan Chase plans have the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plans 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 JPMorgan Chase plans have a first priority equitable lien from any amounts recovered from a third party for the full amount of benefits the plans have paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the JPMorgan Chase plans use this right when requested.

- If you fail to help the JPMorgan Chase plans use this right when requested, the plans may deduct the amount the plans paid from any future benefits payable under the plans.
- The JPMorgan Chase plans have the right to take whatever legal action they deem appropriate against any third party to recover the benefits paid under the plans.
- If the amount you receive as a recovery from a third party is insufficient to satisfy the JPMorgan Chase plans' subrogation claim in full, the plans' subrogation claim shall be first satisfied before any part of a recovery is applied to your claim against the third party.
- The JPMorgan Chase plans have a right to obtain payment of the equitable lien regardless of whether or not you subsequently spend or commingle the funds you obtain from a settlement.
- The JPMorgan Chase plans are not responsible for any attorney fees, attorney liens, or other expenses you may incur without the plans' 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 plans.

If you receive a subrogation request and have questions, please contact your health care company (see contact information in the *Contacts* section).

Right of Reimbursement

In addition to their subrogation rights, the JPMorgan Chase health care plans are entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for health care expenses that have been paid by the plans. The following rules apply to the plans' right of reimbursement:

- You must reimburse the JPMorgan Chase plans 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 JPMorgan Chase plans shall have a right of full reimbursement, in first priority, from the recovery.
- You must hold in trust for the benefit of the JPMorgan Chase plans the gross proceeds of a recovery, to be paid to the plans immediately upon your receipt of the recovery. You must reimburse the plans, in first priority and without any set-off or reduction for attorney fees or other expenses, regardless of whether or not you subsequently spend or commingle the funds you obtain. 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 plans.
- If you fail to reimburse the JPMorgan Chase plans, the plans may deduct any unsatisfied portion of the amount of benefits the plans have paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plans.

If you fail to disclose the amount of your recovery from a third party to the JPMorgan Chase plans, the plans shall be entitled to deduct the full amount of the benefits the plans paid on your behalf from any future benefits payable under the plans.

Special Notice for Employees Who Have Been Rehired by JPMorgan Chase

If your employment has been reinstated with JPMorgan Chase (that is, you have been rehired within 31 days of your employment termination date or your coverage termination date), your coverage for certain benefits under the JPMorgan Chase U.S. Benefits Program may be affected, as highlighted in the following chart:

Medical (including Medical Reimbursement Account and Prescription Drug Plan), Dental, Fertility Benefits Program, and Vision Plans	You and your dependents will be assigned the same coverage you had before your coverage termination date. **Please Note**: If you are a retired employee when rehired, you must take active employee coverage and discontinue any retiree coverage you may have elected.
Health Care Spending Account	Your previously elected annual contribution amount will be reinstated and prorated accordingly for the balance of the plan year. **Please Note**: Expenses incurred during your break in service are not eligible for reimbursement, unless you elected to make after-tax contributions under COBRA.
Dependent Care Spending Account	Your previously elected annual contribution amount will be reinstated and prorated accordingly for the balance of the plan year. **Please Note**: Expenses incurred during your break in service are not eligible for reimbursement.
Transportation Spending Accounts (Transit/Parking)	There are no reinstatement provisions for these accounts. You will need to make a new enrollment election upon your date of hire.
Life Insurance Plan	You and your dependents will be assigned the same coverage amount in effect before your termination date.
Accidental Death and Dismemberment (AD&D) Insurance Plan	You and your dependents will be assigned the same coverage amount in effect before your termination date.
Group Personal Excess Liability Insurance Plan	You will be assigned the same coverage in effect before your termination date.
Group Legal Services Plan	You will be assigned the same coverage in effect before your termination date.

Please Note: If you are rehired after 31 days of your termination date, you will need to make new benefits elections for all plans for which you would like to participate.

Contacts

Effective 1/1/22

My Health, My Rewards and HR Answers for More Information

My Health	In addition to the provider resources noted below, **My Health** provides one-stop access to all your Medical Plan, prescription drug, Medical Reimbursement Account, Spending Accounts, JPMorgan Chase Health & Wellness Centers, wellness programs, and access to the Benefits Web Center where you can access information about the Dental and Vision Plans as well as Life and AD&D Insurance, Group Legal and Personal Excess Liability Insurance. Simply use your Single Sign-On password to access other sites from **My Health.** ▪ From work: My Health from the intranet. ▪ From home: https://myhealth.jpmorganchase.com. **Please Note:** Your covered spouse/domestic partner can access **My Health** without a password, but their health care company's site will require a username and password.
My Rewards	In addition to the provider resources noted below, **My Rewards** provides one-stop access to retirement and savings information. Simply use your Single Sign-On password to access other sites from **My Rewards**. ▪ From work: **My Rewards** from the intranet. ▪ From home: https://myrewards.jpmorganchase.com/.
HR Answers	Like **My Health** and **My Rewards**, HR Answers provides access to benefits information. ▪ 877-JPMChase ((877) 576-2427) ▪ *Quick Path:* Enter your Standard ID or Social Security number; press 1; enter your PIN; press 1. If calling from outside the United States: ▪ (212) 552-5100 (GDP# 352-5100) Service Representatives are available Monday – Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays. For assistance with the Retirement Plan, representatives are available until 8:30 p.m.

Issue/Benefit	Contact Information
Medical (Not Including Prescription Drugs)	Aetna (800) 468-1266 8 a.m. to 8 p.m., all time zones, Monday – Friday **My Health** or www.aetna.com Cigna (800) 790-3086 24/7 **My Health** or www.mycigna.com
Prescription Drugs	CVS Caremark (866) 209-6093 24/7 www.caremark.com
Kaiser HMO (Medical and Prescription Drugs)	Kaiser Permanente (800) 204-6561 8 a.m. to 6 p.m., Pacific time, Monday – Friday **My Health** or kp.org
Employee Assistance Program (EAP)	Cigna (EAP) and LifeCare (Work-Life) (877) 576-2007 www.eapandworklife.com
Tobacco Cessation Program	(866) QUIT-4-LIFE ((866) 784-8454) myquitforlife.com/jpmorganchase.com
Expert Medical Advice	Included Health (888) 868-4693 8 a.m. to 9 p.m. Eastern time, Monday – Friday includedhealth.com/jpmc
LGBTQ+ Health Concierge Service	Included Health (877) 266-2861 9 a.m. to 8 p.m. Eastern time, Monday – Friday www.includedhealth.com/jpmc
Health Care Spending Account **Dependent Care Spending Account**	Your Medical Plan carrier — Aetna or Cigna — is the administrator of your Health Care and Dependent Care Spending Accounts. If you are not enrolled in the Medical Plan, Cigna is your administrator of these accounts. **Aetna (PayFlex is an Aetna company)** PayFlex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 Phone: (800) 468-1266 **Cigna** (800) 790-3086 24/7 www.mycigna.com You can check your spending account balances through **My Health**.

Issue/Benefit	Contact Information
Dental	**Aetna, Inc. Dental Maintenance Organization (DMO) Option: Aetna** (800) 843-3661 8 a.m. to 6 p.m. Eastern time, Monday – Friday www.aetna.com **Cigna Dental Health Maintenance Organization (DHMO) Option: Cigna Dental Health** (800) 790-3086 24/7 http://mycigna.com/ **MetLife Preferred Dentist Program (PDP) Option: MetLife Dental** (888) 673-9582 8 a.m. to 11 p.m. Eastern time, Monday – Friday https://mybenefits.metlife.com
Vision	EyeMed Vision Care (833) 279-4363 7:30 a.m. to 11 p.m. Eastern time, Monday – Friday 8 a.m. to 11 p.m. Eastern time, Saturday 11 a.m. to 8 p.m. Eastern time, Sunday **My Health >** Benefits Web Center
Transportation Spending Accounts (including for questions about eligibility and enrollment)	Health Equity (877) 924-3967 8 a.m. to 8 p.m., all time zones, Monday – Friday www.healthequity.com You can check your Transportation Spending Accounts balances on from the Transportation Spending Accounts Web Center via **My Rewards**. (myrewards.jpmorganchase.com)
Group Long –Term Disability	The Prudential Insurance Company of America (877) 361-4778 Monday – Friday from 8 a.m. to 8 p.m. Eastern time
Individual Disability Insurance	Covala Group (800) 235-3551 Monday – Friday from 8:30 a.m. to 5:30 p.m. Eastern time
Short-Term Disability Plan	Sedgwick Claims Management Services, Inc. (888) 931-3100 Service Representatives are available 24/7, Sunday through Saturday. You can also obtain answers to your questions 24 hours a day, seven days a week online at claimlookup.com/jpmc.
Life and Accidental Death & Dismemberment Insurance	Metropolitan Life Insurance Company (MetLife) (888) 673-9582 8 a.m. to 8 p.m. Eastern time, Monday – Friday **My Health >** Benefits Web Center
SurvivorSupport® Financial Counseling Services	The Ayco Company (800) 235-3417 8 a.m. to 5 p.m. Eastern time, Monday – Friday

Issue/Benefit	Contact Information
ID Theft Assistance Program, Travel Assistance, and Emergency Evacuation Services	AXA Assistance (800) 454-3679 (outside the U.S., call collect at (312) 935-3783) 24/7
Funeral Concierge Services	Dignity Memorial (866) 853-0954 24/7
Business Travel Accident Insurance	AIG-National Union Fire Insurance Company of Pittsburgh, PA (800) 551-0824 or (302) 661-4176 8 a.m. to 5 p.m. Central time, Monday – Friday
401(k) Savings Plan	**My Rewards >** My Web Centers > 401(k) Savings Plan 401(k) Savings Plan Call Center (866) JPMC401k ((866) 576-2401) TTY number (800) 345-1833 Outside the U.S.: (303) 737-7204 Speak to a Representative 8 a.m. to 10 p.m. Eastern time, Monday – Friday (except NYSE holidays)
Retirement (Pension) Plan	**My Rewards >** My Web Centers > Pension Plan HR Answers (877) JPMChase ((877) 576-2427) Outside the U.S.: (212) 552-5100 Speak to a Representative 8 a.m. to 7:00 p.m. Eastern time, Monday – Friday (except certain U.S. holidays)
My Finances and Me (financial coaching benefit for active employees)	**me@jpmc** > Benefits & Rewards > My Financial Well-being > My Finances and Me (833) 283-0031 Speak to a Financial Coach 9 a.m. to 8 p.m. Eastern time, Monday – Friday (except certain U.S. holidays)
Health & Wellness Centers	The Health & Wellness Centers Directory on **My Health** has a list of JPMorgan Chase Health & Wellness Centers locations, phone numbers, and hours. Go to **My Health** > Wellness Activities & Services. This information is also available at go/healthservices from the company intranet browser.
Group Legal Plan	MetLife Legal Plans, Inc. (800) 821-6400 8 a.m. to 8 p.m. Eastern time, Monday – Friday
Personal Excess Liability Insurance	Marsh McLennan Agency Private Client Services (855) 426-1380 9 a.m. to 5 p.m. Eastern Time, Monday – Friday
Back-up Child Care Plan	Bright Horizons (888) 701-2235 https://backup.brighthorizons.com/jpmc (for backup care reservations) **me@jpmc** > Health, Life & Parenting > parents@jpmc (for information about the Plan and other offerings)
Expatriate Medical and Dental Plans	Cigna Global Health Benefits (800) 243-6998 (outside the U.S., call collect at (302) 797-3644 24/7 www.CignaEnvoy.com