

The Short-Term Disability Plan

Effective 1/1/21

The JPMorgan Chase Short-Term Disability Plan (the “STD Plan”) is designed to provide you with time off and short-term disability pay if you become unable to work because of an approved disability caused by illness or injury.

Based on your years of recognized service, the plan may provide short-term disability pay equal to all or a portion of your eligible compensation for up to 25 weeks per qualified disabling event. Employees in New Jersey may be entitled to 26 weeks of paid statutory STD benefits.

This section of Your JPMC Benefits Guide will provide you with a better understanding of how the STD Plan works, including how and when benefits are paid. Other types of leave may be applicable to your situation; for more information, please consult the Leave of Absence policies, available at [me@jpmc](#) > HR Policies > Leaves of Absence.

Leave taken under the STD Plan may run concurrently with other types of leave, including qualifying leave under the Family and Medical Leave Policy. The requirements for each type of leave must be satisfied in order for leaves to run concurrently.

About This Summary Plan Description

This section is the summary plan description (SPD) and the plan document for the JPMorgan Chase Short-Term Disability 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 govern.

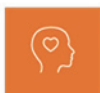
Questions?

For questions about the STD Plan or to report a claim, contact *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.

**For More Information on Time Off Policies**

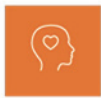
JPMorgan Chase offers a variety of time-off and human resources policies that complement the STD Plan. For more information on these policies, please refer to the *Time Away from Work Policies*, available at me@jpmc > HR Policies > Time Away from Work.

If your Short-Term Disability is related to childbirth, the Parental Leave Policy and the Family and Medical Leave Policy may also apply to you. For more information on these policies, please refer to the Leave of Absence policies, available at me@jpmc > HR Policies > Leaves of Absence.

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. **Note:** The JPMorgan Chase STD Plan allows all part-time employees to be eligible to participate.

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STD Plan Highlights

Your Coverage

The STD Plan provides time off, and if eligible, financial protection of full or partial pay for approved periods of disability.

- Full-time and part-time employees may receive up to 26 weeks of time off for each approved Short-Term Disability Leave.
- Full-time and part-time employees may be eligible to receive short-term disability pay at either 100% or 60% pay in accordance with the “Short-Term Disability Pay Schedule” on page 257 (up to 25 weeks for each approved disability leave – please see “Multiple Short-Term Disability Leaves” on page 261 to learn how the 25 weeks are counted in cases of multiple disabilities during a calendar year).
- Hourly paid employees who are approved for short-term disability pay will be paid according to the number of scheduled work hours in the pay period.
- Exempt salary paid employees will be paid consistent with how regular pay is calculated.
- The STD Plan does not provide for unpaid disability leave. Please consult the Short-Term Disability Leave Policy for information on unpaid disability leave.
- Employees who work in New Jersey may receive 100% or 66.67% of pay in accordance with state statutory benefits.
- Employees who work in New York may receive 100% or 50% of pay in accordance with the statutory benefits.

Short-term disability pay is payable only if your claim is approved for short-term disability or Workers’ Compensation benefits. You may not receive more than 100% of your pay between any non-occupational state disability or occupational Workers’ Compensation disability benefits and the short-term disability pay you may be eligible to receive under the STD Plan. The claims administrator has the discretionary authority to determine employees’ short-term disability pay.

Right to Recovery (Effective 5/1/2019)

If the STD Plan provides pay for approved periods of disability that are later determined to be as a result of an illness or injury for which another person or entity is legally responsible, the STD Plan has the right to recover payment from you or from the person or entity 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 STD Plan. You must notify the STD 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 STD Plan providing financial protection for approved periods of disability.

Participating in the STD Plan

The STD Plan provides time off and short-term disability pay to eligible employees who have an approved disability and are unable to work. The general guidelines of the JPMorgan Chase STD Plan are described below.

Eligibility

You are eligible for short-term disability leave if:

- You are an employee on a U.S. payroll of the firm, subject to FICA withholding;
- You are actively at work or are on a leave of absence approved under the Family and Medical Leave Policy, Parental Leave Policy, are on another type of approved leave of absence (as determined by the JPMC Leave Management), are already on an approved short-term disability leave, or are on an approved safety-related leave (as determined by JPMC Leave Management), when you have another need for short-term disability leave; or you have been released to return to work and are in a job-search period following an approved leave of absence;



- You file your completed claim any time prior to and no later than 30 calendar days after the first day of absence and it is approved by the appropriate claims administrator; and
- You provide the required medical documentation no later than 30 calendar days after the date your completed claim is filed (effective August 1, 2021).

The following individuals (or other similarly situated individuals) are not eligible for short-term disability pay under the STD Plan, even if they are later found by a court order or government entity to be “common law employees” of a participating employer:

- Independent contractors, agents, and their employees;
- Interns; and/or
- Leased, temporary, and occasional/seasonal employees.

Short-Term Disability Leave Duration and Pay

When you take a Short-Term Disability Leave, your maximum short-term disability leave duration (i.e., the maximum amount of leave time available for each short-term disability leave you take), is determined by your employment classification. Depending upon your employment classification and length of service, you may be eligible for short-term disability pay, as described below.

If you are a full-time or part-time employee:

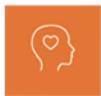
- You are eligible for up to **26** weeks of leave per approved disability.
- Generally, up to **25** weeks of your short-term disability leave is **paid** (see “Short-Term Disability Pay Schedule” on page 258) if you:
 - are a full-time employee who has completed 90 days of employment (i.e., the Introductory Period, as defined under “Defined Terms” beginning on page 269); or
 - are a part-time employee who has completed one year of Recognized Service (please see “Defined Terms” beginning on page 269 for the definition of “Recognized Service”).
 - The STD Plan does not provide for unpaid disability leave. Please consult the Short-Term Disability Leave Policy for information on unpaid disability leave.

Note: Full-time and part-time employees who are approved for short-term disability that is directly related to illness or related medical complications resulting from the COVID-19 virus will **not** be required to complete the 90-day Introductory Period. In addition, part-time employees will **not** be required to complete the one year of recognized service eligibility requirement for COVID-19 related illness.

Please Note: If your short-term disability leave is denied and you are not approved for time off under the Family and Medical Leave Policy or Parental Leave Policy, or other approved leave of absence as determined by the Plan Administrator, you are not eligible for subsequent short-term disability leave unless you have returned to work. For additional information, please refer to the “Return from Leave” section of the Short-Term Disability Leave Policy, available at me@jpmc > HR Policies > Leaves of Absence.

Cost of Coverage

JPMorgan Chase does not charge any costs to employees for their STD Plan benefits. As a result, any paid leave you receive through the STD Plan will be taxable income.



How the STD Plan Works

Length and Amount of Benefits

If you are an eligible employee and suffer a non-occupational illness or injury, short-term disability pay under the STD Plan will not begin immediately. No benefits under the STD Plan are available until you have been disabled for seven consecutive calendar days (the “Wait Period,” as defined under “Defined Terms” beginning on page 269). This means that you will not receive pay for those days unless you have paid time off available to you and you, or someone on your behalf, properly record the paid time off in the Time and Attendance System (TAS).

If you meet the eligibility criteria for short-term disability pay described on page 257, beginning on the eighth consecutive calendar day of your short-term disability leave you may be eligible to receive short-term disability pay at either 100% or 60% pay (for up to 25 weeks for each approved disability), in accordance with the Short-Term Disability Pay Schedule below. (In certain instances, employees may receive short-term disability pay at a higher percentage of pay than 60%, in accordance with applicable statutory requirements in their state.)

The number of weeks of short-term disability pay at 100% or 60% pay for which you may be eligible is determined by your completed years of recognized service and your scheduled hours status as of the beginning of your approved short-term disability leave and the number of weeks of short-term disability pay that you may have already received in the calendar year in which your short-term disability begins. If you have multiple short-term disability leaves that begin within the same calendar year, you will receive the 60% benefit once you have reached the maximum number of weeks at 100% within the calendar year (please see “Multiple Short-Term Disability Leaves” on page 261).

The Long-Term Disability Plan

Should you continue to be disabled longer than 26 consecutive weeks, you may be eligible to receive benefits under the Long-Term Disability (LTD) Plan if, prior to becoming disabled, you either had JPMorgan Chase-provided LTD coverage or you elected LTD coverage, and your disability is approved by the LTD claims administrator.

Short-Term Disability Pay Schedule*

Years of Recognized Service	Weeks at 100% Pay Within a Calendar Year	Weeks at 60% Pay
Less than 1	0	25
1–2	4	21
3–4	7	18
5–6	10	15
7–9	13	12
10–19	16	9
20 or more	25	0

* Full-time employees, including re-employed individuals, must complete the Introductory Period before the beginning of the short-term disability leave to be eligible for short-term disability pay; part-time employees must complete one year of Recognized Service before the beginning of the short-term disability leave to be eligible for short-term disability pay. Re-employed part-time employees must complete the Introductory Period following their re-employment date to be eligible to receive short-term disability pay, even if they previously satisfied the one-year recognized service requirement. (Please see “Defined Terms” beginning on page 269 for the definition of “Introductory Period” and “Recognized Service.”)



Please Note: The following restrictions with respect to short-term disability pay:

- You may not apply any of your available paid time off while you are receiving short-term disability pay, including to benefits that are provided on a partial pay basis (e.g., 60% of pay).
- Hourly paid employees who are approved for short-term disability pay will be paid according to the number of regular work hours in the pay period.
- Exempt salary paid employees will be paid consistent with how scheduled pay is calculated.
- If it is determined that your short-term disability pay benefit was underpaid, you'll be paid the additional amount. If it is determined that your disability pay benefit was overpaid, you will be responsible for repaying any excess payments you received. Failure to do so may result in corrective action, including termination of employment. JPMorgan Chase may satisfy all or a part of this repayment obligation by withholding any future amounts not yet paid to you. In addition, JPMorgan Chase will be entitled to any costs and attorney's fees associated with enforcing this repayment obligation.
- The claims administrator has the discretionary authority to determine employees' short-term disability pay.

Statutory Benefits

Generally, the benefits that you receive under the STD Plan during your approved short-term disability leave include statutory benefits for which you may be eligible, such as state disability or Workers' Compensation disability benefits. The short-term disability pay that you receive during your approved disability period is offset by any Workers' Compensation disability benefits for which you may be eligible. Please see below for information on state disability benefits; Workers' Compensation is discussed in "Filing a Claim for a Non-Occupational Illness or Injury" on page 263.

You are not eligible to receive more than 60% or 100% of your eligible compensation (based on your years of recognized service) between any state disability or Workers' Compensation disability benefits and short-term disability pay under the STD Plan, unless the laws in your state require otherwise. In California, New Jersey, New York, Rhode Island, and Hawaii you cannot receive state statutory disability benefits and Workers' Compensation disability benefits simultaneously. **Please Note:** For California the statutory benefit will be offset until a Workers' Compensation claim is approved.

Please Note: Any overpayment will be collected by JPMorgan Chase or the claims administrator. Failure to reimburse JPMorgan Chase or the claims administrator for any benefits you receive in excess of 100% of your short-term disability pay may result in corrective action, including termination of employment.

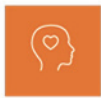
State Disability Benefits

California, Hawaii, New Jersey, New York, and Rhode Island have disability laws requiring short-term disability payments. Disability provisions vary as to eligibility, cost, and the portion of regular pay that's provided.

In Hawaii, New Jersey, and New York, JPMorgan Chase self-insures the state statutory benefits as well as the STD Plan. In these states, if you qualify for short-term disability benefits and are approved, you will receive two checks, one representing the approved short-term disability pay that you receive under the JPMorgan Chase STD Plan and the other for any state disability benefits for which you may be eligible and are approved.

Furthermore, for these states, if the state statutory benefit is more generous, Sedgwick, the claims administrator for the STD Plan, will ensure you receive the appropriate benefit under the applicable state requirement.

If you are not eligible for short-term disability pay under the JPMorgan Chase STD Plan, but are eligible for the state statutory portion of the short-term disability pay benefit, you will receive the state statutory benefit from JPMorgan Chase.



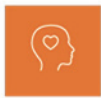
Important Note About California and Rhode Island Disability Benefits

- For employees with non-work related illnesses or injuries who work in California and Rhode Island, any short-term disability pay you are eligible to receive under the JPMorgan Chase STD Plan will be reduced or offset by the amount of the state statutory benefits you are expected to receive. The offset will be taken *even if you do not actually apply for the benefits*. Therefore, it is strongly recommended that you submit a disability claim to the applicable state for these benefits as soon as possible based on the state's guidelines. If you receive a lower amount of state benefits than expected, please contact JPMorgan Chase so that your offset amount can be reviewed and recalculated, if necessary.
- The JPMorgan Chase claims administrator will determine the appropriate offset to be applied.
- Once you report your leave of absence by calling *JPMorgan Chase Disability Service Center* (please see the "Questions" box under the "The Short-Term Disability Plan" on page 254 for contact information), you will receive a packet of information, which will include information and directions to file for the state statutory benefits and for benefits under JPMorgan Chase's STD Plan. **Note:** There are deadlines associated with both state and STD Plan benefits that may affect the total amount you are eligible to receive. You are encouraged to complete and submit your claim form to the state and to Sedgwick in a timely manner.
- For more information regarding California SDI, you may contact a Disability Insurance Customer Service Center at (800) 480-3287. TTY (for deaf or hearing impaired individuals only) is available by calling (800) 563-2441. You may also obtain information online at <http://www.edd.ca.gov/disability/>.
- For more information regarding Rhode Island SDI, you may contact a Rhode Island Temporary Disability Insurance Representative at (401) 462-8420 and select option #1 for an application or file online at <https://uiclaims.ri.gov/tdionline/>.

Temporary Reduced Schedule Return to Work/Partial Short-Term Disability Pay

The partial return to work program is designed to assist employees who are actively recovering from a short-term injury or illness with the expectation that they will return to full duty work without restrictions generally within eight weeks of the start of their partial return to work under this policy.

- If you qualify for a partial return to work program, JPMorgan Chase may provide temporary modifications, including the reduction of your regularly scheduled work hours, to accommodate temporary work-related restrictions and to promote a gradual transition to full duty. The following are generally required:
 - Your health care provider's support of a defined, short-term, transitional/reduced work schedule; and
 - Your line of business management's agreement that a transitional assignment can be made available based on business requirements and critical job function needs.
- If a transitional assignment requires a reduced-work schedule, JPMorgan Chase will pay for your hours worked. You may receive additional pay or disability pay for the non-working portion of the day if you're working less than 80% of your normal work schedule. This pay will follow the short-term disability pay outlined in the Length and Amount of Benefits and Short-term Disability Pay Schedule sections on page 258 for your partial return to work. However, if you return to transitional assignment and are able to work 80% or your normal schedule, you will not be paid disability pay for the hours not worked.
- A transitional assignment is temporary in nature and would normally not exceed six to eight weeks. Your daily hours of work would increase over the course of the transitional assignment.
- Your Sedgwick case manager will work with you and your manager regarding the transitional assignment.
- If you are not able to return to a full schedule in six to eight weeks and you have remaining STD benefits available, you will be returned to full STD status or be considered for Long-Term Disability benefits, if available.



- If you have exhausted all available disability benefits, the Sedgwick case manager will contact the appropriate HR Business Partner or HR Support Team to evaluate further options.
- If you need a different form of accommodation to resume your essential job duties you should contact Sedgwick and your HR Support Team. For details, please see the Accommodating Disabilities and Temporary Work Restrictions Policy, available at me@jpmc > HR Policies > Employee Assistance.
- **Please Note:** Employees on a transitional assignment are not generally eligible for overtime assignments.

Recurrent Disabilities

A recurrent disability occurs if you return to work after being on an approved short-term disability leave and go out again within 60 days due to the same or a related medical or behavioral health condition. If you experience a recurrent disability, you must contact Sedgwick to apply for and re-open your prior short-term disability claim, and you will be required to provide the appropriate medical or behavioral health documentation from your treating provider within 30 calendar days. If approved by Sedgwick, you will not have to complete another one week wait period and your subsequent short-term disability will be considered a continuation of your original short-term disability. The subsequent weeks of short-term disability will count toward the maximum leave duration for which you are eligible, i.e., 26 weeks. If you are eligible for non-occupational short-term disability pay, your benefits will resume at the appropriate rate, i.e., 100% or 60% of pay, based on your length of service as of the beginning of your original approved short-term disability leave, up to the maximum of 25 weeks. For example:

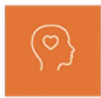
- Assume you are a full-time employee with eight years of recognized service. According to the “Short-Term Disability Pay Schedule” on page 258, in a calendar year you would be eligible for up to 13 weeks of disability pay at 100% of pay and up to 12 weeks of disability pay at 60% of pay. Assume your short-term disability leave is approved from February 8 through April 25 (for 11 weeks). During your first week of leave, you would be required to use available sick time or other available paid time to cover the one-week wait period for short-term disability pay. You would then receive 100% of your pay for the next 10 weeks until your return to work on April 26.
- Further assume that on June 5, you begin leave for the same health condition and your short-term disability leave is approved for an additional four weeks (i.e., June 5 through July 3). Since this leave is a **continuation** of your prior leave, you do not need to complete another one-week wait period. Your total short-term disability leave time is 15 weeks (11 weeks from the prior leave, plus four more as a continuation of that leave). Since you previously received 10 weeks of short-term disability pay at 100% of pay, you would be entitled to receive three additional weeks at 100% of pay, according to the schedule. Your fourth (and final) week of leave would be at 60% of pay.

Please Note: Should you continue to be disabled longer than 26 weeks for the recurring disability, you may be eligible for long-term disability benefits if you had JPMorgan Chase-provided LTD coverage or you elected coverage under the LTD Plan before becoming disabled and you are approved by the LTD claims administrator. You must pursue the LTD claim to its conclusion, including providing all required documentation and exhausting all required appeals, before reapplying for STD benefits related to the same disability.

Multiple Short-Term Disability Leaves

This section applies to situations in which you return to work after being on an approved short-term disability leave and you begin leave again due to an unrelated medical or behavioral health condition or more than 60 days after returning to work. If you have multiple short-term disability leaves, under the following circumstances your leave will be considered a new short-term disability (versus a continuation of the same leave):

- If you begin a short-term disability leave more than 60 calendar days after returning from a prior short-term disability leave; or
- If you begin a short-term disability leave any time after returning from a prior short-term disability leave that was for a different medical or behavioral health condition.



If either of the above circumstances applies, you will be required to complete another one-week wait period. Your maximum short-term disability leave duration (i.e., 26 weeks) will begin anew and will be calculated separately from any previous disability leave taken. If you are eligible and approved for short-term disability pay, you are eligible for up to 25 weeks of pay according to the short-term disability pay schedule. If your disability begins in the same calendar year that your prior disability leave began, your pay will resume at the level you were receiving for the preceding claim. For example:

- Assume you are a full-time employee with five years of recognized service. According to the “Short-Term Disability Pay Schedule” on page 258, in a calendar year you would be eligible for up to 10 weeks of disability pay at 100% of pay and up to 15 weeks of disability pay at 60% of pay. Assume your short-term disability leave is approved for six weeks. During your first week of leave, you would be required to use available sick time to cover the one-week wait period for short-term disability pay. You would then receive 100% of your pay for the next five weeks before your return to work.
- Assume that several months later you begin a new short-term disability leave and it is approved for twelve weeks. Since you previously received five weeks of short-term disability pay at 100% of pay, you would be entitled to receive five additional weeks at 100% of pay. Therefore, the two week remainder of your short-term disability leave would be paid at 60% of pay.

Please Note: Should you continue to be disabled longer than 26 weeks for the same disability, you may be eligible for long-term disability benefits if you had JPMorgan Chase-provided LTD coverage or you elected coverage under the LTD Plan before becoming disabled and you are approved by the LTD claims administrator. You must pursue the LTD claim to its conclusion, including exhausting all required appeals, before reapplying for STD benefits related to the same disability.

What Is Not Covered

The JPMorgan Chase STD Plan does not cover any disability that results from:

- War — declared or undeclared — or any act of war;
- Active participation in a riot;
- Your participation in a felony; or
- Disability related to elective cosmetic surgery or recuperation from such surgery. However, any medical complications resulting from such surgeries may be covered under the STD Plan and will be evaluated on an individual basis at the discretion of Sedgwick, the claims administrator.

If you suffer an illness or injury but are considered able to work, you will not be eligible for short-term disability pay under the STD Plan if the sole reason you do not report to work is due to your inability to commute to your workplace. (If this is an issue that affects you, please see the JPMorgan Chase Accommodating Disabilities and Temporary Work Restrictions Policy, available at [me@jpmc](#) > HR Policies > Employee Assistance.)

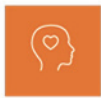
For more information on what is covered and not covered under the JPMorgan Chase STD Plan, please contact HR Answers (please see the “Questions” box under the “The Short-Term Disability Plan” on page 254 for contact information.)

Claiming Benefits

This section explains when and how to submit a claim for short-term disability benefits. For more information on your rights with respect to claims, please see the *Plan Administration* section.

How to File Claims

The claims process differs based on the type of illness or injury that causes you to have an approved short-term disability.



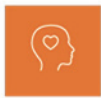
Filing a Claim for a Non-Occupational Illness or Injury

Reporting a Leave

- It is your responsibility to call Sedgwick if you believe that you will be absent due to an illness or injury that will continue for eight or more consecutive calendar days (please see the “Questions” box under the “The Short-Term Disability Plan” on page 254 for contact information). You may report your leave of absence in advance of your leave start date. Applications for short-term disability leave filed more than 30 calendar days after your first date of absence will be denied. When calling to report your leave of absence, you will be required to provide the following:
 - Last day worked;
 - Date of disability;
 - Your health care provider’s name, address, and telephone number;
 - The reason for your leave; and
 - Time that you have taken in the calendar year for sick time, vacation, personal days, etc.
- **Please Note:** If you are unable to call to report your leave due to incapacitation, a designee (such as a spouse or domestic partner), your manager, or a Human Resources Business Partner can report your leave on your behalf.
- If you are out of work 8 or more days due to a work-related illness or injury, please refer to Filing a Claim for an Occupational Illness or Injury section.
- Timely reporting of your short-term disability leave will facilitate a timely determination of the short-term disability pay for which you may be eligible.
- You should also follow your Line of Business absence reporting requirements when reporting a leave of absence. Advance notification will enable your line of business to make the necessary arrangements to cover your work during your absence.
- Following your call to report your leave of absence, Sedgwick, the claims administrator for the STD Plan, will send you a leave request acknowledgement letter that includes disability claims forms and instructions for filing your disability claims to determine if you are eligible for short-term disability leave and pay. California and Rhode Island employees will also receive forms and instructions to apply for the appropriate state disability insurance. Please refer to the “Important Note About California and Rhode Island Disability Benefits” on page 260 for important benefit information and claim filing guidance for these states.
- Your claim will either be approved or denied within 45 days of its submission to Sedgwick, unless you are notified in writing that special circumstances require a delay in the decision. If your claim is denied, you will be notified in writing and provided with instructions on how to appeal the decision.

Submitting Required Information

- You and your licensed physician or registered or licensed behavioral health provider will be required to provide documentation suitable to the claims administrator to support your request for short-term disability leave by sending the completed claims forms to Sedgwick no later than 30 calendar days after the date your claim was filed (effective August 1, 2021). **Please Note:** Any short-term disability pay for which you may be eligible will not commence until your claim is approved. If you do not submit the required documentation suitable to the claims administrator and/or your claim is not approved within the subsequent time frame communicated to you, your claim will be denied and your employment may be terminated.
- The documentation requested of you must be supplied at your expense and within 30 calendar days from the date you filed your claim for your request for short-term disability leave to be evaluated - both initially and on an ongoing basis. You also will be required to provide signed authorization to Sedgwick to obtain and release all reasonably necessary information that supports your short-term disability pay claim.



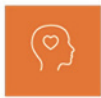
- Based on the documentation supplied, Sedgwick will determine your eligibility for short-term disability pay, including the duration of benefits. If you continue to require leave, periodic updates of documentation may be required at your expense. Short-term disability pay will be suspended and your employment may be terminated if you fail to provide the necessary supporting documentation when it is required.
- JPMorgan Chase reserves the right to require you to be examined by a licensed physician chosen by the firm, at the firm's expense, as often as reasonably necessary while your claim continues. Failure to comply with this examination may result in the denial, suspension, or termination of any short-term disability pay provided under the STD Plan, unless JPMorgan Chase agrees you have a valid and acceptable reason for not complying.

Note: The Genetic Nondiscrimination Act of 2008 (GINA) generally prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual. Your health care provider should not provide any genetic information when responding to requests for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

- You should only provide your personal health information to Sedgwick — it should not be provided to your manager, Human Resources Business Partner, or any other JPMorgan Chase employee. Any personal health information that you submit to Sedgwick is treated as confidential and used only for appropriate purposes.

Return to Work Determination

- Sedgwick will work with your manager and your licensed physician to determine when you may return to work. You are expected to return to work at the conclusion of your approved short-term disability leave (unless your short-term disability leave is extended or you are approved for additional time off under another JPMorgan Chase policy, such as the Accommodating Disabilities and Temporary Work Restrictions Policy).
- If you return to work (or attempt to return to work) prior to the expiration of your approved short-term disability leave, Sedgwick may require a release from your health care provider before allowing you to return to work.
- Except when prohibited by applicable law, JPMorgan Chase may at its expense request that an employee who is returning from a leave complete a fitness for duty evaluation, performed by a licensed physician selected by JPMorgan Chase, if there is a reasonable belief that:
 - The employee's ability to perform essential job functions will be impaired by a medical or behavioral health condition, or
 - The employee will pose a danger to him/herself or others due to a medical condition.
- If your approved short-term disability leave could potentially continue beyond 25 weeks, your claim is automatically referred to the JPMorgan Chase Long-Term Disability plan administrator — as long as you had JPMorgan Chase-provided or elected coverage under that plan before becoming disabled. If your short-term disability leave is not approved and you choose to apply for long-term disability benefits, please contact The Prudential directly at (800) 842-1718.



Filing a Claim for an Occupational Illness or Injury

- If you believe that your illness or injury was sustained in the course of and arose out of work, you must immediately inform your manager — whether or not your illness or injury causes you to be absent — so that the appropriate Workers' Compensation administrator can be notified of your claim of a work-related illness or injury. For further information about JPMorgan Chase's Workers' Compensation administrators, please go to: FWS > Corporate Finance Groups > Global Treasury > Corporate Insurance Services > Workers' Compensation Claims Reporting.
- If you will be out of work for eight or more consecutive days, you must call Sedgwick (please see the "Questions" box under the "The Short-Term Disability Plan" on page 254 for contact information) to report your claim and to be evaluated for a concurrent claim under the JPMorgan Chase STD Plan as well as under the Family and Medical Leave Policy.
- If you are out 8 or more days due to work related illness or injury, your manager may also file a short-term disability claim.
- The applicable Workers' Compensation administrator will make a determination of your eligibility for benefits based on your disability.
 - If your claim for lost time under Workers' Compensation is approved, your short-term disability leave and Family and Medical Leave under the policies will also be approved. If Sedgwick denies your claim prior to a Workers' Compensation approval, you can appeal to have the short-term disability claim reviewed. The duration of benefits for each of these plans will follow as outlined in each policy.
 - If your claim for lost time under Workers' Compensation is denied, your claim for short-term disability leave and Family and Medical Leave will be evaluated in accordance to those policies/plans. If approved, the duration of benefits will follow as outlined in each policy/plan.

While you are receiving Workers' Compensation disability benefits, you may not receive state statutory disability benefits because those benefits apply only to non-occupational illnesses and injuries.

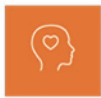
If your short-term disability leave is due to a work-related illness or injury, you may, but are not required to, apply any of your available paid time off as pay during any period of unpaid time, including the one-week wait period for short-term disability pay or an unpaid short-term disability leave that is approved by the Workers' Compensation claims administrator and/or your applicable State Workers' Compensation Board or Industrial Commission, or by Sedgwick. You may also choose not to receive short-term disability pay as stipulated by the STD Plan. However, if you choose not to receive the JPMorgan Chase short-term disability benefit to which you may be entitled to concurrent with a claim for lost time Workers' Compensation, you may not at a later date request the short-term disability pay for that Workers' Compensation lost time claim.

- **Note:** The STD Plan does not provide for unpaid disability leave. Please consult the Short-Term Disability Leave Policy for information on unpaid disability leave.

You may not receive more than 100% of your eligible compensation between Workers' Compensation lost time benefits and any short-term disability pay provided by JPMorgan Chase. Failure to reimburse JPMorgan Chase for any benefits you receive in excess of 100% of your eligible compensation may result in corrective action, including termination of employment.

Appealing Short-Term Disability Claim Denials

If a claim for a short-term disability leave under the JPMorgan Chase STD Plan for a non-occupational illness or injury is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described below.



You have 180 days from the date of your denial to send a written appeal of the short-term disability leave decision. To appeal the short-term disability leave decision, you must send a letter of appeal, medical records, progress notes, test results, and any other applicable documentation to Sedgwick at:

Sedgwick National Appeals Unit
PO Box 14748
Lexington, KY 40512

Fax: (855) 673-2488

- You may request copies of all documents, records, and other information relevant to your claim decision; and you may submit written comments, documents, records, and other information relating to your claim for short-term disability benefits.
- Sedgwick will make a decision no more than 45 days after your appeal is received, unless it is determined special circumstances exist that require an extension of time to process the appeal. If your appeal requires an extension, a decision will be made no more than 90 days after your appeal is received.
- If during the appeal process you determine you will require additional time to secure medical or behavioral health information and documentation to support your appeal, you may contact the Sedgwick Appeals Coordinator to request an extension of time to submit additional information. Up to 45 days of additional time may be granted.
- The written decision will include specific references to the contract provisions on which the decision is based.
- In the appeal of a claim denial based upon medical or behavioral health judgment, the claims administrator will consult with an appropriate, independent licensed physician. You will have the right to obtain the name of such person if your appeal is denied.

For additional information regarding appealing claims under the STD Plan, please see "Additional Plan Information" on page 268. Claims and appeals under the STD Plan will be handled in accordance with applicable Department of Labor regulations.

For Employees Who Work in the State of New Jersey

If you disagree with the determination of Sedgwick, you have the right to appeal to the Division of Temporary Disability Insurance. You have one year from the date your disability began to file your appeal.

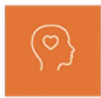
Send your written appeal to:

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

Telephone: (609) 292-6135

Right of Recovery (Effective 5/1/2019)

If the STD Plan provides pay for approved periods of disability that are later determined to be as a result of an illness or injury for which another person or company is legally responsible, the STD Plan has the right to recover payment 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 STD Plan. You must notify the STD 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 STD Plan providing financial protection for approved periods of disability.



Subrogation of Benefits (Effective 5/1/2019)

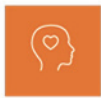
The purpose of the STD Plan is to provide wage protection and pay for approved period of disability that are not the responsibility of any third party. The STD Plan has the right to recover from any third party responsible for compensating you for time lost from work with respect to an illness or injury that results in the STD Plan providing payment to you for approved periods of disability. This is known as subrogation of benefits. The following rules apply to the STD Plan's subrogation of benefits rights:

- The STD Plan has first priority from any amounts recovered from a third party for the full amount of wage replacement benefits it has paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the STD Plan assert this right when requested.
- If you fail to help the STD Plan use this right when requested, the STD Plan may deduct the amount the STD Plan paid from any future wage replacement benefits payable under the STD Plan.
- The STD Plan has the right to take whatever legal action it deems appropriate against any third party to recover the wage replacement benefits paid under the STD Plan.
- If the amount you receive as a recovery from a third party is insufficient to satisfy the STD Plan's subrogation claim in full, the STD Plan's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim against the third party.
- The STD Plan is not responsible for any attorney fees, attorney liens, or other expenses you may incur without the STD Plan's prior written consent. The "common fund" doctrine does not apply to any amount recovered by any attorney you retain regardless of whether the funds recovered are used to repay benefits paid by the STD Plan.
- If you receive a subrogation request and have questions, please contact the claims administrator.

Right of Reimbursement (Effective 5/1/2019)

In addition to its subrogation rights, the STD Plan is entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for Short-Term Disability expenses that have been paid by the STD Plan. The following rules apply to the STD Plan's right of reimbursement:

- You must reimburse the STD Plan in first priority from any recovery from a third party for the full amount of the benefits the STD 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 STD Plan shall have a right of full reimbursement, in first priority, from the recovery.
- You must hold in trust for the benefit of the STD Plan the gross proceeds of a recovery, to be paid to the STD Plan immediately upon your receipt of the recovery. You must reimburse the STD Plan, in first priority and without any set-off or reduction for attorney fees or other expenses. The "common fund" doctrine does not apply to any funds recovered by any attorney you retain, regardless of whether the funds recovered are used to repay benefits paid by the STD Plan.
- If you fail to reimburse the STD Plan, the STD Plan may deduct any unsatisfied portion of the amount of benefits the STD Plan has paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the STD Plan.
- If you fail to disclose the amount of your recovery from a third party to the STD Plan, the STD Plan shall be entitled to deduct the full amount of the benefits the STD Plan paid on your behalf from any future benefits payable under the STD Plan.
- If you fail to reimburse the STD Plan, you agree that JPMorgan Chase may deduct any unsatisfied portion of the amount of benefits the STD Plan has paid from your future earnings, and the plan administrator may, in his or her sole discretion, terminate you from eligibility to participate in the STD Plan.



When Coverage Ends

Your coverage for short-term disability pay under the JPMorgan Chase STD Plan will end on the earliest of the following:

- The date you are no longer disabled as determined by Sedgwick or the applicable Workers' Compensation administrator;
- The date you reach the maximum time limit for short-term disability pay* (i.e., a one-week wait period plus 25 weeks of short-term disability pay for each approved disability)
- The date your employment with JPMorgan Chase ends due to an involuntary termination (excluding a reduction in force);
- The date the STD Plan is discontinued or amended;
- The date you die; or
- The date the plan administrator determines that your coverage ends due to failure to comply with STD Plan provisions.

* *If you're still disabled after a 26-week short-term disability period, you may then be eligible for benefits under the JPMorgan Chase Long-Term Disability (LTD) Plan — provided you had JPMorgan Chase-provided LTD coverage or you elected coverage under the LTD Plan before becoming disabled. Please see the Long-Term Disability (LTD) Plan section for more information.*

If your benefits under the STD Plan end and you are unable to return to work, your employment and your participation and coverage in the JPMorgan Chase benefit plans will generally **end** unless you are approved for additional leave under another JPMorgan Chase policy, such as the Accommodating Disabilities and Temporary Work Restrictions Policy. For details, please refer to the "Return from Leave" section of the Short-Term Disability Policy, available from me@jpmc > HR Policies > Leaves of Absence > Short-Term Disability. If you participate in the LTD Plan and receive LTD benefits, then you may continue to participate in certain benefits plans and receive pay credits under the Retirement Plan.

Please Note: If you voluntarily end your employment during a period of approved short-term disability leave or if you are terminated due to job elimination, you will continue to receive short-term disability pay for the remainder of the leave duration for which you are eligible under the JPMorgan Chase STD Plan. If you voluntarily end your employment prior to an involuntary termination, as determined by the claims administrator, you will not be eligible for continued short-term disability pay.

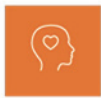
Additional Plan Information

Your primary contact for all matters relating to the general administration of the JPMorgan Chase STD Plan is HR Answers (please see the "Questions" box under the "The Short-Term Disability Plan" on page 254 for contact information).

Your short-term disability pay under the STD Plan is provided under the terms of the official insurance policies and/or contracts, if any, issued to JPMorgan Chase. Sedgwick has complete authority to determine whether your claim of a non-occupational disability meets the standard of the STD Plan for which benefits are payable, and to authorize the payment of any such benefits.

The applicable Workers' Compensation administrator will determine whether you've incurred an occupational disability for which benefits are payable, and will pay any such benefits. All claims appeals for occupational illnesses or injuries should be directed to the appropriate state Workers' Compensation Board or Industrial Commission.

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



Right to Amend

JPMorgan Chase reserves the right to amend, modify (including cost of coverage), reduce or curtail benefits under, or terminate the STD Plan at any time for any reason by act of the Employee Engagement, Culture and Conduct Executive. Upon termination of the STD Plan, all outstanding claims for benefits will be adjudicated and paid in accordance with the STD Plan. Coverage under the STD Plan does not represent a vested benefit.

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. Neither this Guide nor the benefits described in the Guide create a contract of employment or a guarantee of employment between JPMorgan Chase and any employee.

If you have any questions about the STD Plan, please contact HR Answers (please see the “Questions” box under the “The Short-Term Disability Plan” on page 254 for contact information).

Defined Terms

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

Actively-at-Work or on an Active Employment Basis Claims Administrator

Performing all the duties that pertain to your work on a regular basis at the place where they are normally performed or where they’re required to be performed by JPMorgan Chase.

Disability

Sedgwick Claims Management Services, Inc. (herein referred to as “Sedgwick”) is the claims administrator for the STD Plan, a self-insured plan, as it pertains to non-work-related (non-occupational) illnesses or injuries. Sedgwick also administers the statutory disability plans in New York and New Jersey and is the claims administrator in all states for time off approved under the Family and Medical Leave Policy. For additional information, please refer to the Family and Medical Leave Policy, available at [me@jpmc](#) > HR Policies > Leaves of Absence.

For purposes of the STD Plan, “disability” is defined as a period of illness or injury that continues for eight or more consecutive calendar days during which you are unable to perform the material and substantial duties of your position on an active employment basis, and you are not working more than 80% of your normal work schedule.

For Medical Conditions:

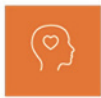
A medical certification (see the definition of Medical Certification, below) by a licensed physician must show that you are disabled with objective documentation that your medical condition disables you from performing your job, and you must be under the care of a licensed physician during your period of illness or injury.

For Behavioral Health Conditions (Effective 5/1/2019):

A behavioral health certification (see the definition of Behavioral Health Certification, below) by a registered or licensed behavioral health provider must show that you are disabled based on clinical findings that your condition limits you from performing your job. You must seek treatment with a registered or licensed behavioral health provider within 10 days of your first date of absence and be seen by a registered or licensed behavioral health provider at least every 30 days throughout the duration of your leave.

For All Conditions:

You must also be determined to be disabled by Sedgwick, the claims administrator for the STD Plan, for non-work-related illnesses or injuries or you must be approved as disabled in accordance with the applicable state Workers’ Compensation law for work-related illnesses or injuries. The claims administrator may use any appropriate information, including surveillance information, to determine whether you are disabled. Furthermore, you are not eligible for leave or pay covered under the STD Plan if the sole reason you cannot report to work is due to your inability to commute to the workplace. (If this is an issue that affects you, please see the Accommodating Disabilities and Temporary Work Restrictions Policy, available at [me@jpmc](#) > HR Policies > Employee Assistance.)



Eligible Compensation

For purposes of the STD Plan, Eligible Compensation generally means your annual base salary plus applicable job differential pay (e.g., shift pay). It does not include any annual incentives, overtime, special recognition, or other incentive awards you might receive. In certain situations, your eligible compensation may include other cash earnings (e.g., commissions and draws) paid under certain non-annual incentive plans that provide compensation in lieu of base salary.

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

Full-Time Employee

For purposes of the STD Plan, a full-time employee is an employee paid through a U.S. payroll of the firm, subject to FICA withholding, and regularly scheduled to work 40 hours per week. Full-time employees include employees who are paid on a salaried basis or an hourly basis, as well as employees who are eligible for draws or commissions. Employees who are eligible for draws or commissions are paid according to line of business commission plans. Full-time employees are generally eligible to participate in the firm's benefits programs and for paid time off, subject to such programs' eligibility criteria.

- *Full-time salaried employees* are exempt employees paid on a salaried basis.
- *Full-time hourly-paid employees* are overtime-eligible employees paid on an hourly basis.

Introductory Period

The first 90 days of employment for newly hired and re-employed employees at JPMorgan Chase.

Licensed Physician

A person who is not your relative or family member and:

- Is determined by the plan administrator or its delegate to be qualified to render an opinion about your physical condition as it relates to your claim of disability;
- Is a healthcare provider licensed in the jurisdiction in which he or she practices and is determined by the claims administrator, in its sole discretion, to be qualified and appropriate under the circumstances to provide medical certification; and
- Whose primary practice is treating patients.

Registered or Licensed Behavioral Health Provider

A person who is not your relative or family member and:

- Is determined by the plan administrator or its delegate to be qualified to render an opinion about your mental condition as it relates to your claim of disability;
- Is a behavioral health provider registered or licensed in the jurisdiction in which he or she practices and is determined by the claims administrator, in its sole discretion, to be qualified and appropriate under the circumstances to provide behavioral health certification; and
- Whose primary practice is treating patients.

Medical Certification

Certification from your licensed physician confirming the status of your medical condition as it relates to your claim of disability and objective documentation that your medical condition disables you from performing your job.

Note: A certification that is based largely or entirely on self-reported symptoms, without objective documentation of inability to perform the job, will not be considered sufficient to support a finding of disability.

Behavioral Health Certification

Certification from your registered or licensed behavioral health provider confirming the status of your mental condition as it relates to your claim of disability and clinical documentation that your condition disables you from performing your job.

Note: A certification that is based largely or entirely on self-reported symptoms, without clinical documentation of inability to perform the job, will not be considered sufficient to support a finding of disability.

Non-Occupational Injury/Illness

A non-occupational injury/illness means an injury, sickness, or disease not related to your employment.

Occupational Injury/Illness

An occupational injury or illness extends to all injuries or diseases that arise out of and are in the course and scope of employment. If you have an occupational illness or injury, you may be eligible for Workers' Compensation benefits, including paid medical expenses and compensation for lost work time.



Recognized Service

The period of service with JPMorgan Chase that may include service with heritage organizations (including predecessors of JPMorgan Chase) as outlined by the following conditions:

If employed as of July 1, 2004:

If employed by JPMorgan Chase & Co. or one of its participating subsidiaries or Bank One Corporation or one of its participating subsidiaries as of the date of the merger (July 1, 2004), only prior service with the specific heritage organization employing the individual on that merger date (July 1, 2004) will count as recognized service, as follows:

- If employed by JPMorgan Chase & Co. or one of its participating subsidiaries as of July 1, 2004, service defined as cumulative service under heritage JPMorgan Chase Human Resources policies (including pre-acquisition service in identified situations) will count as recognized service; or
- If employed by Bank One Corporation or one of its participating subsidiaries as of July 1, 2004, recognized service will be determined by the Bank One Service Date (as documented in official company records).

If re-employed during the period July 2, 2004 through June 30, 2005:

If not employed by a heritage organization on the merger date (July 1, 2004) and re-employed during the period July 2, 2004 through June 30, 2005, the applicable service provisions referenced above will be those of the heritage organization that most recently employed the individual prior to his/her re-employment date.

If re-employed on or after July 1, 2005:

For individuals who were employed by the firm as of July 1, 2005, experience a subsequent break in service and are re-employed by the firm:

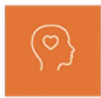
- If the individual's break in employment ending on or after July 1, 2005, is 12 months or less, his/her service will be considered uninterrupted for purposes of recognized service. In other words, the period of the break in employment ending on or after July 1, 2005 counts toward the period of recognized service.
- If the individual's break in employment ending on or after July 1, 2005, is more than 12 months, recognized service upon rehire will include recognized service as in effect on the last day of the previous employment period.

For individuals who were not employed as of June 30, 2005 but who are re-employed on or after July 1, 2005, the employer for purposes of recognized service is the employer who most recently employed the individual prior to the re-employment date.

- If the individual's break in employment, ending on or after July 1, 2005, is 12 months or less, his/her service will be considered uninterrupted for purposes of recognized service. In other words, the period of the break in employment counts toward the period of recognized service.
- If the individual's break in employment, ending on or after July 1, 2005, is more than 12 months:
 - For rehires whose last employer before the break was heritage JPMorgan Chase, recognized service upon rehire will include service defined as cumulative service under heritage JPMorgan Chase Human Resources policies during the previous employment period plus an adjustment for pre-acquisition service in identified situations.
 - For rehires whose last employer before the break was heritage Bank One, recognized service will include service denoted by the employee's Bank One Service Date as in effect on the last day of the previous employment period.

For heritage Bear Stearns employees who were employed by the firm as of August 31, 2008:

- Recognized Service will be determined by the Bear Stearns Service Date (as documented in official company records).



For heritage Bear Stearns employees re-employed on or after September 1, 2008 (whose last employer before the break in service was heritage Bear Stearns versus JPMorgan Chase):

- If the individual's break in employment, ending on or after September 1, 2008, is 12 months or less, his/her service will be considered uninterrupted for purposes of Recognized Service. In other words, the period of the break in employment counts toward the period of Recognized Service.
- If the individual's break in employment, ending on or after September 1, 2008, is more than 12 months, Recognized Service upon rehire will include prior Bear Stearns service, excluding the period of the break in employment.

For heritage Washington Mutual employees who were employed by the firm as of June 30, 2009:

- Recognized Service will be determined by the Washington Mutual Service Date (as documented in official company records).

For heritage Washington Mutual employees re-employed on or after July 1, 2009 (whose last employer before the break in service was heritage Washington Mutual versus JPMorgan Chase):

- If the individual's break in employment, ending on or after July 1, 2009, **is 12 months or less**, his/her service will be considered uninterrupted for purposes of Recognized Service. In other words, the period of the break in employment counts toward the period of Recognized Service.
- If the individual's break in employment, ending on or after July 1, 2009, **is more than 12 months**, Recognized Service upon rehire will include prior Washington Mutual service, excluding the period of the break in employment.

Service with a company at the time of its acquisition (as opposed to a merger) will count toward recognized service, if so provided under the terms of the applicable purchase agreement.

Temporary Employee

For purposes of the STD Plan, a temporary employee is an employee hired onto the U.S. JPMorgan Chase payroll for a specific length of time or for a temporary project, typically for less than six months. In general, these employees are paid on an hourly basis and are not eligible to participate in certain JPMorgan Chase benefit plans and paid time off policies.

Under the Care of a Licensed Physician

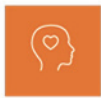
You are considered to be under the care of a licensed physician when you:

- Personally visit a licensed physician as frequently as is medically required (according to generally accepted medical standards) to effectively manage and treat your disability condition(s);
- Are receiving the most appropriate treatment and care (which conforms with generally accepted medical standards for your disability condition(s)), by a licensed physician whose specialty or experience is the most appropriate for your disability; and
- Are receiving active treatment from a licensed healthcare provider on a regular basis that is appropriate for your disability, as determined by the claims administrator.

Under the Care of a Registered or Licensed Behavioral Health Provider (Effective 5/1/2019)

You are considered to be under the care of a Behavior Health Provider when you:

- Have sought an appointment with a registered or licensed behavioral health provider within 10 days of your first date of absence;
- Personally visit a registered or licensed behavioral health provider as frequently as is therapeutically required (according to generally accepted psychological standards) and no less often than every 30 days, to effectively manage and treat your disability condition(s);
- Are receiving the most appropriate treatment and care (which conforms with generally accepted psychological standards for your disability condition(s)), by a registered or licensed behavioral health provider whose specialty or experience is the most appropriate for your disability; and
- Are receiving active treatment from a registered or licensed behavioral health provider that is appropriate for your disability, as determined by the claims administrator.



Wait Period

The first week of short-term disability leave is generally a one-week wait period (i.e., seven consecutive calendar days) before short-term disability pay begins, unless otherwise indicated by state statutory requirements.

If your short-term disability leave is due to a non-work-related illness or injury, available sick time will be applied on your behalf as pay during this first week of short-term disability leave. If your available sick time is exhausted, where allowable by state law, available personal days and floating holidays will be applied on your behalf, if applicable, as well as any accrued and unused vacation as pay during the wait period. In addition, at your request, JPMorgan Chase will advance you unaccrued vacation time for the calendar year in which your leave begins and apply it on your behalf for use during your one-week wait period.

If your short-term disability leave is due to a work-related illness or injury, a Workers' Compensation state-mandated wait period may also apply and will run concurrently with the STD Plan wait period. Furthermore, you may, but are not required to, have your available paid time off applied as pay during the wait period. If all of your paid time off is exhausted, the applicable portion of the first week of your short-term disability or Workers' Compensation leave is unpaid. For more information, please refer to the Time Away from Work Policies, available at me@jpmc > HR Policies > Time Away from Work.

Please Note:

- JPMorgan Chase will apply available paid time off on your behalf during the one week wait period.
- If JPMorgan Chase advanced you unaccrued vacation time for a wait period and your employment later terminates, any vacation time that was paid to you but has not been accrued by your termination date will be considered a salary advance and will be recovered at termination, subject to applicable law.
- The STD Plan does not provide for unpaid disability leave. Please consult the Short-Term Disability Leave Policy for information on unpaid disability leave.

Workers' Compensation Insurance Program

Workers' Compensation insurance provides medical, disability, and other statutory benefits for employee illnesses and injuries arising out of and in the course and scope of work.

Where applicable, short-term disability pay benefits may supplement a Workers' Compensation wage replacement benefit. Workers' Compensation claims are approved in accordance with applicable state Workers' Compensation law. If a Workers' Compensation claim is approved, the approval will also serve as the authorization of applicable pay benefits under the STD Plan.

If a Workers' Compensation claim is denied, the leave will still be considered under the STD Plan and will be required to meet the requirements of the STD Plan in order to qualify as paid leave.

For further information about JPMorgan Chase's Workers' Compensation administrators, please go to: [FWS > Corporate Finance Groups > Global Treasury > Corporate Insurance Services > Workers' Compensation Claims Reporting](#).



Your JPMC Benefits Guide

Effective 1/1/21

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.jpmbenefitsguide.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.jpmbenefitsguide.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.jpmbenefitsguide.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.

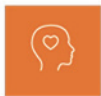
The JPMorgan Chase U.S. Benefits Program is available to most employees on a U.S. payroll who are regularly scheduled to work 20 hours or more a week and who are employed by JPMorgan Chase & Co. or one of its subsidiaries to the extent that such subsidiary has adopted the JPMorgan Chase U.S. Benefits 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.



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About This Guide

Effective 1/1/21

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, 2021:

- *The JPMorgan Chase Core Medical Plan*
- *The JPMorgan Chase Simplified Medical 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.jpmmcbenefitsguide.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.jpmmcbenefitsguide.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 plans include:

- *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.

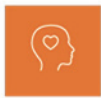
Please Note: You may assign certain employee life insurance benefits and may assign to a health care service provider the right to payment. Please contact HR Answers for more information.

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.

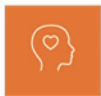
If you have any questions about this plan, please contact HR Answers.



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 1/1/21

*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.

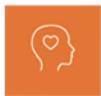
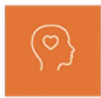


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Qualified Status Changes (QSCs)

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

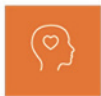
QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner Child
Marriage	Add	Add	Add
Domestic Partner Commitment	Add	Add	Add
Divorce, Legal Separation, or Termination of DP Commitment	Add	Drop	Drop
Death of Spouse/DP	N/A	Drop	Drop
Birth/Adoption/Legal Guardianship	Add	Add	Add
Child Gains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



QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner Child
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
You or Covered Dependent Gains Other Coverage	N/A	Decrease, stop

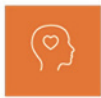


QSC	Health Care Spending Account	Dependent Care Spending Account
You or Covered Dependent Loses Other Coverage	Begin, increase	Begin, increase
Change in Dependent Care Provider or Fees	N/A	Begin, increase, decrease, or stop
Move out of Provider Service Area	N/A	N/A

*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.

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 dependents have the option to continue their 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 dependents don’t elect to continue coverage.

For the Group Personal Excess Liability Plan: In the event of your death, covered surviving members of the household should contact Arthur J. Gallagher Risk Management Services for instructions on paying the balance due. If payment is not received within 31 days of the date of the letter sent by Arthur J. Gallagher Risk Management Services to the participant’s survivor, the policy will be canceled as of the date of your death. The Plan will also cover any legal representative or person having proper temporary custody of the participant’s property. Also, coverage will be provided until the end of the policy period or policy anniversary date, whichever occurs first, for any surviving member of your household who is a covered person at the time of death. Premium payments for this coverage apply.



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 on the date your work status changes and you are then scheduled to work fewer than 20 hours per week. However, you may continue coverage through the end of year by contacting Arthur J. Gallagher Risk Management.

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.
 - 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.
 - In the case of the Basic Life Insurance Plan, your eligible compensation is updated as changes occur throughout the year.
- **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.

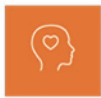
In certain cases, you may be temporarily approved for additional leave under another JPMorgan Chase Policy, such as the Disability and Reasonable Accommodation Policy. (For details on medical plan coverage should you become eligible for Medicare during this timeframe, please see "You Are on LTD and Become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

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 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.

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).

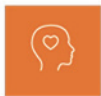
Paid Military Leave

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.

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.

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.

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 when you 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 file 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.

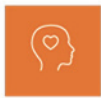
You Return from a Leave of Absence

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.
- 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

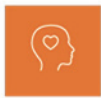
Total Annual Cash Compensation (TACC)

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 an 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 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.

- **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.

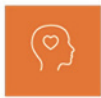
If You Port or Convert

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 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 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.

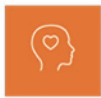
Porting Versus Converting Insurance Policies

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, participation 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 usually ends on your termination date. While you cannot convert or port your coverage, you may continue your current coverage through the end of the calendar year by paying the balance of the remaining premium in full directly to Arthur J. Gallagher Risk Management Services.



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 and dental coverage. For vision coverage, you may enroll for retiree vision coverage even if you were not covered under the Vision Plan at the time of your retirement.

- **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.

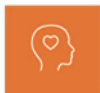
For the Health Care Spending Account, if you are participating in the Health Care Spending Account when your employment with JPMorgan Chase ends, you will be covered for eligible expenses incurred in the plan year up to the end of the month in which you terminate. You then have until March 31 of the 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.

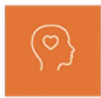


- **For Basic Life**, upon receipt of the MetLife conversion package at your home mailing address, and within 31 days of your retirement date, you may convert any portion of your Basic Life Insurance (over the first \$10,000) to an individual policy by contacting Metropolitan Life Insurance Company (MetLife), 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.
- **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.

If You Port or Convert

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

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 on your retirement date. You are eligible to continue your participation through the end of the policy year in which you retire, provided you pay the balance of the policy in full. After your employment ends, Arthur J. Gallagher & Co., the plan administrator, will contact you with instructions for continuing your coverage and paying the balance. If your payment is not received within 31 days, your policy will be cancelled effective as of your retirement date. For more information, please see the **As You Leave Guide** on me@jpmc.

You Work Past Age 65

For the spending accounts: If you continue to work for JPMorgan Chase after you reach age 65, you can continue participating in the spending accounts, 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.



Plan Administration

Effective 1/1/21

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 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.



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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 355 for a listing of official plan names and numbers.

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 356 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.
28 Liberty Street
22nd Floor
Mail Code: NY1-A302
New York, NY 10005-1401

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.



Claims Administrator

The contact information for claims administrators for the various benefits plans can be found under “Contacting the Claims Administrator” on page 365 and “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 489.

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 357 for information on benefits fiduciaries.

Agent for Service of Legal Process

Legal Papers Served:

JPMorgan Chase & Co.
4 Chase Metrotech Center
FL 18, NY1-C312
Brooklyn, NY 11245

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 489.)

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Medical Plan/502	See “Contacting the Claims Administrator” on page 365 for names, addresses, and telephone numbers for the Medical Plan and the Prescription Drug Plan.	See “Contacting the Claims Administrator” on page 365 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 Dental Plan/502	See "Contacting the Claims Administrator" on page 365 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 365 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
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



Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
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 Family Solutions 200 Talcott Avenue, South Watertown, MA 02472	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
The JPMorgan Chase Health Care Spending Account Plan/510	N/A	See “Contacting the Claims Administrator” on page 365 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



Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Health & Wellness Centers Plan/559	N/A	JPMorgan Chase Medical Director JPMorgan Chase & Co. 270 Park Avenue, 11 th 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.
- Connexions Loyalty Acquisition, LLC
- eCast Settlement Corp
- FNBC Leasing Corporation
- Highbridge Capital Mgmt, LLC
- InstaMed Communications, LLC
- 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 Investment 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 Holding LLC
- JPMorgan Distribution Services, Inc.
- Neovest, Inc.
- 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.
- 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.

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.



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 361.

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 354. 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 365, which sets forth the rules that will apply.

Claiming Benefits: Plans Subject to ERISA

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 357 and “Contacting the Claims Administrator” on page 365. 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 477.

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.

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 489.



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 365.

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	
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***.



Plan/Option	Appropriate Claims Administrator	Timing for Filing Your Initial Claim
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 Medical Director JPMorgan Chase & Co. 270 Park Avenue, 11 th Floor Mail Code: NY1-K318 New York, NY 10017-2014?	No later than December 31 of the year following the year in which services were provided.
Back-up Child Care Plan	Bright Horizons Family Solutions 200 Talcott Avenue, South Watertown, MA 02472	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.

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-routed 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	<ul style="list-style-type: none">• 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.

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	180 days
Back-up Child Care Plan	

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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 45 days, plus one 45-day extension for matters beyond the plan's control.
Individual Disability Insurance	<ul style="list-style-type: none">• 45 days, plus one 45-day extension for matters beyond the plan's control.
Short-Term Disability Plan	<ul style="list-style-type: none">• 45 days, plus one 45-day extension for matters beyond the plan's control.
Life Insurance Plan	<ul style="list-style-type: none">• 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 or a rescission of coverage; 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 or 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.

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 489

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
Prescription Drug Plan*	CVS Caremark Attention: Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196 866-209-6093

**Medical Plan Claims Administrators****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

**Other Health Care and Insurance Plans Subject to ERISA**

Plan	Contact
<i>Health Care Spending Accounts</i>	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
<i>Back-Up Child Care Plan</i>	Bright Horizons Children's Centers LLC. 2 Wells Ave. Newton, MA 02459 (888) 701-2235
<i>Health & Wellness Centers Plan</i>	JPMorgan Chase & Co. Health Services Dept. 277 Park Ave, 1 st Floor Mail Code: NY1-L085 New York, NY 10172 (212) 270-5555
<i>Group Long-Term Disability</i>	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176 (877) 361-4778
<i>Individual Disability Insurance</i>	Unum The Benefits Center P.O. Box 100262 Columbia, SC 29202-3262 (888) 226-7959
<i>Short-Term Disability Plan*</i>	Sedgwick Claims Management Services JPMorgan Chase Leave of Absence Service Center P.O. Box 14648 Lexington, KY 40512-4648 (888) 931-3100
<i>Life and AD&D Insurance Plans</i>	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017 (800) MET-LIFE ((800) 638-5433)
<i>Business Travel Accident Insurance Plan</i>	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

**Other Health Care and Insurance Plans Subject to ERISA**

Plan	Contact
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 361, 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 477.

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



Plan	Contact
Group Personal Excess Liability Insurance Plan	Arthur J. Gallagher & Co. 250 Park Avenue, 5 th Floor New York, NY 10177 (866) 631-4630

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.



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 first priority 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 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. 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.

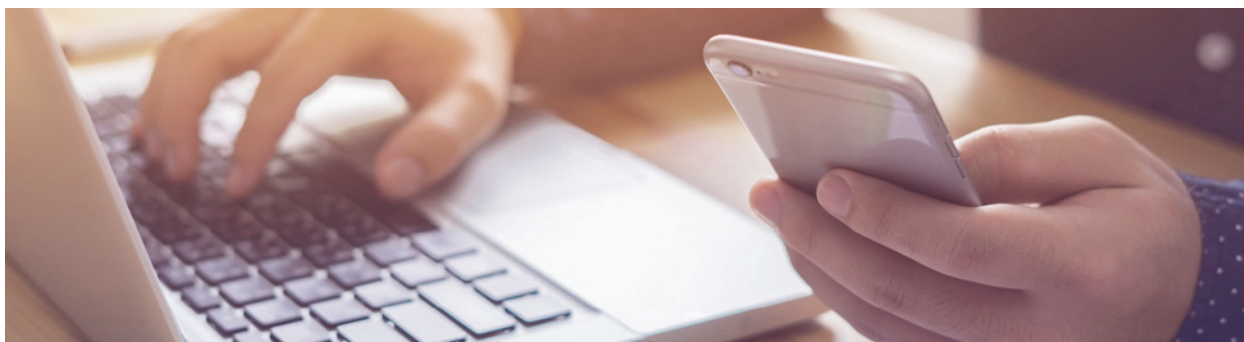


Special Notice for Employees Who Have Been Rehired by JPMorgan Chase

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 1/1/21

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
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	Grand Rounds (888) 868-4693 8 a.m. to 9 p.m. Eastern time, Monday – Friday www.grandrounds.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 – 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 11 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) (800) MET-LIFE ((800) 638-5433) 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
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) 737-7249 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 8:30 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 .
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	Arthur J. Gallagher Risk Management Services (866) 631-4630 9 a.m. to 5 p.m. Eastern time, Monday – Friday
Back-up Child Care Plan	Bright Horizons (877) BH-CARES ((877) 242-2737) https://backup.brighthouse.com/jpmc (for reservations) me@jpmc > Health, Life & Parenting > parents@jpmc (for information about the Plan)
Expatriate Medical and Dental Plans	Cigna Global Health Benefits (800) 390-7183 (outside the U.S., call collect at (302) 797-3644) 24/7 www.CignaEnvoy.com