



The Long-Term Disability Plan

Effective 1/1/25

JPMorganChase recognizes how important income replacement can be to you and your family if you become seriously ill or injured and you can't work. The Long-Term Disability Plan ("LTD Plan") generally pays a benefit if a disability keeps you out of work and you've exhausted your coverage under the Short-Term Disability Plan, provided your disability has been approved by the claims administrator.

The LTD Plan has two components:

- **Group LTD coverage**, insured and administered by The Prudential Insurance Company of America ("Prudential"), which allows you to elect to replace Total Annual Cash Compensation (TACC) up to \$400,000 or \$480,000 (depending on the Group LTD option elected) and pays a monthly benefit of up to \$20,000; and
- **Individual Disability Insurance ("IDI") coverage**, insured and administered by Unum, which covers the remainder of TACC up to \$700,000 or \$840,000 (depending on the Group LTD option elected) and pays an additional monthly benefit of up to \$15,000.

Employees who meet the LTD Plan's eligibility requirements and who have TACC of less than \$80,000 in effect for the plan year are automatically enrolled in Group LTD coverage for that plan year at JPMorganChase's expense – no employee contributions are required.

For all other employees, participation in Group LTD coverage is optional, and is available by making after-tax contributions for coverage. However, if you *don't* enroll and your employment with JPMorganChase ends due to total disability, your coverage under certain U.S. Benefits Plans may end.

It is important to give serious consideration to the advantages of LTD coverage before deciding not to enroll.

If you are eligible for IDI coverage, separate information regarding IDI will be sent to you.

About This Summary Plan Description

This section is the summary plan description (SPD) and the plan document for the JPMorgan Chase Long-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.

This section of the guide will provide you with a better understanding of how your Long-Term Disability Plan coverage works, including how and when benefits are paid.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 50684.**

Questions?

Claim related questions for Group LTD: Prudential, Monday – Friday from 8 a.m. to 8 p.m. Eastern time at (877) 361-4778.

Claim related questions and Evidence of Insurability (EOI) forms for Individual Disability Insurance: Covala Group, the administrative service provider for Unum, Monday – Friday from 8:30 a.m. to 5:30 p.m. Eastern Time at (800) 235-3551 or (212) 527 8025. You can also email questions to JPMCLTD@covalagroup.com.

General coverage questions: 1-844-ASK-JPMC.

Service Representatives are available Monday – Friday, from 8 a.m. to 7 p.m. Eastern Time, except certain U.S. holidays.

You can also obtain answers to your questions 24 hours a day, seven days a week online at **My Health**.

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. JPMorganChase 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 JPMorganChase and any individual. JPMorganChase or you may terminate the employment relationship at any time.

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LTD Plan Highlights

Your Choices

Long-Term Disability Plan includes two options – Group LTD and IDI. Both provide a level of income replacement protection should you continue to be disabled beyond the period of time covered under the Short-Term Disability Plan. Note: Eligibility for LTD benefits does not depend on first having received STD benefits. Group LTD coverage provides income protection for Total Annual Cash Compensation (TACC) of \$400,000 or less (or \$480,000 or less, depending on the Group LTD option elected), while IDI coverage is available as an additional supplement to employees whose TACC is more than \$400,000 (or \$480,000, depending on the Group LTD option elected). IDI covers income above \$400,000 to \$700,000 (or above \$480,000 to \$840,000, depending on the Group LTD option elected).

Group LTD Coverage

Group LTD coverage provides you with a monthly benefit based upon a percentage of your TACC, less certain other disability benefits (see “Defined Terms” on page 226 for the definition of “Benefits Offset”). Prudential is the claims administrator for Group LTD coverage. If your TACC in effect for a plan year is less than \$80,000, you are automatically enrolled in the LTD Plan for that given plan year. If you meet the plan’s definition of disabled, the plan would provide:

- Replacement of 60% of TACC, to a maximum monthly benefit of \$4,000.

If your TACC in effect for a plan year is \$80,000 or more, you can choose long-term disability protection from among the following options:

- **The 50% option:** Replacement of 50% of TACC up to \$480,000, to a maximum monthly benefit of \$20,000;
- **The 60% option:** Replacement of 60% of TACC up to \$400,000, to a maximum monthly benefit of \$20,000; or
- **No coverage.**

Individual Disability Insurance Coverage

If your TACC is greater than \$400,000, you generally can choose additional LTD coverage under fully portable Individual Disability Insurance, insured and administered by Unum. You do not need to be enrolled in Group LTD coverage to elect IDI coverage. You are eligible for IDI if your TACC is more than \$400,000, if you elect the LTD 60% option (or more than \$480,000, if you elected the 50% option) and provides an additional maximum monthly benefit of up to \$15,000. If you do not enroll in Group LTD coverage, then you are defaulted to the 60% option for IDI. If you are eligible, you will receive separate information regarding IDI. Unum is the claims administrator for Individual Disability Insurance.

Benefits Eligibility

Under Group LTD coverage, generally benefits can begin after 182 days of disability.

- **During the elimination period of 182 days and the first 24 months on Group LTD:** It must be determined by Prudential that you cannot perform the material and substantial duties of **your regular occupation** because of an occupational or non-occupational injury or sickness.
- **After 30 months of disability (the 182-day elimination period plus 24 months of Group LTD benefits):** You’re eligible for continued Group LTD benefits if Prudential determines that — because of an occupational or non-occupational illness or injury — you’re unable to perform the duties of **any gainful occupation** for which you’re reasonably fitted by training, education, and experience.

If your TACC is \$200,000 or more, you may qualify for benefits under Group LTD coverage (under the coverage option you choose) if you’re unable to perform the material and substantial duties of **your regular occupation** for the maximum payable duration of the disability. (Your premium will be higher in this case.)

Under IDI, generally benefits can begin after the greater of 180 days of disability or the end of benefits under the Short-Term Disability Plan. It must be determined by Unum that you cannot perform the material and substantial duties of your regular occupation.

Duration of Benefits

Your Long-Term Disability Plan benefits may continue until you are determined not to be disabled, reach the maximum time period for benefits, or pass away.

Generally, if you continue to meet the definition of disability, benefits paid under the LTD Plan for a disability occurring before age 60 (or age 61, in the case of IDI) continue until you recover or you reach age 65, whichever occurs first. Benefits paid under the LTD Plan for a disability occurring after age 60 (or age 61, in the case of IDI) continue for a specified length of time as long as you are continuously disabled, based on the age at which you become disabled. Please see “**Limitations on Certain Benefits**” on page 212 under “When Participation Ends” beginning on page 207 and “When Benefits Begin and End” on page 220 under the “How Individual Disability Insurance (“IDI”) Works” on page 217.

How You Pay for Coverage

If your TACC in effect for a plan year is less than \$80,000, Group LTD coverage is fully paid by JPMorganChase and any benefits you receive if you become disabled would therefore be taxable.

If your TACC in effect for a plan year is \$80,000 or more, you pay the premiums for your elected Group LTD coverage on an after-tax basis. As a result, any future benefits you receive if you become disabled would be tax-free. Your cost per pay period depends on your TACC, the level of coverage you choose, and your status as a tobacco user or non-tobacco user. Please see “Defined Terms” beginning on page 226 for the definition of “Total Annual Cash Compensation.” Please see the definition of “Tobacco User Status” on page 205.

As with Group LTD coverage, if you are eligible for and elect IDI coverage, you pay for it on an after-tax basis, so any benefits you receive if you become disabled would be tax-free. Your cost depends on your TACC, the level of coverage you choose, age, state of residency, and your status as a tobacco user or non-tobacco user.

Participating in the Long-Term Disability Plan

The JPMorgan Chase Long-Term Disability Plan, consisting of Group LTD and Individual Disability Insurance (IDI), can provide income replacement if you are unable to work for an extended period of time due to an illness or injury. Your long-term disability coverage generally pays a benefit after you have exhausted your coverage under the JPMorgan Chase Short-Term Disability Plan. However, eligibility for LTD benefits does not depend on first having received STD benefits.

The general guidelines for participating in the JPMorgan Chase Long-Term Disability Plan are described in this section.

Advantages of Electing LTD Coverage

If you elect LTD and qualify to receive benefits under the JPMorgan Chase Long-Term Disability Plan, you may continue to be considered an employee for up to 24 months. You will also continue to have access to company-sponsored benefits, while you remain an employee, such as subsidized medical and dental coverage, vision benefits, basic life insurance (and other life insurance, if enrolled at the time of your disability), personal excess liability and group legal.

In addition, if you do not enroll for LTD coverage when you are first eligible and then later choose to elect and are approved for coverage, you will not be covered for a claim due to a condition that predates your coverage effective date (see “Pre-Existing Condition Exclusion” on page 210).

Please carefully consider these additional advantages when deciding whether to elect LTD coverage.

Eligibility

Who’s Eligible

In general, you are eligible to participate in the Long-Term Disability Plan if you are:

- Employed by JPMorgan Chase & Co., or one of its subsidiaries that has adopted the Plan, on a U.S. payroll and you are subject to FICA taxes;

- Paid hourly, salary, draw, commissions, or production overrides; and
- Regularly scheduled to work 20 or more hours per week.

Who's Not Eligible

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

Examples of such individuals include an:

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

Cost of Coverage

Group LTD

If your Total Annual Cash Compensation (TACC) in effect for a plan year is less than \$80,000 a year, coverage for that plan year is fully paid for by JPMorganChase and as a result, any benefits you receive if you become disabled would be taxable. TACC is recalculated as of each August 1 to take effect the following January 1 and will remain unchanged throughout the year.

If your TACC in effect for a plan year is \$80,000 or more and you elect Group LTD, you pay for coverage on an after-tax basis, and as a result, any benefits you receive if you become disabled would be tax-free. Your cost depends on your TACC, the level of coverage you choose, and your status as a tobacco user or non-tobacco user. (Please see "Defined Terms" beginning on page 226 for the definition of "Total Annual Cash Compensation". Please see the definition of "Tobacco User Status" on page 205.) Your contributions toward the cost of coverage begin on or near the first day of the pay period in which your coverage begins or after your coverage has been approved if Evidence of Insurability is required. Your contributions are automatically deducted from your paycheck in equal installments (unless retroactive payments are required).

If you become eligible to receive benefits under Group LTD coverage, you won't have to pay for your Group LTD coverage during an approved period of long-term disability.

Individual Disability Insurance ("IDI")

As with Group LTD coverage, if you are eligible for and elect IDI coverage, you pay for it on an after-tax basis, so any benefits you receive if you become disabled would be tax-free. Your cost depends on your Total Annual Cash Compensation (TACC), the level of coverage you choose, age, state of residency, and your status as a tobacco user or non-tobacco user. TACC is recalculated as of each August 1 to take effect the following January 1 and will remain unchanged throughout the year.

Your contributions toward the cost of coverage begin based on your date of hire and on or near the first day of the pay period in which your coverage begins. Your contributions are automatically deducted from your paycheck in equal installments (unless retroactive payments are required).

If you become eligible to receive benefits under IDI, you won't have to pay for your IDI coverage during an approved period of long-term disability.

Tobacco User Status

Employees who do not use tobacco products pay less for Group LTD and IDI coverage. Each year, employees must verify their status as a non-tobacco user or tobacco user. To be considered a non-tobacco user and pay lower, non-tobacco user rates under the plan for a plan year, you must be tobacco-free for at least 12 months as of January 1 of that plan year, or complete an approved tobacco cessation program. If you continue to use tobacco, you will need to complete an approved tobacco cessation course annually to continue to qualify for the lower, non-tobacco user rates. If you meet the definition of a tobacco user but fail to declare your tobacco user status, you may be subject to disciplinary action.

Please Note: In your first calendar year of employment, you will be assigned non-tobacco user rates for your Group LTD coverage even if you declare yourself as a tobacco user, because you may not have had an opportunity to complete a tobacco cessation course in order to qualify for the lower non-tobacco user rates. In subsequent years, however, you will be eligible for non-tobacco user rates only if you have been tobacco-free for 12 months (as of January 1) or if you complete a tobacco cessation course, as described in the preceding paragraph.

However, if you were hired on or after October 1, of the current plan year; the following plan year you will be assigned non-tobacco user rates for your Group LTD coverage even if you declare yourself as a tobacco user, because you may not have had an opportunity to complete a tobacco cessation program in order to qualify for the lower, non-tobacco user rates.

For IDI coverage, you will declare your tobacco user status in your enrollment materials. You will be assigned rates based on your self-reported tobacco use. For those assigned tobacco user rates, your rates will be changed to non-tobacco user rates if you have been tobacco-free for 12 continuous months (as of January 1) or if you have completed the JPMorganChase approved smoker cessation program in the past year (as of January 1).

How Tobacco User Is Defined

Under the JPMorgan Chase Benefits Program, a “tobacco user” (for a plan year) is any person who has used any type of tobacco products (e.g., cigarettes, cigars, chewing tobacco, snuff, or a pipe), regardless of the frequency or location (this includes daily, occasionally, socially, at-home only, etc.) in the 12 months preceding January 1 of the plan year.

Evidence of Insurability

Evidence of insurability (EOI) is required if you are electing Group LTD or IDI coverage after declining when first eligible (and you are not a newly hired employee or a newly eligible employee) and for increases in the Group LTD benefit option above the assigned option indicated on your Personalized Fact Sheet during Annual Benefits Enrollment. If you elect a Group LTD coverage level that requires EOI, you will need to complete an EOI form from Prudential at the time you enroll and/or a Unum EOI form from Covala after you have elected IDI coverage. If you do not complete and return the EOI form or if your application is not approved, only previously assigned coverage amounts not requiring EOI will be effective, which might include no coverage.

Please Note: If you complete Evidence of Insurability (EOI), Prudential considers any statements you make in a signed application for coverage a representation. If any of the statements made by you are not complete and/or not true at the time they are made, Prudential reserves the right to reduce or deny any claim, or cancel your coverage within two (2) years of the effective date of your coverage.

Limited Continuation of Other Benefits

While you're receiving LTD Plan benefits (either Group LTD or IDI), you'll be considered a "benefits-eligible individual" and will remain eligible to participate in a number of other JPMorganChase benefits plans **for up to the first 24 months that you receive LTD benefit payments** – as long as you continue to make any required contributions for your elected coverage and are considered disabled. These plans include:

- **Medical Plan** — You can continue current coverage at active employee rates until the earlier of:
 - your having received 24 months of LTD benefit payments or
 - you become eligible for Medicare;
- **Dental Plan** — You can continue current coverage at active employee rates until the earlier of :
 - your having received 24 months of LTD benefit payments or
 - you become eligible for Medicare;
- **Vision Plan** — You can continue current coverage at active employee rates;
- **Basic Life Insurance** — Coverage will continue at no cost to you;
- **Supplemental Term Life Insurance** — You can continue current coverage at active employee rates; you cannot elect new coverage or increase coverage for yourself or your dependents;
- **Accidental Death and Dismemberment (AD&D) Insurance** — You can continue current coverage at active employee rates; you cannot elect new coverage or increase coverage for you or your dependents;
- **Group Legal Services Plan** — You can continue current coverage at active employee rates;
- **Group Personal Excess Liability Insurance Plan** — You can continue current coverage at active employee rates;
- **Employee Assistance Program and access to JPMorgan Chase Health & Wellness Centers and screenings** — Your participation will continue at no cost to you.

Coverage for the Dependent Care Spending Account and Transportation Spending Accounts, as well as for Business Travel Accident and Disability Leave, automatically stops when you receive LTD benefits. You can continue making contributions to the Health Care Spending Account (HCSA) on an after-tax basis while on LTD on a direct bill basis. Participation in the HCSA will cease at the end of the benefit plan year in which you start to receive LTD benefits. COBRA benefits (for medical, dental and/or vision) will be offered for 18 months when coverage for health care benefits ends (please see the *Health Care Participation* section for more information on COBRA coverage).

Important Note Regarding Eligibility for Other Benefits

If you accept a settlement of your LTD claim from the LTD claims administrator, JPMorganChase will no longer consider you a "benefits-eligible individual" and as such, any health and income protection benefits you were receiving as a result of your active receipt of LTD payments will end. Please consider this carefully if you decide to accept a settlement offer.

If You Became Disabled Before 2011

If you became disabled and qualified for LTD benefits before January 1, 2011, your coverage for the benefits listed at left will continue at active employee rates while you receive benefits under the Long-Term Disability Plan.

Termination of Employment After 24 Months of LTD Benefit Payments

Please Note: Your employment with JPMorganChase will end immediately after you have received 24 months of LTD benefit payments (or while your LTD is approved, whichever is less), unless you have requested and been approved for additional leave time as a reasonable accommodation. If you believe that you may qualify for a reasonable accommodation under JPMorganChase's Accommodating Disabilities Policy (which may include an extension of your employment), please contact 1-844-ASK-JPMC prior to your termination date. JPMorganChase will review your request in light of the medical information you provide as well as its business needs, and will follow up with you as appropriate to determine whether to grant your request or an alternative accommodation, if any.

You will continue to be eligible for Long-Term Disability Plan benefits provided you meet all contractual provisions outlined in the plan. You are not responsible for premiums related to LTD coverage while receiving LTD benefits.

When Participation Ends

Your participation in the Long-Term Disability Plan will end on the earliest of the following:

- The date your employment with JPMorganChase ends for any reason;
- The date you fail to make required contributions for coverage (prior to becoming eligible for long-term disability benefits);
 - **Please Note:** Coverage will continue for a benefits-eligible individual absent due to disability during the elimination period, and any premiums are waived while you're receiving LTD plan benefits;
- The date you no longer meet the plan's eligibility requirements;
- The date the plan is discontinued (except for any approved disability claim originating before the plan was discontinued); or
- The date you pass away.

Please see "If Your Situation Changes" on page 224 for details on how coverage is affected in certain situations.

How Group LTD Coverage Works

This section explains how Group LTD coverage works. IDI coverage is discussed under "How Individual Disability Insurance ("IDI") Works" beginning on page 217.

Group LTD coverage provides a level of income replacement should you continue to be disabled for more than 182 days. If approved by Prudential, the claims administrator, Group LTD coverage provides you with a monthly benefit of up to \$20,000 based upon a percentage of your Total Annual Cash Compensation (TACC), less certain other disability benefits. TACC under the plan is limited to \$400,000 if you elect the 60% option (or \$480,000, if you elect the 50% option described in "If You're An Employee" with TACC \$80,000 or more). If your TACC in effect for a plan year is less than \$80,000, you would receive company-paid coverage if you become disabled with a replacement of 60% of TACC, to a maximum monthly benefit of \$4,000.

In conjunction with disability income benefits you receive (or may be eligible to receive, even if you do not apply) from certain other sources ("other income benefits") — Group LTD coverage will provide a monthly benefit up to the percentage of TACC that you elected. The benefit will be provided when:

- You've been disabled for the elimination period of 182 days of disability;
- You're under the regular care of a licensed doctor during your disability, who you are not related to;
- You have a 20% or more loss of income; and
- Your claim has been approved by Prudential, the claims administrator.

To be considered “disabled” under the plan, you need to submit sufficient proof (as determined by Prudential) of your disability to Prudential.

You are disabled when Prudential determines that you cannot perform the material and substantial duties of your regular occupation and are not working because of an occupational or non-occupational injury or sickness. After 30 months of disability (the 182-day elimination period plus 24 months of Group LTD Plan benefits), you’re eligible for continued Group LTD Plan benefits if Prudential determines that — because of an occupational or non-occupational illness or injury — you’re unable to perform the duties of **any gainful occupation** for which you’re reasonably fitted by training, education, and experience.

If your TACC is equal to or greater than \$200,000, you may qualify for benefits under Group LTD coverage if you’re unable to perform the duties of your **regular occupation** for the maximum payable duration of the disability. (Your premium will be higher in this case.)

Your long-term disability benefits may continue until you are determined not to be disabled, reach the maximum time period for benefits, or die.

Prudential may require you to be examined by a physician, other medical practitioner and/or vocational expert of Prudential’s choice and will pay for this examination. Prudential can require an examination as often as is reasonable to do so, and may also require you to be interviewed by an authorized representative from Prudential. Refusal to be examined or interviewed may result in denial or termination of your claim.

Generally, you must be actively-at-work on the effective date of the coverage (including for any increase in coverage). If you are not, your coverage (including any increase) will take effect on the day you return to work.

If Your TACC Is Less than \$80,000

If you meet the eligibility requirements, whether you are currently an employee, a newly eligible employee, or a newly hired employee and if your Total Annual Cash Compensation (TACC) in effect for a plan year is less than \$80,000, you are **automatically** enrolled in Group LTD coverage, which is fully insured under a policy issued by The Prudential Insurance Company of America. You would receive company-paid coverage if you become disabled with a replacement of 60% of TACC, to a maximum monthly benefit of \$4,000.

If you are a new hire, your coverage effective dates depends on whether you are a full-time or part-time employee.

- **If you are a full-time employee** (regularly scheduled to work 40 hours per week), you have 31 days after you join to make your enrollment elections; however, coverage will begin on your date of hire.
- **If you are a part-time employee** (regularly scheduled to work at least 20 but less than 40 hours per week), your coverage will begin on the first of the month following your 60-day waiting period,

If you are newly eligible for benefits due to a work status change, your coverage effective date will be the date you became eligible for benefits.

Your TACC is recalculated as of each August 1 to take effect the following January 1 and will remain unchanged throughout the year. **Please Note:** If you are not actively-at-work as of January 1 on any given year, your Total Annual Cash Compensation for purposes of the Long-Term Disability Plan will be the TACC amount that was in effect for the previous calendar year, and your long-term disability contributions and benefit will be calculated using that amount. Once you are actively-at-work, your TACC will change to the amount that was communicated to you during Annual Benefits Enrollment.

Please Note: If your TACC increases to \$80,000 or above in a subsequent plan year and you do not make any elections/changes during Annual Enrollment for that plan year, you will be automatically enrolled in the 60% Group LTD option described below for that plan year and after-tax payroll deductions will commence to be taken each pay cycle to pay for the coverage.

If Your TACC Is \$80,000 or More

If your TACC in effect for a plan year is \$80,000 or more, enrollment is optional. Please give serious consideration to the advantages of LTD coverage before deciding not to enroll, see “Advantages of Electing LTD Coverage” on page 203.

You can choose long-term disability protection from among the following options:

- **The 50% option:** Replacement of 50% of TACC up to \$480,000, to a maximum monthly benefit of \$20,000;
- **The 60% option:** Replacement of 60% of TACC up to \$400,000, to a maximum monthly benefit of \$20,000; or
- **No coverage.**

Your Group LTD benefit is subject to offset by other disability-related income benefits. Please see “Defined Terms” beginning on page 226 for the definition of “Benefits Offset.”

If you elect “No Coverage” and your employment subsequently ends due to total disability, your participation in certain JPMorganChase benefits plans will end (see “If You Do Not Enroll” on page 210). If you do not enroll in Group LTD coverage, you may still elect Individual Disability coverage, if eligible.

How to Enroll If Your TACC Is \$80,000 or More

If You Are a Current Employee Already Enrolled

If your TACC in effect for a plan year is \$80,000 or more and you meet the requirements outlined under “Eligibility” on page 203 and you don’t want to make any changes, you do not need to take action during Annual Enrollment.

If you’d like to change your Group LTD coverage election during Annual Benefits Enrollment, you’ll receive information about the choices available to you and their costs at that time. You need to review your available choices carefully and enroll in the option that best meets your needs. You can make your elections through the Benefits Web Center on **My Health** or contact 1-844-ASK-JPMC.

Please Note: Evidence of Insurability (EOI) will be required if you increase your coverage amount, see “Evidence of Insurability” on page 205. If your EOI is approved by Prudential, your new coverage amount is effective as of January 1, assuming it has been approved as of that date. This coverage amount will remain in effect unless you elect to change it during a subsequent annual benefits enrollment (a future election to increase your coverage level would also be subject to EOI).

If you are increasing coverage, until you are approved, LTD benefits will be paid at the original (lower) coverage level you had before making your election increase.

If you do not enroll for LTD coverage when you are first eligible and then later choose to elect and are approved for coverage, you will not be covered for a claim due to a condition that predates your coverage effective date (see “Pre-Existing Condition Exclusion” on page 210).

If You Are a Newly Eligible or Newly Hired Employee

If you’ve just joined JPMorganChase, or you are newly eligible due to a work status change, your TACC is \$80,000 or more and you are enrolling during your initial eligibility period, you can make your elections through the Benefits Web Center on **My Health** or contact 1-844-ASK-JPMC. You must meet the actively-at-work definition in “Defined Terms” beginning on page 226 and the requirements outlined under “Eligibility” on page 203, No Evidence of Insurability is required in these situations.

Your coverage effective date depends on whether you are a full-time or part-time employee. If you are a full-time employee, you have 31 days after you join to make your enrollment elections; however, coverage will be effective as of your date of hire. If you are a part-time employee, you need to make your choices within 31 days before becoming eligible.

- **If you are a full-time employee** (regularly scheduled to work 40 hours per week), you may receive information about benefits enrollment after accepting a position with JPMorganChase but before your date of hire. Your coverage will begin on your date of hire, as long as you enroll within 31 days of your date of hire.
- **If you are a part-time employee** (regularly scheduled to work at least 20 but less than 40 hours per week), your eligibility/coverage date will begin on the first of the month following your 60-day waiting period, and you will receive your enrollment materials within 31 days before becoming eligible for coverage. You need to enroll within 31 days before your effective date.

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

During the 31-day election period, your Group LTD coverage is guaranteed and no health-related questions will be asked. Your next opportunity to enroll will be during Annual Benefits Enrollment and you will be required to submit evidence of insurability if you did not initially enroll or if you increase your coverage level.

If you are hired after October 1, you will be required to complete your newly eligible benefits enrollment elections for the current calendar year before making your enrollment elections the subsequent calendar year. The election for the current calendar year will be considered your first eligible period and no EOI will be required.

If You Do Not Enroll

Generally, if you do not enroll in Group LTD coverage, your participation and coverage in the JPMorganChase benefit plans will end when your benefits under the Short-Term Disability Plan end and you do not return to work (or when you terminate if you are denied benefits under the Short-Term Disability Plan), if:

- Your total annual cash compensation is \$80,000 or more and you choose not to enroll in Group LTD coverage (or the IDI Plan, if you are eligible), or
- You enroll in Group LTD coverage but are denied benefits under the plan,
- You do not elect Group LTD but enroll in IDI coverage and are denied disability benefits, or
- You are not on approved additional leave as a reasonable accommodation under the Accommodating Disabilities and Temporary Work Restrictions Policy. For details, go to the JPMC intranet.

These benefits include subsidized medical and dental coverage, vision benefits, basic life insurance (and other life insurance, if enrolled at the time of your disability) group personal excess liability and group legal.

In addition, if you do not enroll for Group LTD coverage when you are first eligible and then later choose to elect and are approved for coverage, you will not be covered for a claim due to a condition that predates your coverage effective date (see "Pre-Existing Condition Exclusion" on page 210).

Pre-Existing Condition Exclusion

If your Group LTD coverage has not been effective for a consecutive 12 or more months, you may be subject to a pre-existing condition exclusion. Under Group LTD coverage, you have a pre-existing condition if both 1 and 2, below, are true:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 6 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available.
2. Your disability begins within 12 months of the date your coverage under the plan becomes effective.

Please Note

- Special rules apply to pre-existing conditions, if this LTD Plan replaces a prior JPMorgan Chase LTD Plan and you were covered by the former plan on the day before this Plan became effective and you became covered under this Plan within 31 days of its effective date.
- If there is an increase in your benefits due to an amendment of the plan or your enrollment in another plan option, a benefit limit will apply if your disability is due to a pre-existing condition. You will be limited to the benefits you had on the day before the increase. The increase will not take effect until your disability ends.

Offsets for Disability Benefits from Other Sources

Your benefits under Group LTD coverage are reduced by disability income benefits you receive (or may be eligible to receive, even if you do not apply) from certain other sources (“other income benefits”), not including private disability insurance. These sources include, but are not limited to:

- Workers’ compensation; any occupational disease law; or any other act or law with similar intent (including rehabilitation maintenance allowance payments, and payments under a Compromise and Release or Findings Award);
- Federal Social Security disability benefits (including benefits for family members received as a result of your disability);
- Short-term Disability;
- Other federal or state disability plans;
- A governmental retirement system;
- Amounts received as a loss of time benefit under other group insurance plans; maritime doctrine of maintenance, wages, and cures; and partnership, proprietorship, or other draws;
- Amounts received from a third party by judgment, settlement, or otherwise, excluding attorney fees.

Note: Allocation within a workers’ compensation settlement made to attorney’s fees, medical bills, other insurance liens, pain and suffering, loss of use and vocation rehabilitation will not be included.

With the exception of certain retirement payments, Prudential will only subtract sources of income that are payable as a result of the same disability. Prudential will not reduce your payment by your Social Security retirement income if your disability begins after Social Security full retirement age (your retirement age under the Social Security Act where retirement age depends on your date of birth) and you were already receiving Social Security retirement payments.

If any of the “other income benefits” are paid to you in a lump sum, the amount of the lump sum will be prorated for the period of time the sum would have been paid, if paid periodically. The “other income benefits” will also be used to reduce your monthly disability payments under the plan.

Please Note: Payments from the JPMorgan Chase Retirement and 401(k) Savings Plans are not considered “other income benefits” for this purpose and therefore will not reduce your monthly disability payment. Furthermore, in no event will your long-term disability benefit be reduced below \$100 a month — regardless of the amount of any “other income benefits.”

Mental Illness and Substance Abuse Benefits

If you are approved by Prudential as disabled and were deemed disabled because of:

- Mental Illness that results from any cause;
- Any condition that may result from Mental Illness;
- Alcoholism; or
- The non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance,

Then Group LTD benefits will be payable subject to all other policy provisions as well as the following:

- Only for so long as you are confined in a Hospital or other institution licensed to provide medical care for the disabling condition; or
- When you are not so confined, a total of 24 months for all such disabilities during your lifetime; or
- For up to 90 days after release from confinement.

When Disability Benefits Begin and End

Benefits can begin after your elimination period has been satisfied if Prudential determines that you are disabled. Please see “Defined Terms” on page 226 for the definition of “Elimination Period” and “Disabled.”

Benefits continue as long as you meet Group LTD coverage’s definition of disability and continue to provide the necessary evidence of your disability. However, your benefits may also be subject to maximum payment periods, depending on your age at the time the disability begins, as shown in this chart:

Your Age on the Date Benefit Disability Begins	Your Maximum Duration
Under 61	To age 65, but not less than 60 months
61	To age 65, but not less than 48 months
62	To age 65, but not less than 42 months
63	To age 65, but not less than 36 months
64	To age 65, but not less than 30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Your benefits will end at the end of the maximum payment period, or earlier, if:

- You are no longer disabled (as determined by Prudential);
- You fail to provide satisfactory evidence of your disability;
- You refuse to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by an independent doctor;

Important Plan Definitions

Please see “Defined Terms” on page 226 for the definition of “Hospital” and “Mental/Illness.”

Limitations on Certain Benefits

Group LTD Plan benefits for disability due to a Mental Illness or substance abuse generally will not exceed 24 months. For other specific plan provisions or limitations not mentioned here, please contact Prudential directly. See the *Contacts* section for contact information.

- You are no longer under the care of a physician;
- Your disability earnings exceed the amount allowable;
- During the first 24 months of payments, you are able to return to your regular occupation on a part-time basis and choose not to;
- After 24 months of payments, you are able to work in any gainful occupation on a part-time basis but choose not to;
- When you are able to work in your regular occupation on a **part-time basis** but you choose not to (applies only to employees whose TACC is greater than \$200,000);
- No further benefits are payable under any provision of the plan that limits benefit duration (e.g., mental illness and substance abuse); or
- You pass away.

Benefits Provided to Your Family If You Pass Away

Should you pass away while receiving Group LTD benefits, Prudential will pay your eligible survivor a benefit equal to 3 months of your gross disability payment, upon receiving proof that you have passed away.

Payment will be made to your spouse or civil union partner, as long as your spouse or civil union partner was not separated from you at the time of your death. If your spouse or civil union partner has predeceased you, payment will be made in equal shares to your surviving children. Payment may also be made to the guardian of a minor child, at the plan's discretion. If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

Please Note: Prudential will first apply the survivor benefit to any overpayment that may exist on your claim.

Return-to-Work Program

Prudential offers a non-voluntary vocational rehabilitation program to assist you in returning to work. Prudential will notify you if you are a candidate for the rehabilitation service. Or, you can ask Prudential to review your claim to determine whether or not rehabilitation services would help you return to gainful employment.

After its initial review, Prudential may decide to offer you a return-to-work program.

The return-to-work program offers the following services:

- Coordination with JPMorganChase to assist your return to work;
- Evaluation of any medical equipment you may need for your return to work;
- Vocational evaluation to determine how your disability may impact your employment options;
- Job placement services;
- Resume preparation;
- Job-seeking skills training;
- Retraining for a new occupation; and
- Assistance with relocation that may be part of an approved rehabilitation program.

If you refuse to participate in this program, your payments under Group LTD may end. Please contact Prudential for more details on the vocational rehabilitation program. Please see the *Contacts* section for contact information.

How Your Benefits Are Determined If You Are Disabled and Working

If, after you complete the 182-day Elimination Period, you remain disabled according to the plan and work while you are disabled, you may continue to receive a monthly Group LTD benefit from Prudential.

In order to be considered disabled while working, your monthly disability earnings must be *equal to or less than 80% of your "indexed monthly earnings."* (Your "indexed monthly earnings" are your monthly pre-disability earnings adjusted on July 1 (or following the date of disability) by the lesser of 10% or the current annual percentage increase in the Consumer Price Index (CPI). Your indexed monthly earnings may increase or remain the same, but they will never decrease.)

If your earnings while disabled are equal to or less than 80% of your indexed monthly earnings, Prudential will determine your Group LTD Plan benefit as follows:

- **During the first 12 months of working while disabled**, you'll receive the regular monthly Group LTD benefit you're eligible to receive from Prudential, unless your earnings while disabled plus your "gross disability payment" exceed 100% of your indexed monthly earnings. (Your "gross disability payment" is your monthly Group LTD benefit from Prudential before any *other income benefits* are deducted.) If the amount exceeds 100%, Prudential will subtract the amount over 100% from your monthly Group LTD benefit.
- **After the first 12 months of working while disabled**, you'll receive Group LTD benefits from Prudential based on the percentage of income you are losing due to your disability. While you are working and receiving Group LTD benefits, Prudential requires that you provide them with proof of your earnings while disabled. Proof of earnings includes any appropriate financial records that Prudential believes are necessary to determine your earnings while disabled.

Please Note: If you're disabled and working for less than one month after the elimination period, Prudential will send you $\frac{1}{30}$ th of the amount that your monthly payment otherwise would have been for each day of your disability.

Social Security and Group LTD Benefits

If you're disabled due to illness or injury, you may be eligible for disability benefits from the Social Security Administration. These benefit amounts vary depending on your lifetime earnings, employment history, and family size. If you qualify, you may also be eligible to continue to accrue credits toward Social Security retirement benefits. After receiving Social Security disability benefits for two years, you may also qualify for Medicare Parts A, B, and D benefits.

Group LTD benefits requires that you apply for Social Security disability benefits. If the Social Security Administration denies your claim for benefits, you will be required to follow the reconsideration and hearing process established by the Social Security Administration.

If you fail to apply, Prudential can reduce your monthly benefit by estimating the Social Security disability benefits you or your dependent may be eligible to receive even if you do not apply.

Your Group LTD payment will not be reduced by the estimated amount if you:

- Apply for the disability payments, were denied, and appeal your denial to all levels Prudential feels are necessary;
- Sign a form authorizing the Social Security Administration to release information about awards directly to Prudential; and
- Sign Prudential's Reimbursement Agreement. This form states that you promise to repay Prudential any overpayment caused by an award.

If your payment has been reduced by the estimated amount, it will be adjusted when Prudential receives proof:

- Of the amount awarded; or
- That benefits have been denied and all appeals Prudential feels are necessary have been completed. In this case, a lump-sum refund of the estimated amount will be made to you.

If you receive a lump-sum payment from any deductible source of income, it will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, Prudential will use a reasonable one.

Following Social Security’s determination, you need to notify Prudential in writing at the following address:

Prudential
 Disability Management Services
 PO BOX 13480
 Philadelphia, PA 19176

 Phone: (877) 361-4778
 Fax: (877) 889-4885

You also must include a copy of the determination notice you received from Social Security advising you that Social Security benefits are not payable. If Prudential disagrees with the Social Security Administration, you’re obligated to appeal the denial.

If the Social Security Administration has not made a decision on your claim, or if you’re appealing the Social Security Administration’s denial of your claim, you can direct Prudential to estimate your Social Security benefits for offset purposes. (Please see “Social Security Offset Example” table below for more information.) If an estimated Social Security benefit is not assumed, and you later receive a favorable letter of determination from the Social Security Administration, you’ll be responsible for reimbursing Prudential for the applicable offset amounts.

Once you begin receiving plan benefits, any increase in your Social Security disability benefit because of legislated cost-of-living adjustments will not further reduce the amount you’re receiving from the Long-Term Disability Plan. You’ll simply receive this increase in addition to the benefits you’re receiving from the plan.

Social Security Offset Example

The following example shows how Social Security disability benefits would affect your benefit under Group LTD coverage.* It assumes that when you became disabled, you:

<i>Earned this monthly base salary:</i>	\$2,500
<i>Chose this plan coverage option:</i>	60% of Total Annual Cash Compensation (TACC)
<i>Were eligible to receive this monthly Group LTD benefit:</i>	\$1,500
<i>Were eligible to receive this monthly Social Security disability benefit:</i>	\$800

Given these assumptions, Group LTD coverage would pay a monthly benefit of \$700 (\$1,500 minus \$800).

* This example does not consider that your benefits from Social Security may be taxable. The taxability of these benefits is determined by many factors, such as how long you’ve been in the workforce, your income level, etc. You should contact your tax advisor for guidance on this matter.

Overpayment of Group LTD Benefits

As the claims administrator for Group LTD, Prudential has the right to recover from you any amount determined to be an overpayment of benefits.

Repayment is expected within 30 days from your receipt of notice. If you do not make a repayment — or a repayment schedule agreeable to Prudential is not finalized within a 30-day period — Prudential may use any legal means available to recover the overpayment, including but not limited to reducing or withholding any future benefit payments from you or your survivors.

What Is Not Covered

Group LTD coverage does not cover nor shall benefits be paid for any disability:

- In which you are not under the regular care of a physician;
- That is caused or contributed to by war or act of war (declared or not);
- That is the result of active participation in a riot;
- Caused by your commission of a crime for which you have been convicted under state or federal law;
- Caused or contributed to or by intentionally self-inflicted injury; or
- Caused by a pre-existing condition. This list is subject to change at any time.

Please Note

If your disability continues beyond 26 weeks and you're not enrolled in the Long-Term Disability Plan — or Prudential has determined that you're not totally disabled — then your employment status as an employee with JPMorganChase will end.

Claiming Benefits

The following information explains when and how to file claims for Group LTD Plan benefits.

How to File Claims

If your disability under the JPMorgan Chase Short-Term Disability Plan could potentially continue beyond 26 weeks and you participate in Group LTD coverage, your claim is automatically transferred to the Group LTD administrator. Prudential will make a determination as to your eligibility for long-term disability benefits. Then, Prudential will work with you to ensure that you are aware of all requirements to continue benefits under Group LTD.

Written notice of a claim must be sent to the Group LTD administrator within 30 days after the date your disability begins. However, written proof of your claim must be sent no later than 90 days after your elimination period ends.

The following information explains the claims process to receive benefits under Group LTD.

Group LTD Claims Process

If You Have a Non-Occupational Total Disability	If You Have an Occupational Disability
<ul style="list-style-type: none"> • If your disability under the Short-Term Disability Plan could potentially continue beyond 26 weeks, your claim is automatically referred to the Group LTD administrator, if you were automatically enrolled for Group LTD or you elected this coverage; and • Prudential will determine whether you're eligible for benefits under Group LTD. 	<ul style="list-style-type: none"> • Prudential is notified of an occupational disability (workers' compensation) claim for Group LTD benefits; and • Prudential determines your eligibility under Group LTD, and works with the workers' compensation carrier.

Prudential will stay in contact with you through the duration of your disability, requiring updates on your medical information and/or proof of continued disability. Proof of continued disability must be received within 30 days of a request by the Group LTD administrator. The Group LTD administrator will deny your claim or stop sending payments if the appropriate information is not submitted. When your licensed practitioner determines you may return to work, you should immediately notify your Prudential disability claim manager.

How Individual Disability Insurance (“IDI”) Works

This section explains how Individual Disability Insurance (“IDI”) coverage works. Unum is the claims administrator for IDI.

Individual Disability Insurance (“IDI”) coverage is available if your Total Annual Cash Compensation (TACC) is more than \$400,000 (or \$480,000 if you elected the 50% Group LTD option). IDI provides a level of income replacement should you continue to be disabled for more than 180 days. Individual Disability Insurance coverage is fully portable insured by Unum. IDI provides an additional maximum monthly benefit of up to \$15,000, based on your TACC.

Once issued, your Individual Disability Insurance is noncancelable and guaranteed renewable to age 65, which means that as long as premiums are paid on time, the provisions and premiums are guaranteed until age 65. Renewal premiums for individual coverage may change if:

- You have an increase in TACC, or
- You continue coverage beyond age 65.

You can renew coverage after age 65 by paying premiums as long as you are working at least 20 hours per week, regardless of your age. IDI is fully portable.

Eligibility

You are eligible to purchase additional LTD coverage under fully portable Individual Disability Insurance if you meet one of the three following conditions:

- If your Total Annual Cash Compensation (TACC) is \$480,000 or more and you elect the 50% option under Group LTD coverage; or
- If your Total Annual Cash Compensation (TACC) is \$400,000 or more and you elect the 60% option; or
- If you elect no coverage under Group LTD coverage.

If you are disabled under the terms of the coverage, IDI benefits would provide:

- Replacement of 50% of TACC from \$480,000 to \$840,000, to a maximum monthly benefit of \$15,000 – as long as you elected coverage under Group LTD coverage; or
- Replacement of 60% of TACC from \$400,000 to \$700,000, to a maximum monthly benefit of \$15,000.

How to Enroll

If your TACC is more than \$400,000 and you meet the requirements outlined under “Eligibility” on page 203, you will receive separate IDI enrollment information regarding the IDI coverage after the Group LTD enrollment period concludes. In order to receive Individual Disability Insurance, you must complete the IDI enrollment application and authorize Unum to issue your policy.

If you are a current employee and did not elect IDI coverage when you were first eligible and later wish to enroll, you will be required to submit evidence of insurability, see “Evidence of Insurability” on page 205. Please contact Covala to request the appropriate Unum EOI forms. Your contributions toward the cost of coverage will begin on or near the first day of the pay period after your coverage has been approved. Your IDI coverage can be reduced or discontinued at any time. If you reduce or discontinue your coverage, you will need to provide EOI to increase your benefit amount or re-enroll. If you become newly eligible for IDI due to a change in TACC (set in August of each year), you will receive IDI enrollment information during the fall. No EOI is required if you elect coverage when you are first eligible for IDI coverage.

If you are a newly hired employee, or newly eligible due to a work status change, and want to elect IDI coverage, and meet the actively-at-work definition as stated under “Defined Terms” beginning on page 226, your IDI coverage is guaranteed and no EOI is required as long as you elect coverage during this first eligibility period. Coverage takes effect as follows:

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

Your contributions toward the cost of coverage, if applicable, will begin on or near the first day of the pay period after your coverage has been approved.

Employees who are not actively at work can still make changes in IDI coverage. However, the change in coverage will not become effective until the day you return to active employment.

Please Note: Changes to Individual Disability Insurance (“IDI”) can be made during Annual Benefits Enrollment. Mid-year plan changes (unrelated to a change in status) are not permitted.

If You Do Not Enroll

Generally, your participation and coverage in the JPMorganChase benefit plans will end when your benefits under the Short-Term Disability Plan end and you do not return to work (or when you terminate if you are denied benefits under the Short-Term Disability Plan), if:

- Your total annual cash compensation is \$80,000 or more and you choose not to enroll in Group LTD coverage (or the IDI Plan, if you are eligible), or
- You enroll in Group LTD coverage but are denied benefits under the plan,
- You do not elect Group LTD but enroll in IDI coverage and are denied disability benefits, or
- You are not on approved additional leave as a reasonable accommodation under the Accommodating Disabilities and Temporary Work Restrictions Policy. For details, go to the JPMC intranet.

These benefits include subsidized medical and dental coverage, vision benefits, basic life insurance (and other life insurance, if enrolled at the time of your disability), group personal excess liability and group legal.

If you elect to reduce or discontinue your IDI coverage during Annual Benefits Enrollment, your election will take effect the following January 1.

Differences from Group LTD coverage

Individual Disability Insurance coverage has some notable differences from Group LTD coverage, as explained below:

- **Definition of Disability.** The Individual Disability Insurance definition of disability is based on being unable to perform the material and substantial duties of your regular occupation for the entire duration of your disability. This definition will remain the same regardless of future fluctuations in your Total Annual Cash Compensation (TACC).

- **Pre-Existing Condition Limitation.** Individual Disability Insurance coverage has no pre-existing condition limitation.
- **Offsets for Disability Benefits from Other Sources.** Individual Disability Insurance coverage has no offsets for disability benefits from other sources, such as from Social Security disability income.
- **Mental Disorders:** Benefits for disability caused by mental disorders are limited to a total of 24 months of IDI benefits for all such disabilities during your lifetime. Mental disorder means any disorder (except dementia resulting from stroke, trauma, infections, or degenerative diseases such as Alzheimer's disease) classified in the most current edition (at the start of the disability) of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. Such disorders include, but are not limited to, psychotic, emotional, and behavioral disorders, and disorders related to stress and substance abuse or dependency. If the DSM is discontinued or replaced, the mental disorders covered by IDI will be those addressed by the diagnostic manual then in use by the American Psychiatric Association as of the start of a disability.
- **Rehabilitation Benefit:** The Rehabilitation Benefit through the Individual Disability Insurance is entirely voluntary on your part. If Unum approves your proposed program of occupational rehabilitation in advance by written agreement, the expenses for such a program that are not already covered by another social or insurance program will be fully paid for by IDI.

Some of the services that might be provided could include, but are not limited to:

- coordination of physical rehabilitation and medical services;
- financial and business planning;
- vocational evaluation and transferable skills analysis;
- career counseling and retraining;
- labor market surveys and job placement services; and
- evaluation of necessary worksite modifications and adaptive equipment.

Unum will periodically review the program and your progress in it, and will continue to pay for the agreed-upon program as long as it is determined to be helping you return to work. Participation in a rehabilitation program will not be considered a recovery from injury and sickness.

Recovery Benefit

A Recovery Benefit is provided through Individual Disability Insurance to encourage your return to work after an approved disability when you are no longer disabled. You are eligible for the Recovery Benefit if you:

- Have satisfied the elimination period;
- Are no longer disabled;
- Have returned to work in your occupation at full-time and duties; and
- Have a loss of earnings of at least 20% due to the injury or sickness which caused your disability.

The Recovery Benefit is proportionate to your loss of earnings (for example, if you have a loss of earnings of 40% of your prior monthly earnings, you will receive 40% of your monthly benefit). Please see your individual policy for the exact definition of loss of earnings. The maximum length of your recovery benefit period is 12 months. If your loss of earnings is no longer at least 20% and you are still in your Recovery Benefit period, then you will no longer be eligible for the Recovery Benefit and your Individual Disability Insurance benefit payments will end.

When Benefits Begin and End

Individual Disability Insurance has an elimination period of 180 days. This means that no benefits are payable under IDI until you have been disabled for 180 days. Benefits can begin after your elimination period has been satisfied if Unum determines that you are disabled. Please see “How to Enroll” on page 217 for the definition of “Disabled” under IDI.

Benefits continue as long as you meet the terms and conditions of your policy and continue to provide the necessary evidence of your disability. However, your benefits may also be subject to maximum payment periods, depending on your age at the time the disability begins, as shown in this chart:

If You're This Age When Disability Begins...	Benefits Are Payable up to...
<i>Under 61</i>	Age 65
61	48 months
62	42 months
63	36 months
64	30 months
65 - 74	24 months
75 or older	12 months

Your benefits will end at the end of the maximum payment period, or earlier, if:

- You are no longer disabled (as determined by Unum);
- You fail to provide satisfactory evidence of your disability;
- You are no longer under the care of a physician, unless you provide written proof signed by a doctor to Unum that further physician’s care would be of no benefit to you;
- Your disability earnings exceed the amount allowable; or
- You pass away.

Benefits Provided to Your Family If You Pass Away

If you die while receiving benefits from IDI, a death benefit is payable. When Unum receives proof that you have died, it will pay your estate a single lump-sum benefit equal to three times the IDI benefit that you received in the month immediately prior to your death.

Please Note: Unum will first apply the survivor benefit to any overpayment that may exist on your claim.

Continuation of Coverage

If you leave JPMorganChase you can continue your Individual Disability Insurance by paying premiums directly to Unum. You will maintain the 35% discount from Unum’s regular retail rates for Individual Disability Insurance. The discount remains in place for the life of the policy, regardless of whether you are still employed by JPMorganChase.

How Your Benefits Are Determined If You Are Disabled and Working

If, after you complete the 180-day Elimination Period, you remain disabled and work while you are disabled, you may continue to receive a reduced monthly benefit under IDI.

In order to be considered disabled while working, your monthly disability earnings must be *equal to or less than 80% of your "prior monthly earnings."* (Your "prior monthly earnings" are your monthly pre-disability earnings adjusted each anniversary of your claim by the greater of 2% or the current annual percentage increase in the Consumer Price Index (CPI). In no case will the adjustment be more than 10%.)

If your earnings while disabled are equal to or less than 80% of your prior monthly earnings, Unum will determine your IDI Plan benefit as follows:

- **During the first 12 months of working while disabled**, you'll receive the regular monthly IDI benefit you're eligible to receive from Unum, unless your earnings while disabled plus your IDI benefit exceed 100% of your prior monthly earnings. If the amount exceeds 100%, Unum will subtract the amount over 100% from your monthly IDI benefit.
- **After the first 12 months of working while disabled**, you'll receive the IDI benefits from Unum proportionate to your loss of earnings due to your disability.

While you are working and receiving IDI benefits, Unum requires that you provide proof of your earnings while disabled. Proof of earnings includes any appropriate financial records that Unum believes are necessary to determine your earnings while disabled.

Please Note: If you're disabled and working for less than one month after the elimination period, Unum will send you $\frac{1}{30}$ th of the amount that your monthly payment otherwise would have been for each day of your disability.

Overpayment of Plan Benefits

As the claims administrator for IDI, Unum has the right to recover from you any amount determined to be an overpayment of benefits. If Unum determines that an overpayment has occurred, it will contact you to make a reimbursement arrangement.

What Is Not Covered

IDI does not cover nor shall benefits be paid for any disability:

- Caused or contributed to by war or act of war (declared or not);
- Caused by your commission or an attempt to commit a felony or to which a contributory cause was your being engaged in an illegal occupation;
- Caused or contributed to or by intentionally self-inflicted injury; or
- Caused by the suspension, revocation, or surrender of your license to practice in your occupation.

This list is subject to change at any time.

Claiming Benefits

If you are receiving benefits under the Short-Term Disability Plan, at approximately 90 days after your date of disability, Covala Group, the administrative service provider for Individual Disability Insurance, will send claim forms to your home address. If you need forms earlier or have any questions, you can call Covala.

Right of Recovery for the Long-Term Disability Plan

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

Subrogation

The purpose of the Long-Term Disability Plan is to provide benefits for eligible Long-Term Disability expenses that are not the responsibility of any third party. The Long-Term Disability Plan has the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the plan making payments on your behalf or on behalf of a covered dependent. This is known as subrogation of benefits. The following rules apply to the plan's subrogation of benefits rights:

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

Right of Reimbursement

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

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

- If you fail to reimburse the plan, the plan may deduct any unsatisfied portion of the amount of benefits the plan has paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plan.
- If you fail to disclose the amount of your recovery from a third party to the plan, the plan shall be entitled to deduct the full amount of the benefits the plan paid on your behalf from any future benefits payable under the plan.

Additional Long-Term Disability Plan Information

Your primary contact for all matters relating to the general administration of the JPMorgan Chase Long-Term Disability Plan is 1-844-ASK-JPMC.

Your benefits as a participant in the LTD Plan (Group LTD and IDI) are provided under the terms of this document and the insurance contracts, if any, issued to JPMorganChase, or you in the case of IDI. If there is a discrepancy between the insurance contracts and this document, the insurance contracts will control. Prudential and Unum, the claims administrators, have complete authority to determine whether you've incurred a disability for which benefits are payable under the LTD Plan, and to administer the payment of any such benefits.

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 LTD Plan (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 sole and absolute discretion to construe and interpret the terms of the LTD Plan and any underlying policies and/or contracts, including the eligibility to participate in the plan. All decisions of the plan administrator for the JPMorgan Chase U.S. Benefits Program are final and binding upon all affected parties.

Recurrent Periods of Disability

You can immediately begin receiving benefits again if you return to work at JPMorganChase after receiving benefits under Group LTD or IDI, are still eligible for coverage, and then become disabled again due to the same or a related illness or injury within six months after your return.

If the same or a related illness or injury causes your disability more than six months after your return to work, you'll have to complete another elimination period before receiving benefits. You may be eligible to receive benefits under the JPMorgan Chase Short-Term Disability Plan during the elimination period.

If, during your JPMorganChase disability, you suffer a different or unrelated illness or injury, your benefits will continue without interruption. If you suffer a different or unrelated illness or injury after returning to work at JPMorganChase, you'll have to complete a new elimination period before receiving benefits.

If Your Situation Changes

The following chart summarizes how your JPMorgan Chase Long-Term Disability Plan coverage may be affected in certain situations:

Situation	Provision
<p>If Your Work Status Changes</p>	<p>If your work status changes and you become newly eligible for benefits, you will receive enrollment information. You will have 31 days to enroll in Long-Term Disability Plan coverage. No evidence of insurability is required if you enroll during this initial offering. Your coverage begins on the date of your status change.</p> <p>Your Long-Term Disability Plan coverage will end if your work status changes and you are then scheduled to work fewer than 20 hours per week. Your coverage will end on the date of the work status change.</p>
<p>If You Go on Disability Leave</p>	<p>Under the Short-Term Disability Plan, you may have the financial protection of full or partial pay for up to 25 weeks. For the approved period of your disability leave, you'll remain eligible to be covered under the Long-Term Disability Plan. JPMorganChase will deduct any required contributions for long-term disability coverage from the pay you receive during this leave period. If your TACC is \$80,000 or greater and your STD leave is denied at any point during the 182 day elimination period, you must continue to pay your LTD premiums on a direct bill basis to be considered for the LTD benefits by Prudential. Payments made on a direct bill basis made on an after tax basis. Note: If you wish to continue certain benefits, you must make the necessary contributions on a timely basis, even if you do not receive a bill.</p>
<p>If You Qualify for Long-Term Disability Benefits</p>	<p>If you receive long-term disability benefits, your contributions for Long-Term Disability Plan coverage are waived for the duration of your approved LTD leave.</p> <p>Please Note: Your employment with JPMorganChase will end immediately after you have received 24 months of payments under the Long-Term Disability Plan, unless you have requested and been approved for additional leave time as a reasonable accommodation (please see "Termination of Employment After 24 Months of LTD Benefit Payments" on page 207 for more information).</p> <p>You will continue to be eligible for LTD benefits provided you meet all contractual provisions outlined in the plan; however you will cease to be eligible for many of the U.S. benefits plans.</p> <p>If you were on an approved disability leave prior to January 1, 2011, your benefits coverage will continue at active employee rates while you receive benefits under the Long-Term Disability Plan.</p>

Situation	Provision
<p>If You Go on Leave</p>	<p>Your participation in the Long-Term Disability Plan will end after 16 weeks if you go on:</p> <ul style="list-style-type: none"> • An approved, non-medical paid or unpaid leave of absence, paid or unpaid personal leave of absence; or • Military leave (paid or unpaid). <p>For any unpaid approved leave of absence, you'll still be covered by the Long-Term Disability Plan. JPMorganChase will directly bill you for any required contributions on an after-tax basis. However, regardless of whether or not you receive a bill, if you do not make the required contributions to continue your LTD coverage or your approved leave exceeds 16 weeks, your coverage will be canceled. Note: 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. Please note your coverage will be automatically reinstated when you return to work if your LTD is company paid (earn less than \$80K in Total Annual Cash Compensation). If you pay for your LTD coverage (earn \$80K or more in Total Annual Cash Compensation) and your coverage is cancelled, you must re-elect LTD coverage within 31 days of your return to work and you must satisfy Evidence of Insurability before your coverage will be reinstated. Please see the <i>What Happens If...</i> section of this Guide for more Information about what happens to your benefits during unpaid Leave of absence (i.e., FMLA, Military Leave).</p>
<p>If You Work Past Age 65</p>	<p>If you continue to work for JPMorganChase after you reach age 65, you can continue to be covered under the Long-Term Disability Plan as long as you continue to meet the eligibility requirements and pay the required premiums.</p>
<p>If You Leave JPMorganChase</p>	<p>Your participation in the Long-Term Disability Plan will end on the date your employment with JPMorganChase terminates. If you elected to be covered by Individual Disability Insurance, you may retain it upon leaving JPMorganChase by continuing to pay premiums directly to the insurer.</p>

Appealing Claims

If a claim for reimbursement under the JPMorgan Chase Long-Term Disability Plan is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the *Plan Administration* section. **Please Note:** JPMorganChase is not involved in deciding appeals for any benefit claim denied under the LTD Plan unless specifically related to eligibility or as otherwise described in the Plan Administration section. All fiduciary responsibility and decisions regarding a claim for a denied benefit under the plan rest solely with the claims administrators.

Right to Amend

JPMorganChase reserves the right to amend, modify, reduce or curtail benefits under, or terminate the Long-Term Disability Plan (which includes Group LTD and IDI) at any time for any reason by act of the Benefits Executive, other authorized officers, or the Board of Directors. In addition, the Long-Term Disability Plan does not represent a vested benefit.

JPMorganChase 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 this Guide create a contract of employment or a guarantee of employment between JPMorganChase and any employee.

If you have any questions about this plan, contact 1-844-ASK-JPMC (please see “Questions?” on page 200 under this LTD section for contact information).

Defined Terms

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

IDI Definitions Differ

For the items marked below with an asterisk, Individual Disability Insurance (“IDI”) uses a different definition or has different rules regarding this term. Please see “Differences from Group LTD coverage” on page 218 for information about how this term applies to IDI.

Actively-at-Work

Performing all the duties that pertain to your work on a regular basis at the place where they’re normally performed or where they’re required to be performed by JPMorganChase. A person who works at home must be able to report to a place of employment outside the home.

You must be actively-at-work on the date designated by Prudential and/or Unum for either your new coverage or your newly approved increase in your coverage to take effect. Prudential and/or Unum may have additional actively-at-work requirements that are specific to their plans.

After-Tax Contributions

Contributions that are taken from your pay after federal (and in most cases, state and local income taxes) have been withheld. By paying for the plan with after-tax contributions, any benefits you receive from the plan if you become disabled would be tax-free.

Benefits Offset*

Under Group LTD coverage, a reduction for any benefits that could be paid by other disability programs (for example, Social Security or workers’ compensation). As a result, your disability benefits paid by other disability programs and Group LTD coverage combined, equal the replacement percentage of Group LTD coverage option you chose (up to the maximum monthly benefit for that option).

Claims Administrator

The company, or its affiliate, that provides certain claims administration services for the Long-Term Disability Plan. The Prudential Insurance Company of America and Unum are the claims administrators for Group LTD coverage and Individual Disability Insurance coverage, respectively.

Group LTD Elimination Period*

A period of 182 days before benefits are paid, in which you’re prevented from performing the material and substantial duties of your occupation because of an occupational or non-occupational injury or illness. If during an elimination period you recover and are able to return to work as an active employee, the period of time before your return to work will count toward satisfying the requirements for the elimination period if your return to work is for 60 days or less. However, the days that you work as an active employee will not count toward satisfying the requirements for the elimination period.

Evidence of Insurability*

Under Group LTD, information that must be provided to Prudential, the claims administrator, before you can be approved for certain levels of coverage under the plan or if you increase your coverage amount.

Evidence of insurability is also required if you apply for Group LTD or Individual Disability Insurance benefits after you are first eligible.

Hospital

Under the LTD Plan, an accredited facility licensed to provide care and treatment for the condition causing the covered person’s disability.

Indexed Monthly Earnings

Your monthly pre-disability earnings adjusted on the first of July or following the date of disability by the lesser of 10% or the current annual percentage increase in the Consumer Price Index (CPI). Your indexed monthly earnings may increase or remain the same, but they will never decrease.

Material and Substantial Duties of Your Occupation

Under The Group LTD Plan, a duty that is normally required for the performance of your regular occupation, either because of an occupational or non-occupational injury or sickness, and you are unable to perform the duties of any gainful occupation for which you're reasonable fitted by training, education, and experience.

Mental Illness*

Under Group LTD, mental, nervous, substance abuse, or emotional disease or disorders of any type. Conditions that are found to be organic in nature are not considered mental illness.

Other Income Benefits*

Under Group LTD, long-term disability benefits are reduced by certain "Other Income Benefits." These may include other income you may be eligible to receive as a result of the same disability for which the plan benefit is payable or income associated with employment in the same or different occupations. Please see "Offsets for Disability Benefits from Other Sources" on page 211 for examples.

Pre-Existing

Under Group LTD, you have a pre-existing condition if both 1 and 2, below, are true:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 6 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available.
2. Your disability begins within 12 months of the date your coverage under the plan becomes effective.

Please Note: Special rules apply to pre-existing conditions, if this LTD Plan replaces a prior JPMorgan Chase LTD Plan and you were covered by the former plan on the day before this Plan became effective and you became covered under this Plan within 31 days of its effective date.

Total Annual Cash Compensation

Generally, your 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 base salary/regular pay plus applicable job differentials.

Please Note: If you are not actively-at-work as of January 1 on any given year, your Total Annual Cash Compensation for purposes of the Long-Term Disability Plan will be the TACC amount that was in effect for the previous calendar year, and your long-term disability contributions and benefit will be calculated using that amount. Once you are actively-at-work, your TACC will change to the amount that was communicated to you during the fall Annual Benefit Enrollment.



Your JPMC Benefits Guide

Effective 1/1/25

JPMorganChase 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 dark gray 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.

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 *Long-Term Disability Plan*;
- *Other Benefits*, which includes the *Health & Wellness Centers Plan*, the *Group Legal Services Plan*, the *Group Personal Excess Liability Plan*, the *Child Care Plan*, the *Expatriate Medical and Dental Plans* and the *Hawaii Medical Plan*.

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.

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

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

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

Retirement Savings

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

Questions?

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

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

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About This Guide

Effective 1/1/25

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, 2025:

- *The JPMorgan Chase U.S. Medical Plan*
- *The Kaiser HMO Plan*
- *The Centivo Select 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 Long-Term Disability Plan*
- *The JPMorgan Chase Health and Wellness Centers Plan*
- *The JPMorgan Chase Group Legal Services Plan*
- *The JPMorgan Chase Group Personal Excess Liability Insurance Plan*
- *The JPMorgan Chase 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.jpmbenefitsguide.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.jpmbenefitsguide.com for the entire SPD for the JPMorgan Chase 401(k) Savings Plan)*

About This Summary

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

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

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

- *Plan Administration*
- *What Happens If...*
- *Health Care Participation*

Additional Plan Information

Your primary contact for matters relating to plan benefits is each plan's claims administrator or service provider. Contact 1-844-ASK-JPMC 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 JPMorganChase. 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 JPMorganChase 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 1-844-ASK-JPMC for more information.

Right to Amend

JPMorganChase 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.

JPMorganChase 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 1-844-ASK-JPMC.

Not a Contract of Employment

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



What Happens If...

Effective 1/1/25

*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**.*

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 JPMorganChase 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. JPMorganChase 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 JPMorganChase and any individual. JPMorganChase 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 1-844-ASK-JPMC 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. Related to Life and Accident Insurance, any newborn, newly adopted, or child newly placed for adoption, is automatically covered for 90 days from the QSC date should they pass away within this 90-day period. For coverage to continue beyond 90 days, you must enroll the newborn, newly adopted, or child newly placed for adoption into coverage before the end of 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

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner Child
Child Gains Eligibility	Add	Add	Add
DP's Child Becomes Eligible	Add	Add	Add
Child Gains Eligibility due to QMCSO	Add	N/A	Add
Child/DP Child no Longer Eligible	N/A	N/A	Drop
Death of Child/DP Child	N/A	N/A	Drop
You or Covered Dependent Gains Other Coverage	Drop/reduce # 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

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

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

QSCs for Supplemental Term Life Insurance Benefits

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

QSC	Employee	Adult Dependent	Dependent Child/Domestic Partner Child
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

QSC	Employee	Adult	Child
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; Related to Life and Accident Insurance, any newborn, newly adopted, or child newly placed for adoption is automatically covered for 90 days from the QSC date should they pass away within this 90-day period. For coverage to continue beyond 90 days, you must enroll the newborn, newly adopted, or child newly placed for adoption into coverage before the end of this 90-day period. If you do not elect coverage during this 90-day period, your newborn, newly adopted, or child newly placed for adoption will not have coverage on the 91st day. Please contact 1-844-ASK-JPMC if this situation applies to you.)

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

A Covered Dependent Becomes Ineligible

If your dependent becomes ineligible (such as when a dependent child reaches age 26, for health care coverage), the dependent's coverage will end on the last day of the month in which he or she no longer meets the eligibility requirements. For Supplemental Term Life and AD&D, once your dependent is no longer eligible, it is your responsibility to remove the dependent from your coverage, otherwise payroll deductions will continue, but coverage will not. You must contact 1-844-ASK-JPMC for assistance with removing an ineligible dependent.

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

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

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

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

You and/or Your Dependents Lose Other Coverage

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

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

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

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

You and/or Your Dependents Gain Other Coverage

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

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

You Move

If you move out of your Medical or Dental Plan option service area and your current option is no longer available, you can change Medical and/or Dental Plan option for yourself and your covered dependents. **(Please Note:** In this situation, you will be assigned new coverage by JPMorganChase 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). JPMorganChase is legally required to recognize qualified medical child support orders within the limits of the JPMorganChase plans. If you’re a party in a divorce settlement that involves the JPMorganChase plans, you should have your attorney contact 1-844-ASK-JPMC 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 JPMorganChase 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 JPMorganChase, any dependents who were covered under your JPMorganChase 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 JPMorganChase-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 the JPMC intranet.); 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 JPMorganChase.

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 JPMorganChase, coverage for your spouse ends on the date of your death. Your spouse has the option to continue coverage by enrolling in an Individual Legal Plan by visiting MetLife.com/individual-legal-plans. Any services in progress at the time of your death will be provided, even if your spouse does not elect to continue coverage.

For the Group Personal Excess Liability Plan: In the event of your death, coverage for any surviving household member who is a covered person at the time of death, including your spouse, legal representative, or any person having proper temporary custody of your property, will end on the date of your death.

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 JPMorganChase 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 have the option to continue coverage by enrolling in an Individual Legal Plan by visiting MetLife.com/individual-legal-plans.
- **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.

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. JPMorganChase will deduct any required contributions for medical coverage from the pay you receive during this period on a before-tax basis for the health care plans and the Health Care Spending Account and on an after-tax basis for the Group Legal Services Plan and the Group Personal Excess Liability Insurance Plan. However, certain states require that no benefits deductions may be taken from your disability pay or state disability pay for which JPMC pays you. In these instances, impacted employees will be mailed a bill to their home address on record. Initial bills require payment within 45 days from the date on the bill and subsequent bills are due within 30 days of the bill date. If you receive a bill and do not pay it in full by the due date, all coverages reflected on the bill will be dropped. Only medical coverage, which you had in place prior to your leave, is eligible for reinstatement within 6 months following the date the coverage dropped. Employees can contact 1-844-ASK-JPMC for payment information and how to request reinstatement of dropped medical coverage.
 - This medical and dental coverage continuation includes expatriate medical and dental coverage. If you are not receiving pay via Expat Payroll during your leave, JPMorganChase will bill you directly for any required contributions.
- **For the Dependent Care Spending Account**, your participation is suspended during a period of paid or unpaid leave.
- **For the Transportation Spending Account**, your participation is terminated during a period of paid or unpaid leave and any unused credits in your account(s) will be forfeited if you do not return to work and reenroll in the Transportation Spending Account. If you know you will be going on a leave, you should change your contribution amount to zero approximately one month before your leave begins in order to avoid forfeiting any contributions. Expenses incurred after your leave begins will not be eligible for reimbursement or payment from your account(s). If you wish to continue participation after you return to active service, you must re-enroll. However if you participated in the "Pay Me Back" option, you have 180 days following the end of any particular benefit month you participated in the program to file claims for reimbursement from your "Pay Me Back" account.
- **For the Basic Life Insurance Plan, Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan:** For the approved period of your disability leave, you'll remain eligible to be covered under the Basic Life Insurance Plan (including Identity Theft (ID) Assistance Program, Travel Assistance and Emergency Evacuation services, funeral concierge services, and SurvivorSupport® financial counseling services), Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan.
- **For the Business Travel Accident Insurance Plan:** While you are on disability leave, your business travel accident insurance will be suspended.

You Go on Long-Term Disability

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

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

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

You'll be eligible to continue these benefit plans at active employee rates for the first 24 months after going on approved LTD (that is, 30 months from the date of disability). The premiums will be converted to a monthly rate, and you will be required to pay for this coverage monthly on an after-tax basis. You will pay for this coverage on a direct-bill basis with JPMorganChase'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 20.)

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

Please Note: If you became disabled before January 1, 2011, your coverage will continue at active employee rates while you receive benefits under the Long-Term Disability Plan. If you do not make the required contributions to continue your coverage, your coverage will be canceled. Reinstatement is available for only the JPMC Medical plan within 6 months of coverage termination. Impacted employees should call 1-844-ASK-JPMC for the amount owed to reinstate coverage and information about the process.

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

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

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

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

You Are on LTD and Become Eligible for Medicare

If you are receiving full Long-Term Disability (LTD) benefits from the JPMorgan Chase Long-Term Disability Plan (LTD Plan), are not actively at work and become eligible for Medicare, Medicare becomes the primary source of your medical coverage. You will no longer be eligible for the active JPMorgan Chase medical coverage. Instead, Medicare-eligible participants have access to individual supplemental Medicare coverage available through Via Benefits, a private Medicare exchange, which is not coverage sponsored by JPMorganChase. For those Medicare-eligible individuals who enroll in coverage through Via Benefits and are eligible for a medical subsidy, JPMorganChase sponsors the Health Reimbursement Arrangement Plan associated with that coverage. For further details, contact 1-844-ASK-JPMC.

You Become Eligible for Medicare

If you are a JPMorganChase employee enrolled in an active JPMorganChase 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 JPMorganChase 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 the JPMC intranet. In all cases, JPMorganChase 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 within 31 days following your return to work.

Special Rules for Health Care Spending Account

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

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

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

You Go on Unpaid Leave

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

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

For the Health Care Spending and Dependent Care Spending Accounts: During an approved unpaid leave of absence, you may continue to make monthly contributions to the Health Care Spending Account on an after-tax basis, via your benefits invoice. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on a leave and you may not receive reimbursement for any health care expenses you incur after your coverage terminated. You may not make contributions to a Dependent Care Spending Account during an unpaid leave. For the Dependent Care Spending Account, you may use your account balance only for eligible expenses incurred prior to the date of your approval to go on unpaid leave, and must 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 JPMorganChase. 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 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 \$80,000, you will be reinstated in LTD coverage immediately upon your return to active status.
- If your TACC is equal to or greater than \$80,000, 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 1-844-ASK-JPMC 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 JPMorganChase

For health care coverage: If your employment with JPMorganChase 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 JPMorganChase unless you choose to continue your participation under COBRA or under JPMorganChase retiree coverage. For more information, please see the **As You Leave Guide** on the JPMC intranet.

- The provisions noted above for the health care plans also apply to the expatriate medical and dental options. If you are a U.S. home-based expatriate or on expatriate assignment to the U.S., under

certain circumstances, you may be eligible to continue participation for a certain period of time under COBRA. Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for COBRA continuation coverage.

For the Health Care Spending Account, if you are participating in the Health Care Spending Account when your employment with JPMorganChase 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 JPMorganChase 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 JPMorganChase cannot be reimbursed by the JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase Dependent Care Spending Account. You may not continue to make contributions to the Dependent Care Spending Account after your termination.

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

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

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

If You Port or Convert

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

- **For Supplemental Term Life**, within 31 days of your termination date, you have the option to convert your employee and/or dependent life insurance coverage to an individual life policy or port that coverage following your termination of employment as follows:
 - Employee Supplemental Life Insurance:
 - You may convert the coverage to an individual policy; OR
 - You may port the lesser of your total life insurance in effect at date of termination – you can port a minimum of \$10,000 or up to \$2 million (in increments of \$25,000)

- You must provide MetLife evidence of insurability for the additional coverage amount
- If you are already at the \$2 million maximum you may not increase your coverage.
- Dependent Spouse Supplemental Life Insurance:
 - You may convert the coverage to an individual policy; OR
 - You may port the minimum of \$2,500 (\$10,000 when porting Dependent Spouse life insurance alone) to a maximum of the lesser of your total dependent spouse life insurance in effect at date of termination, or \$300,000.
- Dependent Child Supplemental Life Insurance:
 - You may convert the coverage to an individual policy; OR
 - You may port your dependent child supplemental life insurance coverage at a minimum of \$1,000 to a maximum of the lesser of the total amount in effect at the date of termination or \$20,000.
- **For Accidental Death and Dismemberment (AD&D) Insurance:**
 - You may port the lesser of your total AD&D Insurance in effect on the day you elect to port or up to \$2 million of your employee AD&D coverage with Metropolitan Life Insurance Company (MetLife) within 31 days of your termination date.
 - When you leave JPMorganChase, you may increase the amount of your portable AD&D coverage in increments of \$25,000, up to a maximum of \$2 million. Generally, evidence of insurability is not required to port an existing eligible amount or an increased amount as noted above; however, to qualify for a lower premium rate you must satisfy evidence of insurability.
 - 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 JPMorganChase terminates, coverage for you and your covered dependents ends on your termination date. You have the option to continue coverage by enrolling in an Individual Legal Plan by visiting [MetLife.com/individual-legal-plans](https://www.metlife.com/individual-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 JPMorganChase terminates, coverage for you and your covered dependents ends on your termination date. Marsh McLennan Agency Private Client Services can assist with securing replacement coverage. For more information, please see the **As You Leave Guide** on the JPMC intranet.

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 JPMorganChase employee, you will need to elect coverage under your local/domestic, home-country medical plan and/or dental plan.

You Retire from JPMorganChase

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

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

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

For the Health Care Spending Account, if you are participating in the Health Care Spending Account when your employment with JPMorganChase 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 JPMorganChase 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 JPMorganChase cannot be reimbursed by the JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase 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**.
- **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 JPMorganChase, 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 JPMorganChase, 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 JPMorganChase, you may increase the amount of your portable AD&D coverage in increments of \$25,000, up to a maximum of \$2 million. Generally, evidence of insurability is not required to port an existing eligible amount or an increased amount as noted above; however, to qualify for a lower premium rate you must satisfy evidence of insurability.
 - 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 JPMorganChase, 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**.

For the Group Legal Services Plan, if you retire from JPMorganChase, coverage for you and your covered dependents ends on your retirement date. You have the option to continue coverage by enrolling in an Individual Legal Plan by visiting MetLife.com/individual-legal-plans. 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**.

For the Group Personal Excess Liability Insurance Plan, if you retire from JPMorganChase, coverage for you and your covered dependents ends on your retirement date. For more information, please see the **As You Leave Guide**.

You Work Past Age 65

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

For Life and Accident Insurance Plans: If you continue to work for JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 1/1/25

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

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.

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 1-844-ASK-JPMC (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.

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.

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. JPMorganChase 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 JPMorganChase and any individual. JPMorganChase 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 369 for a listing of official plan names and numbers.

Keep Your Information Current

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

Plan Sponsor

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

(Certain participating companies have adopted some or all of the plans for their eligible employees. See “Participating Companies” on page 372 for a list of participating companies.)

Plan Year

January 1 – December 31

Plan Administrator

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

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

For the Business Travel Accident Insurance Plan:

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

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

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

Claims Administrator

The contact information for claims administrators for the various benefits plans can be found under “Contacting the Claims Administrators: Plans Subject to ERISA” on page 386 and “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 390.

COBRA Administrator

COBRA questions should be directed to JPMorganChase at 1-844-ASK-JPMC.

COBRA payments should be directed to:

COBRA Payments JPMorganChase
 P.O. Box 27524
 New York, NY 10087-7524
 (844) ASK-JPMC

Benefits Fiduciaries

Please see “About Plan Fiduciaries” on page 374 for information on benefits fiduciaries.

Agent for Service of Legal Process

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

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

Employer Identification Number

13-4994650

Plan Administrative Information

The following chart shows the information that varies by plan. All of the following plans are governed by ERISA. The Dependent Care Spending Account, Transportation Spending Accounts, and the Group Personal Excess Liability Insurance Plan are not governed by ERISA and are not listed here. For more information, see “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 390. In no event will any of these Administrators pay, on behalf of the JPMorganChase benefit programs, any benefit that may be illegal under the law of the State in which the benefit is provided or performed.

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Medical Plan/502	Aetna, Cigna, and Centivo	See “Contacting the Claims Administrators: Plans Subject to ERISA” on page 386 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug Plan.	Self-Insured/Trustee

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Medical Plan/502	Kaiser HMO	See “Contacting the Claims Administrators: Plans Subject to ERISA” on page 386 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug Plan.	Fully-Insured
The JPMorgan Chase Medical Plan/502	Hawaii Medical	See “Contacting the Claims Administrators: Plans Subject to ERISA” on page 386 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug Plan.	Fully-Insured
The JPMorgan Chase Dental Plan/502	See “Contacting the Claims Administrators: Plans Subject to ERISA” on page 386 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 Administrators: Plans Subject to ERISA” on page 386 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: (underwritten by Fidelity Security Life Insurance)
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

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
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
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	N/A	Administrator: Spring Care, Inc Official Address: 60 Madison Ave, 2 nd floor New York, NY 10010 President/Director: April Koh	Fully-Insured (CA & NV—clinical component only) Pre-Paid Service (all other)
The JPMorgan Chase Back-up Child Care Plan/502	N/A	Bright Horizons Children's Centers LLC 2 Wells Avenue Newton, MA 02459	Self-Insured
The JPMorgan Chase Business Travel Accident (BTA) Insurance Plan/506	National Union Fire Insurance Company of Pittsburgh, PA 175 Water Street 15 th Floor New York, NY 10038	AIG — National Union Fire Insurance Company of Pittsburgh, PA 11250 Corporate Ave Lenexa, Kansas 66219	Fully Insured

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Health Care Spending Account Plan/510	N/A	See “Contacting the Claims Administrators: Plans Subject to ERISA” on page 386 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 JPMorganChase Leave of Absence Service Center P.O. Box 14648 Lexington, KY 40512-4648	Self-Insured
The JPMorgan Chase Health & Wellness Centers Plan/559	N/A	JPMorganChase 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 JPMorganChase have decided to participate in the JPMorganChase 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.

- 55i, LLC
- Aumni, Inc.
- Bear Stearns Asset Management, Inc.
- Campbell Global, LLC
- cxLoyalty Services, LLC
- eCAST Settlement Corporation
- Figg Inc.
- FNBC Leasing Corporation
- Frosch International Travel, LLC
- Global Shares, Inc.
- Highbridge Capital Management, LLC
- InstaMed Communications, LLC
- The Infatuation Inc.
- JPMorgan Chase & Co.
- JPMorgan Chase Travel LLC
- J.P. Morgan Alternative Asset Management, Inc.
- J.P. Morgan Chase Custody Services, Inc.
- J.P. Morgan Institutional Investments, Inc.
- J.P. Morgan Invest Holdings LLC
- J.P. Morgan Investment Management Inc.

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

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 JPMorganChase 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 the JPMC intranet – Personal Information – Contact Information. You can also contact 1-844-ASK-JPMC. 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 1-844-ASK-JPMC (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

We are committed to protecting your personal health information, and complying with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), as applicable. When you participate in health and benefits plans and related activities, including a wellness screening, wellness assessment, health coaching activities, benefits-related surveys or treatment at a JPMC or Vera onsite Health & Wellness Center, your personal health information will be maintained and used in accordance with appropriate notices, privacy policies and applicable law.

The plan administrator (or its designee) may use your personal health information along with other information about you, including other HR and demographic data, medical claims and survey data, wellness screening results (“Your Medical Information”) and/or share Your Medical Information with other entities (such as service providers, vendors, consultants or other recipients designated by the plan administrator) that need such information in order to provide services in connection with the JPMC Medical Plan, for plan administration and design purposes including to assess, identify, offer, and/or determine eligibility for programs and services that can help you stay healthy, improve your health, or address other health-related matters. Your Medical Information may also be shared and used in aggregate form for health care-related research and other health care-related purposes. For more information, go to My Health > Benefits Enrollment > Benefits Resources > Privacy Notice.

Privacy Notice

JPMorganChase 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 JPMorganChase—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, JPMorganChase 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 1-844-ASK-JPMC 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 JPMorganChase;
- Notify you if a breach of your protected health information is discovered;
- Report to the JPMorganChase 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 JPMorganChase 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 JPMorganChase 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
JPMorganChase 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: Plans Subject to ERISA" beginning on page 379.

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 1-844-ASK-JPMC.

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 1-844-ASK-JPMC. (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 368. 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 386, 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 374 and “Contacting the Claims Administrators: Plans Subject to ERISA” on page 386. 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 377.

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 390.

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 Administrators: Plans Subject to ERISA” on page 386.

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	

Plan/Option	Appropriate Claims Administrator	Timing for Filing Your Initial Claim
Vision Plan*	FAA/EyeMed Vision Care	
Health Care Spending Account	Claims administrator for your Health Care Spending Account	March 31 of the year following the year for which the expense is incurred.
Life Insurance Plan	Metropolitan Life Insurance Company (MetLife)**	There is no time limit to file a claim after a covered individual passes away.
AD&D Insurance Plan	Metropolitan Life Insurance Company (MetLife)**	Notification of a loss must be made 20 days from the date of loss. Proof must be provided to MetLife within 90 days following the date of an employee's loss.
Business Travel Accident Insurance Plan	AIG-National Union Fire Insurance Company of Pittsburgh, PA	Within 20 days after an employee's loss, or as soon as reasonably possible thereafter.
Group Long-Term Disability	The Prudential Insurance Company of America	Within 272 days (nine months) following the start of the disability***.
Individual Disability Insurance	Unum	Within 30 days following the start of the disability.
Short-Term Disability Plan	Sedgwick	Within 30 days of first day of absence from work.
Group Legal Services Plan****	MetLife Legal Plans, Inc.	No later than December 31 of the year following the year in which services were provided.
Employee Assistance Program	Spring Care, Inc Official Address: 60 Madison Ave, 2 nd floor New York, NY 10010 President/Director: April Koh	Within 90 days from date of service.
Health & Wellness Centers Plan*****	JPMorgan Chase & Co. Health Services Dept. 277 Park Ave, 1 st Floor Mail Code: NY1-L085 New York, NY 10172 (212) 270-5555	No later than December 31 of the year following the year in which services were provided.
Back-up Child Care Plan	Bright Horizons Children's Centers LLC 2 Wells Avenue Newton, MA 02459 (888) 701-2235	Within 60 days from the date of service.

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

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

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

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

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

Life Insurance Claims & Appeals

Life insurance claims and appeals are divided between two parties.

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

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

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

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

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

What Qualifies as a “Denied Benefit”?

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

Plan/Option	Timing for Notification of a Denial of Benefits Claim
Medical Plan, Prescription Drug Plan, 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

Plan/Option	Timing for Notification of a Denial of Benefits Claim
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. JPMorganChase is not involved in deciding appeals for any denied benefit claim under the:

- Medical Plan, including Prescription Drug Plan;
- 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;

- 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 the above-listed plans to the applicable claims administrator.

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

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

- Medical Plan;
- Prescription Drug Plan; 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
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, 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.

Plan/Option	Timing for Notification of a Denial of Benefits Claim
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; and
- Health & Wellness Centers Plan.

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

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

Filing a Court Action

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

If you bring a civil action under ERISA, you first must follow the procedures described above regarding filing a claim and up to two levels of internal appeals with the claims administrator. You must start the court action by the earlier of: (i) one year after the date of the denial of your final appeal; or (ii) three years after the date when your initial claim should have been filed, regardless of any state 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.

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

Contacting the Claims Administrators: Plans Subject to ERISA

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

For contact information for the plans that are not subject to ERISA (which include the Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan), please see “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 390

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 calling 1-844-ASK-JPMC. (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
Centivo*	Centivo 199 Scott St., 8 th Floor Buffalo, NY 14203 833-543-4676
Hawaii Medical Plan	Medical appeals: Cigna Appeals Unit P.O. Box 188011 Chattanooga, TN 37422-8011 Medical paper claims: P.O. Box 182223 Chattanooga, TN 37422-7223
Kaiser HMO Plan	CALIFORNIA – SCAL Claim Address: P.O. Box 7004 Downey, CA 90242-7004 Member Services: (800) 464-4000 CALIFORNIA – NCAL Claim Address: P.O. Box 12923 Oakland, CA 94604-2923 Member Services: (800) 464-4000
Prescription Drug Plan*	CVS Caremark Attention: Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196 866-209-6093
WINFertility	WINFertility, Inc. Greenwich American Center One American Lane Terrace Level Greenwich, CT 06831 (833) 439-1517

Medical Plan Claims Administrators

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.)
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* 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 JPMorganChase Dedicated Service Center P.O. Box 15050 Wilmington, DE 19850-5050 (800) 390-7183 (302) 797-3644 (if calling from outside the U.S.)

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

Other Health Care and Insurance Plans Subject to ERISA

Plan	Contact
Vision Plan	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111 (833) 279-4363
Health Care Spending Accounts	Refer to the same provider that you selected for your Medical Plan coverage. If you do not enroll in the Medical Plan coverage, or enroll with Centivo, contact Cigna. Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 790-3086 Inspira Financial (if enrolled with Aetna) Inspira Financial P.O. Box 2495 Omaha, NE 68103 Fax: (888) 238-3539 (888) 678-8242 (TTY: 711)

Other Health Care and Insurance Plans Subject to ERISA	
Plan	Contact
<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 JPMorganChase 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 (888) 673-9582
<i>Business Travel Accident Insurance Plan</i>	JPMorganChase Corporate Insurance Services JPMorgan Chase & Co. 8181 Communications Pkwy Bldg B, Floor 03 Mail Code TXW-3305 Plano, TX, 75024-0239, United States
<i>Group Legal Services Plan</i>	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114 (800) 821-6400
<i>Employee Assistance Program</i>	Spring Care, Inc Official Address: 60 Madison Ave, 2 nd floor New York, NY 10010 President/Director: April Koh (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: Plans Subject to ERISA” on page 379, 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 377.

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, or enroll with Centivo, contact Cigna. Cigna P.O. Box 188061 Chattanooga, TN 37422-8061 (800) 790-3086 Inspira Financial (if enrolled with Aetna) Inspira Financial P.O. Box 2495 Omaha, NE 68103 Fax: (888) 238-3539 (888) 678-8242 (TTY: 711)
Transportation Spending Accounts	Health Equity P.O. Box 14053 Lexington, KY 40511 (877) 924-3967
Group Personal Excess Liability Insurance Plan	Marsh McLennan Agency Private Client Services 7201 W. Lake Mead #400 Las Vegas, NV 89128 (855) 426-1380

If You Are Covered by More Than One Health Care Plan

The JPMorganChase 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 JPMorganChase plans would pay if they were your only coverage.

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

Non-Duplication of Benefits

The JPMorganChase 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 JPMorganChase health care plans will ensure that, in total, you receive benefits up to what you would have received with the JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase plan.
- If, however, your JPMorganChase plan considered the R&C charge to be \$80, no additional benefit would be payable, as the JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase, your JPMorganChase 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 JPMorganChase coverage as primary.

- While you remain an active JPMorganChase employee, the JPMorganChase 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 JPMorganChase 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.

Important: If you, your spouse, or covered dependents do not elect to enroll in Medicare Parts A and/or B when first eligible, in certain situations (e.g., when covered due to COBRA), the JPMorganChase health care plans will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled in Medicare coverage. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective even if the person does not enroll in Medicare. If you have any questions on how Medicare eligibility may affect your coverage under the JPMorganChase health care plans, please contact your applicable health care company.

Right of Recovery

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

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

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

Subrogation of Benefits

The purpose of the JPMorganChase health care plans is to provide benefits for eligible health care expenses that are not the responsibility of any third party. The JPMorganChase 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 JPMorganChase 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 JPMorganChase plans have a first priority equitable lien from any amounts recovered from a third party for the full amount of benefits the plans have paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the JPMorganChase plans use this right when requested.
- If you fail to help the JPMorganChase plans use this right when requested, the plans may deduct the amount the plans paid from any future benefits payable under the plans.
- The JPMorganChase 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 JPMorganChase 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 JPMorganChase plans have a right to obtain payment of the equitable lien regardless of whether or not you subsequently spend or commingle the funds you obtain from a settlement.
- The JPMorganChase 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 JPMorganChase 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 JPMorganChase 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 JPMorganChase plans shall have a right of full reimbursement, in first priority, from the recovery.
- You must hold in trust for the benefit of the JPMorganChase plans the gross proceeds of a recovery, to be paid to the plans immediately upon your receipt of the recovery. You must reimburse the plans, in first priority and without any set-off or reduction for attorney fees or other expenses, regardless of whether or not you subsequently spend or commingle the funds you obtain. The "common fund" doctrine does not apply to any funds recovered by any attorney you retain, regardless of whether the funds recovered are used to repay benefits paid by the plans.
- If you fail to reimburse the JPMorganChase 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 JPMorganChase 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 JPMorganChase

If your employment has been reinstated with JPMorganChase (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, , 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 1/1/25

My Health, My Rewards and 1-844-ASK-JPMC 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, JPMorganChase 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/>.

1-844-ASK-JPMC

Like **My Health** and **My Rewards**, 1-844-ASK-JPMC provides access to benefits information.

- *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)	<p>Aetna (800) 468-1266 8 a.m. to 8 p.m., all time zones, Monday – Friday My Health or www.aetna.com</p> <p>Cigna (800) 790-3086 24/7 My Health or www.mycigna.com</p> <p>Centivo (833) 543-4676 7 a.m. to 7 p.m. Central time My Health or my.centivo.com</p>
Prescription Drugs	<p>CVS Caremark (866) 209-6093 24/7 www.caremark.com</p>
Kaiser HMO (Medical and Prescription Drugs)	<p>Kaiser Permanente (800) 204-6561 8 a.m. to 6 p.m., Pacific time, Monday – Friday My Health or kp.org</p>
Centivo Select Plan	<p>Centivo (833) 543-4676 7 a.m. to 7 p.m. Central time My Health or my.centivo.com</p>
Employee Assistance Program (EAP)	<p>Cigna (EAP) and LifeCare (Work-Life) (877) 576-2007 www.eapandworklife.com</p>
Tobacco Cessation Program	<p>(866) QUIT-4-LIFE ((866) 784-8454) myquitforlife.com/jpmorganchase.com</p>
Expert Medical Advice	<p>Included Health (888) 868-4693 8 a.m. to 9 p.m. Eastern time, Monday – Friday includedhealth.com/jpmc</p>
LGBTQ+ Health Concierge Service	<p>Included Health (877) 266-2861 9 a.m. to 8 p.m. Eastern time, Monday – Friday includedhealth.com/jpmc</p>

Issue/Benefit	Contact Information
<p>Health Care Spending Account Dependent Care Spending Account</p>	<p>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.</p> <p>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</p> <p>Cigna (800) 790-3086 24/7 www.mycigna.com</p> <p>You can check your spending account balances through My Health.</p>
<p>Dental</p>	<p>Aetna, Inc. Dental Maintenance Organization (DMO) Option: Aetna (800) 843-3661 8 a.m. to 6 p.m. Eastern time, Monday – Friday My Health or www.aetna.com</p> <p>Cigna Dental Health Maintenance Organization (DHMO) Option: Cigna Dental Health (800) 790-3086 24/7 My Health or http://mycigna.com/</p> <p>MetLife Preferred Dentist Program (PDP) Option: MetLife Dental (888) 673-9582 8 a.m. to 11 p.m. Eastern time, Monday – Friday My Health or https://mybenefits.metlife.com</p>
<p>Vision</p>	<p>EyeMed Vision Care (833) 279-4363 7:30 a.m. to 11 p.m. Eastern time, Monday – Friday 8 a.m. to 11 p.m. Eastern time, Saturday 11 a.m. to 8 p.m. Eastern time, Sunday My Health or http://www.eyemedvisioncare.com/jpmc</p>
<p>Transportation Spending Accounts (including for questions about eligibility and enrollment)</p>	<p>Health Equity (877) 924-3967 8 a.m. to 8 p.m., all time zones, Monday – Friday www.healthequity.com</p> <p>You can check your Transportation Spending Accounts balances on from the Transportation Spending Accounts Web Center via My Rewards. (myrewards.jpmorganchase.com)</p>
<p>Group Long –Term Disability</p>	<p>The Prudential Insurance Company of America (877) 361-4778 Monday – Friday from 8 a.m. to 8 p.m. Eastern time</p>

Issue/Benefit	Contact Information
Individual Disability Insurance	Covala Group (800) 235-3551 Monday – Friday from 8:30 a.m. to 5:30 p.m. Eastern time
Short-Term Disability Plan	Sedgwick Claims Management Services, Inc. (888) 931-3100 Service Representatives are available 24/7, Sunday through Saturday. You can also obtain answers to your questions 24 hours a day, seven days a week online at claimlookup.com/jpmc .
Life and Accidental Death & Dismemberment Insurance	Metropolitan Life Insurance Company (MetLife) (888) 673-9582 8 a.m. to 8 p.m. Eastern time, Monday – Friday
SurvivorSupport® Financial Counseling Services	The Ayco Company (800) 235-3417 8 a.m. to 5 p.m. Eastern time, Monday – Friday
ID Theft Assistance Program, Travel Assistance, and Emergency Evacuation Services	AXA Assistance (800) 454-3679 (outside the U.S., call collect at (312) 935-3783) 24/7
Funeral Concierge Services	Dignity Memorial (866) 853-0954 24/7
Business Travel Accident Insurance	AIG-National Union Fire Insurance Company of Pittsburgh, PA (800) 551-0824 or (302) 661-4176 8 a.m. to 5 p.m. Central time, Monday – Friday
401(k) Savings Plan	My Rewards > My Web Centers > 401(k) Savings Plan 401(k) Savings Plan Call Center (866) JPMC401k ((866) 576-2401) TTY number (800) 345-1833 Outside the U.S.: (303) 737-7204 Speak to a Representative 8 a.m. to 10 p.m. Eastern time, Monday – Friday (except NYSE holidays)
Retirement (Pension) Plan	My Rewards > My Web Centers > Pension Plan 1-844-ASK-JPMC Outside the U.S.: (212) 552-5100 Speak to a Representative 8 a.m. to 7 p.m. Eastern time, Monday – Friday (except certain U.S. holidays)
My Finances and Me (financial coaching benefit for active employees)	The JPMC Intranet > Benefits & Rewards > My Financial Well-being > My Finances and Me (833) 283-0031 Speak to a Financial Coach 9 a.m. to 8 p.m. Eastern time, Monday – Friday (except certain U.S. holidays)
Health & Wellness Centers	The Health & Wellness Centers Directory on My Health has a list of JPMorganChase Health & Wellness Centers locations, phone numbers, and hours. Go to My Health > Wellness Activities & Services . This information is also available at go/healthservices on the company intranet browser.

Issue/Benefit	Contact Information
Group Legal Plan	MetLife Legal Plans, Inc. (800) 821-6400 8 a.m. to 8 p.m. Eastern time, Monday – Friday
Group Personal Excess Liability Insurance	Marsh McLennan Agency Private Client Services (855) 426-1380 8 a.m. to 6 p.m. Eastern time, Monday – Friday
Child Care Plan	Bright Horizons (888) 701-2235 https://backup.brighthorizons.com/jpmc (for backup care reservations) The JPMC Intranet > Health, Life & Parenting > parents@jpmc (for information about the Plan and other offerings)
Expatriate Medical and Dental Plans	Cigna Global Health Benefits (800) 243-6998 (outside the U.S., call collect at (302) 797-3644 24/7 www.CignaEnvoy.com