Expatriate Medical and Dental Plans

Effective 1/1/22

The Expatriate Medical and Dental Plans are features of the U.S. Medical and Dental Plan. The expatriate plans are intended to offer global coverage to employees on expatriate assignment, because most local plans do not provide sufficient coverage while outside of your home country.

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

The Expatriate Medical Plan is built on the principle of a shared commitment to health. JPMorgan Chase provides valuable benefits, funding, and a suite of features designed to help you get and pay for the treatment you need, manage your health care expenses, and most importantly, take care of yourself. In addition to providing coverage in the event of illness, the Expatriate Medical Plan offers full coverage for eligible preventive care and no pre-existing condition exclusions.

This summary plan description explains the details of the Expatriate Medical and Dental Plans, including how to use the Plans and how and when benefits are paid.

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

About This Summary Plan Description

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

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

Questions?

If you still have questions after reviewing this Guide, there are a number of resources that can provide answers. As a first stop for expatriate plans, contact the claims administrator:

Cigna Global Health Benefits
www.CignaEnvoy.com
From the U.S.: (800) 390-7183
From outside the U.S., call collect: (302) 797-3644

Representatives are available 24 hours a day, 7 days a week.

For additional resources, consult the *Contacts* section.

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

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Your Options by Group

JPMorgan Chase offers a variety of benefits plans to expatriate employees. Your eligibility for benefits depends on your expatriate group.

Expatriate Group	Available Plans
U.S. Home-Based Expatriates	• All U.S. Health Care and Insurance Plan benefits, except for the U.S. Medical Plan and U.S. Dental Plans, and the Transportation Spending Accounts • The Expatriate Medical Plan and Expatriate Dental Plans
Non-U.S. Home-Based Expatriates Assigned to the United States	• The Expatriate Medical Plan and Expatriate Dental Plans* • The Vision Plan, Spending Accounts (Health Care, Dependent Care, and Transportation), Group Personal Excess Liability Insurance Plan, and Group Legal Services Plan
Non U.S. Home Based Expatriates Assigned Outside the United States	• The Expatriate Medical Plan and Expatriate Dental Plans*

* Swiss home-based expatriate employees are not eligible to participate in the Expatriate Medical Plan and/or Expatriate Dental Plans unless they are exempt from Swiss legal requirements mandating that Swiss residents maintain basic Swiss health care coverage while on assignment outside Switzerland.

Already Enrolled?

If you are already enrolled in the Expatriate Medical Plan, visit the Expatriate Wellness Program page on **me@jpmc** for information and access to the Wellness Assessment and Basic Condition Management Program tools for Expatriate Medical Plan participants.

Expatriate Plan Highlights

Enrollment Resources	The **Expatriate Health Benefits Resources** page is your central online resource for finding information about the Expatriate Medical Plan and Dental Plans as well as enrollment resources, wellness tools and links to important web centers: From your work device, visit https://me.jpmchase.net > Career > Global Mobility > **Expatriate Health Benefits Resources**
Medical Coverage	You have access to any licensed hospital or physician around the world. ▪ Coverage for any pre-existing condition begins as soon as you enroll. ▪ Preventive care is available at 100% with no deductible or coinsurance. Preventive care includes routine physical exams and recommended screenings. ▪ Other medical costs are subject to a deductible — a set amount that you pay out-of-pocket before the Plan shares in the costs for care. ▪ After you satisfy the deductible, the Plan and you both pay a percentage of the cost, known as "coinsurance." ▪ The Plan's coinsurance maximum — your financial "safety net" — limits the amount you are required to pay in coinsurance each year. There is a higher coinsurance maximum for out-of-network charges incurred in the U.S. ▪ Prescription drug benefits are part of your coverage. Prescription drug purchases are subject to coinsurance, but are not subject to the annual deductible.
Dental Coverage	You have access to any licensed dentist around the world. ▪ Preventive dental care is covered at 100%. ▪ For restorative care, after you satisfy a deductible, you pay your share of dental costs through coinsurance until you reach the annual and/or lifetime maximum benefits. ▪ The maximum benefit is $2,000 per person per year for preventive and restorative care. ▪ The lifetime maximum benefit for orthodontia is $2,500 per child (under age 19).
Coverage Levels	You can choose to cover: ▪ Yourself only; ▪ Yourself and your spouse/domestic partner; or Yourself and your child(ren); or ▪ Your family (yourself, your spouse/domestic partner, and your children).
Cost of Coverage	Contribution rates vary by the types of dependent whom you choose to cover — e.g., a spouse/domestic partner vs. a child. You will be charged for up to a maximum of four children, regardless of how many additional children you choose to cover (you can cover all of your children, as long as they met eligibility requirements).
Claims Administrator	Coverage is administered by Cigna Global Health Benefits, an established company that offers broad global provider networks. They also offer tools and resources to help you research and understand your health treatment alternatives.

Eligibility and Enrollment

This section describes the general guidelines for participating in the JPMorgan Chase Expatriate Medical and Dental Plans. Participating in the Plans is optional — the choice is yours!

Who's Eligible?

In general, you are eligible to participate if you are:

- Employed by JPMorgan Chase & Co or one of its subsidiaries to the extent that such subsidiary has adopted the Plans;
- An expatriate employee who receives salary or is eligible to receive draws, commissions, incentives, or overrides ("salaried employee"); and
- Regularly scheduled to work 20 or more hours per week.

Who's Not Eligible?

You are not eligible if you are an individual who does not meet the criteria under "Who's Eligible?," or if you are an individual classified or employed in a work status other than as a common law salaried employee by your employer.

Examples of such individuals include an:

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

Eligible Dependents

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

Your eligible dependents under the Expatriate Medical and Dental Plans — and if you're a U.S. home-based expatriate or an expatriate assigned to the U.S., under certain other plans as referenced in this Guide — include:

- Your spouse or domestic partner (see "Domestic Partners" on page 422 for more information); and
- Your and/or your spouse's/domestic partner's children up to the last day of the month in which they reach age 26, regardless of student or marital status, financial dependence on parents, residency with parents, or eligibility for coverage under another health plan. To cover your domestic partner's children, you must elect coverage for your domestic partner.

Please Note: You may continue coverage beyond age 26 for an unmarried child who is unable to support himself or herself because of a mental or physical disability that began before age 26 and who depends fully on you for financial support. Contact Cigna Global Health for more information before your dependent turns 26.

Important Note on Dependent Eligibility

You are responsible for understanding the dependent eligibility rules and abiding by them. Each year during Annual Benefits Enrollment, you must review your covered dependents and confirm that they continue to meet the eligibility requirements. It is important that you review both the dependent eligibility rules and the status of your dependents on file, and make any necessary adjustments during your enrollment period or within 31 days of a Qualified Status Change (QSC), 90 days if the qualifying event is the birth or adoption of a child or if your newly eligible dependent passes away within the 90 day window (for example, gain or loss of other coverage, etc.). JPMorgan Chase reserves the right to conduct eligibility verifications on existing dependents at any time. If you fail to provide satisfactory proof (when requested) that your covered dependents meet the current eligibility requirements, you could face penalties ranging from **loss of coverage for your dependents** to **termination of employment.**

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

Spouse

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

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

Children

"Children" include the following:

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

Domestic Partners

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

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

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

  OR

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

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

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

Qualified Medical Child Support Orders

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

Enrolling

Because participating in these plans is optional, you must enroll to have coverage. If you decide to participate, when you enroll you will choose:

1. The Plan(s) you want (the Expatriate Medical Plan only, the Expatriate Dental Plan only, or both plans); and.
2. The coverage level.

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

Coverage Levels

JPMorgan Chase provides a range of coverage levels. When you enroll in the Expatriate Medical and/or Dental Plans, your coverage level is based on the number of dependents you enroll and includes the following coverage categories:

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

You can enroll yourself and your eligible dependents in the Expatriate Medical Plan and/or the Expatriate Dental Plan. You can also elect "No Coverage" for one or both of these Plans.

If you are eligible for coverage and do not enroll, your eligible dependents cannot enroll.

You are responsible for understanding the dependent eligibility rules and abiding by them (see "Important Note on Dependent Eligibility" on page 422.

An Important Note on Dependent Coverage

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

Cost of Coverage

You and JPMorgan Chase share the cost of coverage.

During your designated enrollment period, your cost for each Plan will be available on the **Benefits Web Center** via **me@jpmc**.

Before-Tax Costs

U.S. home-based expatriate employees or expatriates assigned to the U.S. pay for coverage with before-tax dollars, which means your U.S. federal, state, and local income taxes (if applicable) are reduced.

Domestic Partner Costs

If you're covering a domestic partner as described in "Eligible Dependents" in the *Health Care Participation* section, there are tax implications of which you should be aware.

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

To offset the additional federal and state tax that is payable in order to cover a domestic partner, employees who cover same-sex domestic partners receive special "gross up" pay to compensate for the cost of the additional taxes. You will receive recurring payments, each of which represents an offset for federal (including FICA) and state taxes, if applicable, that you paid on benefits in the prior pay period. You can identify these payments on your pay statement under Earnings, "Benefit Tax Offset — GUDP."

Because these payments will be taxable payments, the payments include an additional amount to help adjust for the taxes that you will pay on the payments themselves. They are based on estimated federal (25%) and state tax rates and include a FICA adjustment for individuals whose prior-year wages do not exceed the FICA wage limit for the prior year.

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

Enrolling a Domestic Partner

Additional information on enrolling and the tax consequences of covering a domestic partner can be found on **My Health**. **Domestic Partner Coverage Guide** available via the **Expatriate Health Benefits Resources** page.

How to Enroll

Participation in the Plans is optional.

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

- an expatriate employee
- a newly hired U.S. home-based expatriate employee or a non-U.S. home-based expatriate new to expatriate status; or
- Have a change in work status or Qualified Status Change (QSC).

Enrolling When You Start Your Expatriate Assignment and Change to Expatriate Status

If you're staring your expatriate assignment and are enrolling for the first time, you need to make your choices online in the **Benefits Web Center** via the **Expatriate Health Benefits Resources** page on **me@jpmc** or over the phone through HR Answers.

Enrollment elections must be made as explained below:

- If you are a U.S. home based expatriate employee, within 31 days of commencing your expatriate assignment
- If you are a new non-U.S. home-based expatriate, within 31 days of commencing your expatriate assignment; or

You can access your benefits enrollment materials online at the **Expatriate Health Benefits Resources** page via **me@jpmc**: From your work device, visit **me@jpmc** > Career > Global Mobility > **Expatriate Health Benefits Resources**

Enrolling During Your Expatriate Assignment

During an Annual Benefits Enrollment, you can make and confirm your elections for the following calendar year through the Benefits Web Center on the **Expatriate Health Benefits Resources** page on **me@jpmc** or through HR Answers. At the beginning of each enrollment period, you'll receive instructions on how to enroll.

To access the Benefits Web Center, from your work device, visit **me@jpmc** > Career > Global Mobility > **Expatriate Health Benefits Resources** > Benefits Web Center.

You'll also receive information about the choices available to you and their costs at that time on Benefits Web Center. You need to review your available choices carefully and enroll in the Plans that best meet your needs. You can't change your choices during the year unless you have a Qualified Status Change (QSC). Please see "Changing Your Coverage Midyear" on page 426 for more information.

Enrolling if You Have a Qualified Status Change (QSC)

If you're enrolling during the year because you have a Qualified Status Change (QSC), you'll have 31 days from the date of the change in status (including losing coverage under a spouse's plan, the birth or adoption of a child, etc.) to make your new choices through the **Benefits Web Center** via the **Expatriate Health Benefits Resources** page on **me@jpmc** or through HR Answers. From your work device, visit **me@jpmc** > Career > Global Mobility > **Expatriate Health Benefits Resources** > Benefits Web Center.

Please see "Changing Your Coverage Midyear" on page 426 for more information.

Coverage if You Do Not Enroll

If you choose not to enroll or do not take action during the 31 day enrollment period as a new expatriate employee, you will continue without coverage for the remainder of the year. During Annual Benefits Enrollment (if available), you will have the opportunity to change your elections for the following calendar year.

Coverage if You Have Not Enrolled and You Have a Qualified Status Change (QSC)

If you have a Qualified Status Change (QSC) that allows you to enroll in the Expatriate Medical Plan and/or Expatriate Dental Plans and you do not enroll within the designated 31-day period, coverage for certain benefits will be effective as of the date you contact HR Answers. You may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact HR Answers. Otherwise, you will not be able to make the change in coverage until the next Annual Benefits Enrollment.

Please see “Changing Your Coverage Midyear” on page 426 for more information.

When Coverage Begins

If You Enroll at the Start of Your Expatriate Assignment

The coverage you elect as an eligible expatriate employee takes effect on the date of your transfer to expatriate status.

If You Make Changes to Your Elections During Annual Enrollment

The coverage you elect during Annual Benefits Enrollment takes effect at the beginning of the following plan year (January 1).

If You Have a Change in Work Status or Qualified Status Change (QSC)

The coverage you elect as a result of a qualifying event (such as marriage, divorce, or the birth or adoption of a child or a work-related event such as an adjustment to your regularly scheduled work hours that results in a change in eligibility) will take effect as of the day of the qualifying event, if you enroll within 31 days of the event and if you have already met the Plans’ eligibility requirements. If you miss the 31-day deadline, coverage for certain benefits will be effective as of the date you contact HR Answers. You may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact HR Answers. Otherwise, you will not be able to make the change in coverage until the following Annual Benefits Enrollment.

Please see “Changing Your Coverage Midyear” on page 426 for more information.

Pre-Existing Conditions
The Expatriate Medical Plan covers pre-existing conditions. Your coverage begins as soon as you’re eligible and enroll.

When Payroll Contributions Begin

Your contributions toward the cost of coverage start when your coverage begins. Your contributions are automatically deducted from your pay in monthly installments (unless retroactive payments are required) via the Expatriate Payroll.

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

Changing Your Coverage Midyear

You may be permitted to change your elections before the next Annual Benefits Enrollment if you have a Qualified Status Change (QSC).

You need to enroll and/or add your eligible dependents **within 31 days of the qualifying event** (90 days if the qualifying event is the birth or adoption of a child) for benefits to be effective on the date of the event. **Please Note:** See “Coverage if You Do Not Enroll” on page 425 for details on what happens if you miss the 31-day enrollment period. (You will have 90 days from the QSC to add any newly eligible dependents should that dependent pass away within this 90-day period; please contact HR Answers if this situation applies to you.)

You can make these elections through the Benefits Web Center via the **Expatriate Health Benefits Resources** page on **me@jpmc** or through HR Answers.

QSCs for eligible dependents under the Expatriate Medical Plan and/or Expatriate Dental Plans are listed in the following table.

Event	Medical Plan Changes
You get married	Add coverage for yourself and/or your eligible dependents
You enter into a domestic partner relationship or civil union	Add coverage for yourself, your domestic partner, and any eligible children.
You have, adopt, or obtain legal guardianship of a child*	Add coverage for yourself and/or your eligible dependents
You and/or your covered dependents gain other benefits coverage*	Cancel coverage for yourself and/or your covered dependents who have gained other coverage
You and/or your eligible dependents lose other benefits coverage*	Add coverage for yourself and/or your eligible dependents who have lost other coverage
You get legally separated or divorced	Cancel coverage for your former spouse and/or children who are no longer eligible
You end a domestic partner relationship or civil union	Cancel coverage for your domestic partner and your domestic partner's eligible children who are no longer eligible
A child is no longer eligible*	Cancel coverage for your child
A covered family member dies*	Cancel coverage for your deceased dependent and any children who are no longer eligible

* Also applies to a domestic partner relationship.

HIPAA Special Enrollment Rights

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

If you or your eligible dependent declined coverage under the Medical Plan, you may enroll for medical coverage within 31 days of one of the following events for coverage to be effective the date of the event. If you miss the 31-day deadline, coverage for certain benefits will be effective as of the date you contact HR Answers. To have retroactive coverage, you will be required to pay for your coverage on an after-tax basis for the period before you first contact HR Answers. Otherwise, you will not be able to make the change until the following Annual Benefits Enrollment:

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

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

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

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

When Coverage Ends

Coverage under the Expatriate Medical and Dental Plans ends according to the same provisions as the Medical, Dental and Vision Plans, as described under "When Coverage Ends" in the *Health Care Participation* section. Except for non-U.S. home-based expatriate employees assigned outside the United States, you may be able to continue coverage for you and/or your covered dependents under COBRA, as described in "Continuing Health Coverage Under COBRA" *Health Care Participation* section.

Expatriate Medical Plan

In addition to providing coverage in the event of illness, the Expatriate Medical Plan offers full coverage for eligible preventive care (without a deductible) and for inpatient hospital expenses (after a per-admission copayment) received in-network in the U.S. or outside the U.S.

The Expatriate Medical Plan also provides resources to help you understand the care and services available to you and to be informed about opportunities to save money while using quality in-network providers.

Key features include:

- **Preventive care received outside the U.S. or in-network in the U.S. is covered at 100% with no deductible, copayment or coinsurance.** Preventive care includes annual physical exams and recommended screenings.
- **Other medical costs are subject to an annual deductible.** After you satisfy the deductible, the Plan and you pay a coinsurance — a percentage of the costs. You pay a lower coinsurance amount for services received outside the U.S. or in-network in the U.S.
- **You can use out-of-network providers in the U.S. without a referral, but you will pay a higher deductible and a higher coinsurance amount.** You'll also be responsible for amounts above "reasonable and customary" costs, which are based on average claims data in your area and have been determined by Cigna Global Health Benefits, the plan administrator, to be appropriate fees for medical services.
- **The Plan's out-of-pocket coinsurance maximum — your financial "safety net" — limits the amount you are required to pay in coinsurance each year.** There are separate coinsurance maximums for in-network and out-of-network charges incurred in the U.S.
- **Prescription drug benefits are part of your coverage.** Prescription drug purchases are subject to coinsurance but are not subject to the annual deductible. You can lower your out-of-pocket expenses by opting for generic drugs when they are available.

Privacy Information

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

For more information, go to **me@jpmc** > Career > Global Mobility > **Expatriate Health Benefits Resources** > Privacy Notice.

How Your Medical Benefits Work

If You Receive Care in the United States

When you need health care services in the United States, you can choose to receive your care from an in-network or out-of-network medical provider. (See "If You Receive Care Outside the United States" on page 431 if you will be receiving care outside the U.S.)

You will generally pay less when you receive your care from an in-network provider because network providers have agreed to charge pre-negotiated discounted rates. In addition, the deductible is lower for in-network care, so you incur less expense before the Plan begins to pay benefits, and your coinsurance rate is lower.

In-Network Care in the United States

- The Plan generally pays 100% of the cost for preventive care without a deductible, 100% of the cost of hospitalization, and 80% of most other covered services after you meet the annual deductible.
- See "Coinsurance Paid by the Expatriate Medical Plan" on page 439 for tables that show the coinsurance percentage paid by the Expatriate Medical Plan on an in-network and out-of-network basis in the U.S.

In-Network Hospital Admissions

When you visit an in-network facility for a scheduled surgery, the Expatriate Medical Plan will cover care provided by radiologists, anesthesiologists, and/or pathologists (RAPs) at the in-network percentage of the reasonable and customary (R&C) charge, even if the provider is considered an out-of-network provider.

For example, assume you visit an in-network facility for surgery and are treated by an out-of-network anesthesiologist whose charge is $500. If the R&C charge for the anesthesiologist’s services is $400, the Plan will reimburse you 80% of $400 ($320) after you have met the annual deductible; you will be responsible for payment of the remaining $180. Fees for services provided by any other out-of-network specialists who attend to you while you are confined in an in-network facility will be paid at the out-of-network level of benefits. Services performed in an out-of-network facility will be paid at the out-of-network level of benefits.

Out-of-Network Care in the United States

- You may use any licensed provider. **Note**: Charges from out-of-network providers are typically higher than the pre-negotiated fees charged by in-network providers.
- Covered services will be reimbursed at the out-of-network level of benefits, subject to reasonable and customary (R&C) charges. These charges are based on average claims data in your area and are determined by Cigna to be appropriate fees for medical services. **Please Note:** You will be responsible for paying all charges above the R&C amount. Charges in excess of reasonable and customary levels are not considered a covered expense, and they are thus not applied towards your annual coinsurance maximum.
- The Plan generally pays 60% of medically-necessary eligible expenses (subject to reasonable and customary charge limits) after you meet the annual deductible.
- You may need to pay for services at the time you receive care and submit a claim for reimbursement to Cigna Global Health Benefits. Please see “Filing a Claim for Benefits” on page 462 for more information. Certain providers may choose to accept a guarantee of payment directly from Cigna Global Health Benefits. You would then be responsible for the difference not paid by the Plan.
- See "Out-of-Network Care in the United States" on page 430 for tables that show the coinsurance percentage paid by the Expatriate Medical Plan on an in-network and out-of-network basis in the U.S.

Out-of-Network Expenses

All out-of-network expenses are subject to reasonable and customary (R&C) limits; you are responsible for 100% of all charges above the R&C amounts. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

Prescription Drug Purchases at Retail Pharmacies in the United States

For prescription drug purchases in the United States, Puerto Rico, and the U.S. Virgin Islands, you can use the Cigna Pharmacy Management network of participating pharmacies to obtain discounted brand-name and generic prescription drugs through more than 62,000 pharmacies. Simply present your Cigna Global Health Benefits ID card at any participating network pharmacy to take advantage of the savings. You can use the Provider Directory on the Cigna Envoy website at www.cignaenvoy.com to locate in-network pharmacies in the U.S., Puerto Rico, or the U.S. Virgin Islands.

When you have prescriptions filled at an in-network pharmacy, you pay only your coinsurance, and the pharmacy will bill Cigna Global Health Benefits directly for the balance.

Please Note: If you do not show your Cigna Global Health Benefits ID card at a network pharmacy, you will have to pay for the prescription drug and submit a claim form to Cigna Global Health Benefits to be reimbursed for the amount covered by the Expatriate Medical Plan (see “Filing a Claim for Benefits” on page 462.)

If you plan to be outside of the U.S. for an extended period of time, you may be able to obtain a 12-month supply of prescription medications prior to leaving. If you have questions about the Cigna Pharmacy Management network or concerns about travel restrictions, please call Cigna Global Health Benefits Customer Service.

Important Note About Prescription Drugs

Due to U.S. and/or foreign laws, some controlled medications are limited to a 30-month supply at one time or may have other distribution limits.

To learn if you can purchase a 90-day or one-year supply of your prescription medications and if there are any associated travel restrictions, please call Cigna Global Health Benefits Customer Service at the telephone number on the back of your Cigna ID card.

Mail-Order Prescription Drug Purchases in the United States

Cigna Home Delivery Pharmacy is a convenient and economical alternative to obtaining your prescriptions at a retail pharmacy in the United States. This service allows you to purchase a three-month supply of medication that is delivered directly to your home at no additional cost. You can have your prescription drugs shipped to any address (including a post office box) in the United States, Puerto Rico, or the U.S. Virgin Islands.

If you plan to be outside of the U.S. for an extended period of time, you may be able to obtain a 12-month supply of prescription medications prior to leaving.

Filling a prescription with Cigna Home Delivery Pharmacy is easy. If you have a mailing address in the United States or an APO address, you can request that Cigna Home Delivery Pharmacy contact your U.S. physician for a copy of your prescription or you can mail your prescription to:

Cigna Home Delivery Pharmacy
PO Box 5101
Horsham, PA 19044
U.S.A.

For new orders, please allow five to seven business days after Cigna Home Delivery Pharmacy receives your request. Refills ship within two business days of receipt of your request.

Purchase or Transport of Prescription Drugs Outside the United States

If you have questions or concerns about travel restrictions or the availability of prescription medications in your assignment location, please call Cigna Global Health Benefits at the telephone number on the back of your Cigna ID card.

Important Note: You cannot use the JPMorgan Chase New York City post office box address to receive your mail-order prescriptions in the U.S., as JPMorgan Chase cannot legally forward medications to your overseas location.

Out-of-Network Pharmacy Benefits in the United States

Filing a Claim If You Use an Out-of-Network Pharmacy

If you purchase your prescription drugs through an out-of-network pharmacy in the United States, you will have to pay for the prescription drug and submit a claim form to Cigna Global Health Benefits to be reimbursed for the amount covered by the Expatriate Medical Plan (see “Filing a Claim for Benefits” on page 462.)

If You Receive Care Outside the United States

When you receive care in select locations outside the United States, you can choose between receiving care in the Cigna*Links*® network or out-of-network. You will generally pay less when you use a Cigna*Links*® network provider.

- You may use any licensed provider.
- The Plan offers 100% coverage with no deductible for many preventive screenings.
- The Plan generally pays 80% of the cost of most other covered services after you pay the annual deductible.
- The Plan offers 75% coverage without a deductible for eligible prescription drug expenses.

Did You Know?

By using Cigna*Links*® network providers, almost 500 — 30% — of Expatriate Medical Plan participants and/or their families assigned to and/or from a Cigna*Links*® location paid no deductible and/or copayments in 2014, helping them save up to $1,700 per individual/$5,100 per family.

- Generally, you must pay for services at the time you receive care and file a claim to be reimbursed. Certain providers may accept assignment of benefits and choose to accept payment directly from Cigna Global Health Benefits. You would then be responsible for the difference not paid by the Plan. Visit the Cigna Envoy website at www.cignaenvoy.com to identify providers in your location who will bill Cigna Global Health Benefits directly.
- If you expect to incur a large expense(s), you can ask Cigna Global Health Benefits to contact your health care provider in an effort to arrange for a guarantee of payment letter to be issued to the provider. (It remains the choice of the provider to accept this arrangement.)
- Call the Cigna Global Customer Service Center or check the Provider Directory on the Cigna Envoy website at www.cignaenvoy.com to locate out-of-network providers in your location who will bill Cigna Global Health Benefits directly.

Purchase or Transport of Prescription Drugs

If you have questions or concerns about travel restrictions or the availability of prescription medications in your assignment location, please call Cigna Global Health Benefits at the telephone number on the back of your Cigna ID card.

Important Note: You cannot use the JPMorgan Chase New York City post office box address to receive your mail-order prescriptions, as JPMorgan Chase cannot legally forward medications to an overseas location.

If You Use a Pharmacy Outside of the United States

If you purchase your prescription drugs through a pharmacy located outside of the United States, you will have to pay for the prescription drug and submit a claim to Cigna Global Health Benefits to be reimbursed for the amount covered by the Expatriate Medical Plan (see “Filing a Claim for Benefits” on page 462.)

If you have questions about the availability of prescription medications in your home or assignment location, please call Cigna Global Health Benefits at the telephone number on the back of your Cigna ID card.

CignaLinks® offers a network of quality doctors, hospitals, and clinics in select locations outside the United States. Because of local regulations and other considerations, when you use a Cigna*Links*® network provider, your benefits will differ somewhat from the provisions of the global Expatriate Medical Plan. For more information please contact the Cigna Global Customer Center.

CignaLinks® Network Care Outside the United States

CignaLinks® offers a network of quality doctors, hospitals, and clinics in select locations outside the United States.

Because of local regulations and other considerations, when you use a Cigna*Links*® network provider, your benefits will differ somewhat from the provisions of the global Expatriate Medical Plan. The following chart highlights some of those differences by location.

Country[1]	Cigna*Links*® Partner	Discounted Fees	In-Network Coinsurance[2]	Comment
Australia	GU Health	Not applicable	100% for most persons not eligible for Medicare	Those eligible for Australian Medicare have coverage coordinated with Medicare. Customers should submit their claims to Medicare first for consideration, and then to GU Health. Hospital services and ancillary services, including chiropractors, podiatrists, osteopaths, and physiotherapists covered at 100%. Dental services are covered for "Regulated Members" (Medicare Eligible) through GU.
Bahrain	SAICO	Yes	100%	Precertification may be required for some services.
Brazil	Gama Saúde	Yes	100%	Precertification may be required for some services.
Canada	Cowan	Yes	100% major medical; 80% pharmacy/ paramedical services	Precertification may be required for some services.
China	QHMS	Yes	80%/100%	Global plan limits waived on all services (80% for physician services and 100% for I/P and O/P Hospital Fees)
Hong Kong	QHMS	Yes	80%	Global plan limits waived on all services (80% for physician services and 100% for I/P and O/P Hospital Fees)
Indonesia	Parkway	Not applicable	100%	
Kenya	MSO	Yes	80%	80% for physician services and 100% for I/P and O/P Hospital Fees
Kuwait	SAICO	Yes	100%	
Macau	QHMS	Yes	80%	Global plan limits waived on all services (80% for physician services and 100% for I/P and O/P Hospital Fees)
Malaysia	Parkway	Not applicable	100%	
Morocco	MSO	Yes	80%/100%	80% for physician services and 100% for I/P and O/P Hospital Fees

Country[1]	Cigna*Links*® Partner	Discounted Fees	In-Network Coinsurance[2]	Comment
Nigeria	MSO	Yes	80%/100%	80% for physician services and 100% for I/P and O/P Hospital Fees
Oman	SAICO	Yes	100%	Precertification may be required for some services.
Qatar	SAICO	Yes	100%	Precertification may be required for some services.
Saudi Arabia	SAICO	Yes	100%	Local limitations and/or exclusions apply; some dental and vision expenses also covered (call Cigna Global or SAICO for more information).
Singapore	Parkway	Yes	100%	
South Africa	MSO	Yes	80%/100%	80% for physician services and 100% for I/P and O/P Hospital Fees
Spain	Cigna Spain	Yes	100%	
Taiwan	QHMS	Yes	80%/100%	Global plan limits waived on all services. (80% for physician services and 100% for I/P and O/P Hospital Fees)
Tanzania	MSO	Yes	80%/100%	80% for physician services and 100% for I/P and O/P Hospital Fees
United Arab Emirates	SAICO	Yes	100%	Local limitations and/or exclusions apply in select locations (e.g., Abu Dhabi and Dubai); some dental and vision expenses also covered (call Cigna Global or SAICO for more information).
United Kingdom	Cigna UK	Yes	80%	Discounts apply only for services at in-network clinics and hospitals. Dental services are covered as well.

[1] Deductibles are waived in all locations. In most circumstances there are no claim forms required; however, for GU, SAICO, and QHMS member paid claims require a claim form. The claim form will correspond to each partnership (i.e., SAICO claim form for member paid claims incurred in Abu Dhabi).

[2] Fertility services are covered in accordance with the provisions of the global JPMorgan Chase Expatriate Medical Plan.

If you are eligible to participate in CignaLinks, you will receive communication from Cigna Global. To take advantage of these enhanced benefits, generally you need only to present your Cigna Global Health Benefits ID card (which includes contact information for your local CignaLinks® network partner) at the time you receive medical services. In most instances, providers in the network will file their claims directly with Cigna — limiting your out-of-pocket costs when services are rendered.

Multiple ID Cards in Some Locations

Employees assigned to and/or from select locations will have multiple ID cards — a Cigna Global Health Benefits ID card* and:

- **Africa —** a Medical Services Organization (MSO-Africa) ID card for use when receiving medical care in Kenya, Morocco, Nigeria, South Africa and Tanzania
- **Australia —** a Grand United ID card for use when receiving medical care in Australia
- **Brazil —** a Gama Saúde ID card for use when receiving medical care from a Gama Saúde network provider in Brazil
- **Canada —** a Cowan Pay-Direct ID card for use when receiving medical care from a Cowan network provider in Canada
- **Middle East —** a Saudi Arabian Insurance Company (SAICO) ID card for use when receiving medical care in Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates, and Bahrain
- **Spain —** a Cigna HealthCare Spain ID card for use when receiving care in Spain

* When accessing care from non-network providers, you should continue to use your global Cigna ID card.

Forms Required for ID Cards in Some Locations

Before the CignaLinks® partner will issue an ID card, employees assigned to and from these locations must complete a form:

- **Australia —** Grand United Customer Information Form, which must be completed and returned to Cigna Global Health Benefits (Australian or Reciprocal Citizens only)
- **Canada** — Cowan Insurance Group Consent Form, which must be completed and returned to Cowan Insurance Group
- **Abu Dhabi —** SAICO (Saudi Arabian Insurance Company) Member Data Collection Form, which must be completed and returned to SAICO
- **Dubai —** SAICO Member Data Collection Form, which must be completed and returned to SAICO
- **Kingdom of Saudi Arabia** — SAICO Member Data Collection Form, which must be completed and returned to SAICO

Forms are available on the Cigna*Links*® page on **me@jpmc**.

How the Expatriate Medical Plan Pays Benefits

The Expatriate Medical Plan pays the full cost for preventive care received outside the U.S. or in-network in the U.S., including physical exams and recommended screenings. Inpatient hospital expenses received outside the U.S. or in-network in the U.S. are also fully covered after a per-admission copayment. For most other medical costs, after you satisfy the annual deductible, you pay your share of medical costs through coinsurance until you reach the annual coinsurance maximum.

Did You Know?

The annual deductible is waived in certain CignaLinks locations, reducing your overall costs. See 'CignaLinks® Network Care Outside the United States" on page 432 for more information.

Don't Forget that Health Advocate Can Help!

Health Advocate, Inc., a leading health advocacy and assistance company in the United States, provides a range of services, including help in resolving claims issues, scheduling appointments with specialists, facilitating the transfer of medical records, and explaining conditions and treatment options. These services are provided at no additional cost to you.

When you call Health Advocate, you will be assigned a personal health advocate who will work with you through the entire process, so you will have an advocate who is familiar with your case. **This program is available on a limited basis when receiving care outside the United States.** For more information, go to **me@jpmc** > Career > Global Mobility > **Expatriate Health Benefits Resources** > Health Advocate Program or call Health Advocate at (866) 611-8298. Personal health advisors are available Monday – Friday, from 8 a.m. to 9 p.m. Eastern time.

The Annual Deductible

Under the Expatriate Medical Plan option, you must satisfy an annual **deductible —** a set dollar amount that you pay out of pocket before that plan shares in the cost of care. The deductible does not apply to prescription drug expenses or certain services like preventive care if services are received outside the U.S. or in-network in the U.S. After the deductible has been met, you only pay the applicable coinsurance percentage for any subsequent care for the remainder of that calendar year. Out-of-network care in the U.S. has a higher deductible, and amounts in excess of reasonable and customary (R&C) charges do not count toward the out-of-network deductible.

If you elect coverage for yourself or yourself plus one dependent, each covered person must pay all eligible expenses until the per-person deductible is met. Then, eligible expenses are covered at the coinsurance rate indicated for that service. Expenses for two covered individuals are not combined. Once a covered person meets the per-person deductible, that person is no longer subject to a deductible for any subsequent care they receive during that remaining calendar year.

If you elect coverage for yourself plus two or more dependents, all expenses incurred by you and/or your covered dependents combine to meet the appropriate total deductible (employee plus children or family deductible). If no one person meets the per-person deductible, but combined participant expenses meet the total deductible amount, no further deductible is required for that calendar year. After a covered person meets the per-person deductible amount, that person will pay no further deductible.

The maximum deductible any one covered person must pay during each calendar year is equal to the per-person amount. After one person meets the per-person deductible, that person will pay no further deductible, but other covered persons must continue to pay deductibles until the total family deductible is satisfied.

The following table shows the annual deductibles for the different coverage levels.

	Deductible for Care Received Inside the U.S.		Deductible for Care Received Outside the U.S.
Coverage Level	**In-Network**	**Out-of-Network**	
Employee (Also functions as a "per-person" deductible under the other coverage levels.)	$350	$900	$350
Employee + spouse/domestic partner or Employee + child(ren)	$700	$1,700	$700
Family (employee + spouse/domestic partner + child(ren))	$1,050	$2,550	$1,050

The Annual Coinsurance Maximum

Under the Expatriate Medical Plan, the annual coinsurance maximum is the maximum amount you must pay in coinsurance in a plan year toward eligible expenses. The annual coinsurance maximum does not include the deductible and there are separate coinsurance maximums for out-of-network charges incurred in the U.S. The annual coinsurance maximum functions as your built-in "safety net" and protects you from having to pay high expenses in the event of a serious medical situation. Once the coinsurance maximum is reached, the Expatriate Medical Plan will pay 100% of negotiated fees for covered in-network care and 100% of reasonable and customary charges for covered services received out-of-network in the U.S. and outside the U.S. for the result of the year. Amounts you pay toward your deductible, copayment amounts, and amounts above reasonable and customary charges do not count towards your coinsurance maximum.

The following table shows the coinsurance maximums for the different coverage levels.

	Coinsurance Maximum for Care Received Inside the U.S.		Coinsurance Maximum for Care Received Outside the U.S.
Coverage Level	**In-Network**	**Out-of-Network**	
Employee (Also functions as a "per-person" coinsurance maximum under the other coverage levels.)	$1,700	$3,300	$1,700
Employee + spouse/domestic partner or Employee + child(ren)	$3,400	$6,600	$3,400
Family (employee + spouse/domestic partner + child(ren))	$5,100	$9,900	$5,100

The Per-person Deductible and Coinsurance Maximum Provision

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

If you cover dependents, the "per person" rule allows any single person (e.g., the employee or a covered spouse/domestic partner or child) within a coverage level to reach the individual deductible or coinsurance maximum, after which the deductible or coinsurance maximum is satisfied for the year for that person. Covered family members who have not met the deductible or coinsurance maximum may then combine to meet the remainder of the deductible or coinsurance maximum for that coverage level. If no one person has met the individual deductible or coinsurance maximum, the expenses of all covered members can combine to meet the deductible or coinsurance maximum for that coverage level.

Example: Amounts Applied Toward Deductibles for In-Network Care Received in the U.S.	
On behalf of you (meets per-person deductible)	$350
On behalf of your spouse/domestic partner	$250
On behalf of one child	$175
On behalf of a second child	$275
TOTAL (meets family deductible)	**$1,050**

In this example, you have met the $350 per-person deductible, and the combined costs for you and all of your dependents have satisfied the family deductible ($1,050). So any additional reasonable and customary (R&C) charges for medically necessary covered services would be reimbursable at 60% until your coinsurance limit is met, even if they were on behalf of a person who has not yet met the $350 per-person deductible. No other covered family members need to meet their per-person deductible for the rest of the year.

Example: Amounts Applied Toward Family Coinsurance Maximum for In-Network Care Received in the U.S.	
On behalf of you (meets per-person coinsurance maximum)	$1,700
On behalf of your spouse/domestic partner	$1,300
On behalf of one child	$1,150
On behalf of a second child	$950
TOTAL (meets family coinsurance maximum)	**$5,100**

In this example, one person has met the $1,700 per-person coinsurance maximum (you), and the combined coinsurance costs have reached $5,100. So, any additional reasonable and customary (R&C) charges for medically necessary covered services would be reimbursable at 100% for the remainder of the year, even if they were on behalf of a person who has not yet met the per-person coinsurance maximum. No other covered family members need to meet their per-person coinsurance maximum for the rest of the year.

Maximum Lifetime Benefit

There is no dollar limit on the amount the Expatriate Medical Plan would pay for essential benefits during the period you and your covered dependents are enrolled in the Plan. However, there is a $20,000 lifetime infertility services maximum. There is also a lifetime limit of 365 days for care received in a skilled nursing facility. The infertility services and skilled nursing facility lifetime maximum benefits apply to care received in-/out-of-network in the U.S. and care received outside the U.S.

Infertility and Skilled Nursing Benefit Maximums Combine U.S., Expatriate, and Medicare Indemnity Plans

The benefit maximums for infertility services and skilled nursing facility care reflect services received across the:

- U.S. domestic and Expatriate Medical Plans; and
- The Medicare Indemnity Plans.

You do not gain a new benefit maximum if you switch your coverage between the U.S. domestic and expatriate plans. In addition, any benefits that were applied to a lifetime maximum provision under prior U.S. medical plans of JPMorgan Chase (such as the Point of Service High/Low and the Consumer Driven Health Plans) and medical plans of a heritage organization that was acquired by JPMorgan Chase will also be applied to the lifetime benefit maximums of the Expatriate Medical Plan.

Coinsurance Paid by the Expatriate Medical Plan

The following tables show the coinsurance percentage paid by the Expatriate Medical Plan for covered expenses.

Please Note

Whenever benefits are limited to a certain dollar amount or number of visits/days, care received in-network, out-of-network, and outside the United States will be combined and counted toward the annual deductible.

Out of Network Coverage

Out-of-network expenses incurred in the U.S. or outside the U.S. are subject to reasonable and customary (R&C) limits; you are responsible for 100% of all charges above those R&C amounts. Amounts that you pay above R&C limits do not count toward your deductible or coinsurance maximum. Because in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

Eligible Preventive Care

Please Note: A medical service will only be covered at 100% if it is coded as **preventive**. Before receiving any service, you should check with your physician to be sure the procedure is considered, and will be submitted to the claims administrator, as preventive medical care rather than as a diagnostic service. Cigna determines the eligible preventive care services covered at 100%. See "Preventive Care Services" page 444 for more information about eligible preventive care services.

	Care Received Inside the United States		Care Received Outside the United States
Provision	**In-Network**	**Out-of-Network**	
Routine Physical Exams at the following frequency: • From birth to 12 months: seven exams • Age 13 – 24 months: three exams • Age 2 and over: one exam every year	• 100%	60% **after** deductible	100%
Routine Immunizations (adult and child; including immunizations related to travel)	100%	60% **after** deductible	100%
Routine Mammograms (annually age 40 and up)	100%	60% **after** deductible	100%
Routine Gynecological Exams and Pap Smears, including related laboratory fees (annually; age guidelines apply)	100%	60% **after** deductible	100%
Routine Prostate Specific Antigen (PSA) Test (annually age 40 and up)	100%	60% **after** deductible	100%

Provision	Care Received Inside the United States In-Network	 Out-of-Network	Care Received Outside the United States
Routine Digital Rectal Exam (annually age 40 and up)	100%	60% **after** deductible	100%
Routine Fecal Occult Blood Test (annually age 50 and up)	100%	60% **after** deductible	100%
Routine Sigmoidoscopy /Colonoscopy (baseline screening beginning at age 50; follow-up screening every five years)	100%	60% **after** deductible	100%
Routine Eye Exams (maximum one exam per year)	100%	60% **after** deductible	100%
Routine Hearing Exams (maximum one exam every 2 years)	100%	60% **after** deductible	100%

Outpatient Services

Provision	Care Received Inside the United States In-Network	 Out-of-Network	Care Received Outside the United States
Doctor's Office Visits (to family practitioners, internists, pediatricians, and OB/GYNs, and consultations, specialist visits, convenience care clinic visits and second surgical opinions; also includes tests, injection drugs, supplies, and other services authorized by the Plan and provided during the visit and billed by the physician)	80% **after** deductible	60% **after** deductible	80% **after** deductible
X-rays and Labs (when performed to diagnose a medical problem or treat an illness or injury)	80% **after** deductible	60% **after** deductible	80% **after** deductible
Surgery/Major Medical	80% **after** deductible	60% **after** deductible	80% **after** deductible

Provision	Care Received Inside the United States In-Network	 Out-of-Network	Care Received Outside the United States
Infertility Services (includes diagnostic procedures, in vitro fertilization, artificial insemination, etc.; limited to combined in-/out-of-network/outside the U.S. maximum of $20,000 lifetime for each covered employee and/or spouse/domestic partner*)	80% **after** deductible	60% **after** deductible	80% **after** deductible
Speech, Physical, or Occupational Therapy — outpatient (combined in-/out-of-network/ outside U.S. limit of 60 visits/calendar year per therapy type*)	80% **after** deductible	60% **after** deductible	80% **after** deductible
Spinal Treatment/ Chiropractic Care (coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year*)	80% **after** deductible	60% **after** deductible	80% **after** deductible
Mental Health Care	80% **after** deductible	60% **after** deductible	80% **after** deductible
Substance Abuse Care	80% **after** deductible	60% **after** deductible	80% **after** deductible

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

Inpatient Services

Provision	Care Received Inside the United States In-Network	 Out-of-Network	Care Received Outside the United States
Hospital (based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases; excluding emergency room care)	100% **after** $250 copayment per admission; waived if readmitted for same condition within 14 days	60% **after** deductible per admission	100% **after** $250 copayment per admission; waived if readmitted for same condition within 14 days

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Surgery/Major Medical	80% **after** deductible	60% **after** deductible	80% **after** deductible
Skilled Nursing Facility (must be ordered by physician as medically necessary; limited to combined in-/out-of-network/outside U.S. maximum of 365 days per lifetime for each covered individual)	100% **after** $250 copayment; waived if admitted from hospital	60% **after** deductible	100% **after** $250 copayment; waived if admitted from hospital
Hospice Care	100% **after** $250 copayment; waived if admitted from hospital	60% **after** deductible	100% **after** $250 copayment; waived if admitted from hospital
Mental Health Care	100% **after** $250 copayment per admission	60% **after** deductible	100% **after** $250 copayment per admission
Substance Abuse Care	100% **after** $250 copayment per admission	60% **after** deductible	100% **after** $250 copayment per admission
Home Health Care (medically necessary only; limited to combined in-/out-of-network/outside U.S. maximum of 200 visits/calendar year; one visit = four hours)	80% **after** deductible	60% **after** deductible	80% **after** deductible
Durable medical equipment	80% **after** deductible	60% **after** deductible	80% **after** deductible
Prosthetics	Covered 100%	60% **after** deductible	Covered 100%

Prescription Drugs

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Prescription drugs ($10,000 lifetime maximum for infertility drugs; exclusive of treatment)	75% (deductible waived)	75% (deductible waived)	75% (deductible waived)

Other Services

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Hospital — emergency room	100% **after** $150 copayment per visit; must be sudden and serious; waived if admitted. 80% coverage **after** deductible if not considered an emergency	100% **after** $150 copayment per visit; must be sudden and serious; waived if admitted 60% coverage **after** deductible if not considered an emergency	100% **after** $150 copayment per visit; must be sudden and serious; waived if admitted 80% coverage **after** deductible if not considered an emergency

If You Need Urgent and/or Emergency Care

- If you're experiencing symptoms, you can phone Cigna Global Health Benefits Customer Service and a representative will immediately connect you with a regional coordinating doctor experienced in international medicine, who is knowledgeable about providers in your location. You will be referred to a medical provider based on your symptoms and locations.
- If you have a medical emergency that's sudden, urgent, and life-threatening, you should go to the nearest physician, hospital emergency room, or other urgent care facility. Your emergency care will be covered at 100% after a $150 copayment per visit as long as Cigna Global Health Benefits approves the care as being required for a true emergency.
- If Cigna Global Health Benefits determines that the situation was not sudden, urgent and life-threatening, your benefits will be paid as a doctor's office visit, subject to the annual deductible and reasonable and customary limits.

What Is Covered

The Expatriate Medical Plan covers a wide variety of services, as long as the services are medically necessary (please see the definition of "Medically Necessary" in "Defined Terms" on page 465). However, covered services under the Expatriate Medical Plan may differ from the lists below and/or be subject to limits or restrictions. For specific information on covered services, please contact Cigna Global Health Benefits.

Certain Limitations
Keep in mind that certain services listed here are limited to a specific number of visits or days of treatment. Any services that have such limits (for example, chiropractic treatment) are determined by medical necessity. In other words, the treatment must be medically necessary, even if the number of visits or days of treatment is within the prescribed limitations. The limitations are described within the coverage chart.

Preventive Care Services

Preventive care services covered at 100% are determined by Cigna Global Health Benefits based on guidelines and clinical recommendations developed for the general population by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorgan Chase does not make this determination.

Preventive care services received outside the U.S. or in-network in the U.S. are covered at 100% by the Expatriate Medical Plan. Preventive care services received out-of-network in the U.S. are covered at 60% after you and/or your covered dependent(s) have satisfied the per-person out-of-network deductible

The list of preventive care services, which is subject to change at any time, generally include:

- Routine care including:
  - PAP tests (one per year, includes related laboratory fees);
  - Prostate exams (age 40 and over, one exam per year);
  - Flexible sigmoidoscopy (age 50 and over, one baseline screening, and one follow-up screening every five years);
  - Screening colonoscopy (age 50 and over, one baseline screening and one follow-up screening every five years);
  - Fecal occult blood test (age 50 and over, one test per year);
  - Routine physical exams (office visit with appropriate laboratory and radiology services);
  - Mammography screenings (age 40 and over, one mammogram per year);
  - Routine screenings during pregnancy (e.g., for gestational diabetes and bacteriuria);
  - Breast pumps (please contact your health care company for details regarding which breast pumps are fully covered); and
  - Well-child/adult care office visits (plus immunization and labs):
    - Birth to age 12 months: seven exams
    - Age 13 – 24 months: three exams
    - Age 25 – 36 months: three exams
    - Age 3 and over: one exam per year

Preventive Care Must Be Coded Properly

Medical services will only be covered as preventive care if they are coded as preventive. Before receiving any services, you should check with your physician to be sure a procedure is considered, and will be submitted to Cigna Global Health Benefits, as preventive medical care rather than as a diagnostic service.

Inpatient Hospital and Related Services

The Expatriate Medical Plan covers medically necessary inpatient hospital admissions for an unlimited number of days. Covered services include, but are not limited to the following services and is subject to change at any time, also subject to any limitations or requirements of the Plan and based on medical necessity:

- Allergy testing and treatment, when provided as part of inpatient care for another covered condition;
- Anesthetics and their administration;
- Bariatric surgery subject to claims administrator guidelines;
- Basic metabolic examinations;

- Cosmetic surgery when needed to:
  - Reconstruct or treat a functional defect of a congenital disorder or malfunction;
  - Treat an infection or disease;
  - Treat an injury or accident; or
  - Reconstruct a breast after mastectomy. Coverage for the following services is available in a manner determined in consultation with you and your physician:
    - Reconstruction of the breast on which the mastectomy was performed;
    - Surgery and reconstruction for the other breast to produce a symmetrical appearance; and
    - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.
- Diagnostic services, including:
  - EEG, EKG, and other diagnostic medical procedures;
  - Laboratory and pathology tests; and
  - Radiology services.
- Electrocardiographic and physiotherapeutic equipment usage;
- Hemodialysis for kidney failure;
- Intensive care unit service;
- Maternity care, including:
  - Any required care for an illness or injury that the newborn develops either before or after birth as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames;
  - Care required due to miscarriage or ectopic pregnancy;
  - Coverage of eligible expenses if your covered child has a baby, but not including nursery or other expenses incurred by the newborn child;
  - Delivery by a certified, registered nurse or midwife in a birthing center;
  - Drugs, medications, and anesthesia;
  - Normal or cesarean section delivery;
  - Routine medical and hospital nursery care for your covered newborn child, as long as you and your newborn are enrolled in the appropriate coverage category within prescribed time frames;
  - Circumcision by a licensed provider (for your covered newborn child), as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames; and
  - A semi-private room. The period of hospitalization for childbirth (for either the mother or the covered newborn child) is up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. (However, your attending physician — after consulting with the mother — may decide to discharge the mother or newborn child earlier.)
- Mental health care/substance abuse care;

Enrolling Your Children

You must enroll a new dependent within 31 days of birth in order for coverage to be effective retroactive to the date of birth. Please see “Eligible Dependents” on page 421 and “Changing Your Coverage Midyear” on page 426 for more information.

- Operative and surgical procedures by a licensed provider for the treatment of a disease or injury, including pre-operative preparation and post-operative care;
- Organ and tissue transplants including replacing a non-functioning or damaged organ or tissue with a working organ or tissue from another person. Covered services include physician and hospital costs, donor search, test to establish donor suitability, organ harvesting and procurement, and anti-rejection drugs. Donor expenses related to the transplant procedure are covered if the transplant recipient is a covered member under the Expatriate Medical Plan, but only to the extent that the donor expenses are not covered under another health insurance plan.
- Pre-admission testing when completed within seven days of hospital admission;
- Semi-private room and board; and
- Take-home drugs and medications.

This list is subject to change at any time.

Multiple Surgical Procedure Reduction Policy

The Expatriate Medical Plan limits the benefits you are eligible to receive if you have more than one surgical procedure performed at the same time. When you have multiple procedures performed at the same time, the Expatriate Medical Plan will pay:

- 100% of the coinsurance percentage amount for the primary or major surgical procedure;
- 50% of the coinsurance percentage amount for the secondary procedure; and
- If more than two procedures are performed, please check with Cigna Global Health Benefits for coverage details.
- Please see contact information for Cigna Global Health Benefits at the beginning of this *Expatriate Medical and Dental Plans* section, on page 416.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act of 1998

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

If you or your dependent(s) (including your spouse/domestic partner) are receiving benefits under the Plan in connection with a mastectomy and you or your dependent(s) (including your spouse) elect breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and you or your covered dependent(s) (including your spouse/domestic partner) for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

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

Outpatient Services

Covered outpatient services include, but are not limited to the following services and is subject to change at any time, also subject to any limitations or requirements and based on medical necessity:

- Acupuncture when used as a form of pain control and performed by a licensed provider (check with Cigna Global Health Benefits);
- Allergy testing and treatment;
- Chemotherapy and radiation treatments;
- Chiropractic care when medically necessary as determined by Cigna Global Health Benefits to diagnose or treat illness, injury, or disease. Coverage is limited to 20 visits per year and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
- Diagnostic services, including:
  - EEG, EKG, and other medical electronic procedures;
  - Laboratory and pathology tests; and
  - Radiology services.
- Education therapy, but only for participants with a diagnosis of diabetes mellitus;
- Eye exams for patients with diabetes (covered as a specialist office visit);
- Hemodialysis provided at a free-standing facility such as a dialysis center, or your home, when ordered by a licensed provider;
  - Licensed, general hospital emergency room use for treatment of an injury or sudden illness, including:
  - Emergency treatment rooms;
  - Laboratory and pathology tests;
  - Licensed providers' services;
  - Supplies and medicines administered during the visit; and
  - Radiology services.
- Licensed provider-prescribed respiratory therapy approved by Cigna Global Health Benefits;
- Mental health care/substance abuse care;
- Occupational therapy rendered by a licensed therapist, up to a combined total of 60 visits per calendar year for care received in-/out-of-network and outside the U.S.;
- Outpatient surgery and related follow-up care;
- Physical therapy rendered by a licensed therapist, up to a combined total of 60 visits per calendar year for care received in-/out-of-network and outside the U.S.;
- Podiatric care when medically necessary as determined by Cigna Global Health Benefits to diagnose or treat illness, injury, or disease. Coverage ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
- Prenatal care;
- Speech therapy rendered by a licensed therapist, up to a combined total of 60 visits per calendar year for care received in-/out-of-network and outside the U.S.; and
- Temporomandibular joint syndrome (TMJ) medical treatment only, including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery up to $1,000 combined for in-/out-of-network care and care received outside the United States (appliances are not covered).

This list is subject to change at any time.

Other Covered Services

The Expatriate Medical Plan covers a wide variety of other medically necessary services, although benefits levels may differ substantially. These services include, but are not limited to the following services and is subject to change at any time, also subject to any limitations or requirements and based on medical necessity:

- Compression stockings (two pair per calendar year for the following conditions only: diabetes, varicose veins, varicose ulcers, stasis dermatitis, post-phlebitic syndrome, and lymphedema);
- Dental procedures resulting from a congenital disorder or medical disorder or accidental injury (treatment must be received within 12 months of the accident). Includes surgical removal of wisdom teeth only if procedure is done in medical setting. **Please Note:** The charges must not be covered by the Expatriate Dental Plan;
- Gender Reassignment Surgery (GRS) — in order to be eligible, the participant must meet certain medically established guidelines for obtaining the surgery (Harry Benjamin guidelines) which require the participant to, among other things:
  - Be at least 18 years old;
  - Have a GID (Gender Identity Disorder) diagnosis;
  - Have been approved for hormone therapy;
  - Have at least one year's real life experience living and working in desired gender; and
  - Have two letters endorsing surgery, including one from a mental health provider at the doctorate level.
- Follow-up procedures such as electrolysis, breast augmentation surgery, and facial surgery will *not* be covered.
- Surgery must be preauthorized by the medical plan administrator whether in or out-of-network or outside the United States.
- Hearing aid evaluations and hearing tests;
- Hearing aids up to $3,000 every 36 months;
- Home health care approved by Cigna Global Health Benefits. The attending physician must submit a detailed description of the medical necessity and scope of services to Cigna Global Health Benefits. The following are covered if ordered by the physician under the home health care plan and provided in the patient's home. (Please check with Cigna Global Health Benefits for any age or frequency limitations.):
  - Part-time or intermittent nursing care provided or supervised by a registered nurse (R.N.);
  - Part-time or intermittent home health services, primarily for the patient's medical care;
  - Physical, occupational, speech, or respiratory therapy by a licensed qualified therapist;
  - Nutrition counseling provided by or under the supervision of a registered dietitian; and
  - Medical supplies, laboratory services, drugs, and medications prescribed by a physician.
- Intensive behavior therapy, such as Applied Behavior Analysis (ABA) for Autism Spectrum Disorder, subject to precertification from Cigna Global Health Benefits;
- Local ambulance service or air ambulance to the nearest hospital if medically necessary and confirmed by a licensed provider;

- Medical equipment and supplies including blood and blood plasma (unless donated on behalf of the patient); artificial limbs (excluding replacements), artificial eyes and larynx (including fitting); heart pacemaker; surgical dressings; casts; splints; trusses; orthopedic braces; crutches; wheelchair; walker; cane; insulin pump; Athner monitor; custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot; hospital bed; ventilator; iron lung; ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters; and other items necessary to the treatment of an illness or injury that are not excluded under the Plan. Prior authorization or precertification may be required for coverage of some medical equipment and supplies. Cigna Global Health Benefits may authorize purchase of an item if more cost-effective than rental.
- Medically necessary visits to licensed physicians, surgeons, and chiropractors, whether in the office or in your home;
- Nutritional support, including nutritional counseling (limited to three visits for diabetes and three visits for non-diabetes counseling, for a total of six visits) and durable medical equipment to treat inborn errors of metabolism and/or to function as the majority source of nutrition*, as long as each of the following conditions are met:

  — Without enteral (feeding tube) feedings, the individual is unable to obtain sufficient nutrients to maintain appropriate weight by dietary and/or oral supplements;

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

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

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

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

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

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

  — Parenteral feedings are covered when considered “medically necessary” and used when oral or enteral alone are not possible.
- Oxygen and supplies for its administration;
- Prosthetic devices and supplies, including fitting, adjustments, and repairs, if ordered by a licensed provider. Please check with Cigna Global Health Benefits for frequency or other limitations. (**Please Note:** Dentures, bridges, etc., are not considered medical prosthetic devices.);
- Radiation, chemotherapy, and kidney dialysis;
- Rental or purchase of durable medical equipment as determined by Cigna Global Health Benefits, if ordered by a licensed provider. Please check with Cigna Global Health Benefits for frequency or other limitations;
- Services and supplies that are part of an alternate care proposal. This is a course of treatment developed and authorized by Cigna Global Health Benefits as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless specified otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, copayments, and deductible will apply to these services;

- Skilled nursing facility for up to 365 days per lifetime (combined in-/out-of-network care and care received outside the United States) under the Expatriate Medical Plan and for up to 120 days per lifetime combined in-network and out-of-network under the Medicare Indemnity Plans. The lifetime maximums reflect services received across the Expatriate Medical Plan, the Consumer Driven Health Plans (Option 1 and Option 2), and under prior medical plans of JPMorgan Chase (such as the Point Service High/Low and the Consumer Driven Health Plan) and the medical plans of a heritage organization that was acquired by JPMorgan Chase;
- Urgent care;
- Voluntary sterilization; and
- Wigs up to a $500 per year limit, for burns, chemotherapy or radiation, accidental injury, following a diagnosis of Alopecia, or for other medically necessary reasons.

This list is subject to change at any time.

Hospice Care

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

To be eligible for reimbursement, a hospice facility must offer a hospice program approved by Cigna Global Health Benefits. It must be either a hospital or a free-standing hospice facility that provides inpatient care or an organization that provides health care services in your own home.

Hospice services include:

- Hospice room and board while the terminally ill person is an inpatient in a hospice;
- Outpatient and other customary hospice services provided by a hospice or hospice team; and
- Counseling services provided by a member of the hospice team.
- These services and supplies are eligible only if the hospice operates as an integral part of a hospice care program, and the hospice team includes at least a doctor and a registered graduate nurse. Each service or supply must be ordered by the doctor directing the hospice care program and be:
- Provided under a hospice care program that meets standards set by Cigna Global Health Benefits. If such a program is required by law to be licensed, certified, or registered, it must meet that requirement; and
- Provided while the terminally ill person is in a hospice care program.
- Hospice benefits also include eligible expenses for counseling services for the family unit, if ordered and received under the hospice care program. Benefits will be paid if:
  - On the day before the terminally ill person passed away, he/she was:
    - In a hospice care program;
    - A member of the family unit; and
    - A covered participant.
  - The charges are incurred within three months after the death of the terminally ill person.

This list is subject to change at any time.

Infertility Treatment Procedures

There are special covered procedures that induce pregnancy but do not treat the underlying medical condition. They include (but are not limited to) artificial insemination and in-vitro fertilization. Infertility services are subject to a $20,000 combined lifetime maximum benefit for each covered individual (yourself and/or your spouse/domestic partner). This limit applies to all benefits combined in a lifetime, and applies regardless of whether the services were received in-/out-of-network or outside the United States or under a U.S. domestic Medical Plan such as Option 1, Option 2 and the Medicare Indemnity and under prior U.S. medical plans of JPMorgan Chase (such as the Point of Service High/Low and the Consumer Driven Health Plan) and the medical plans of a heritage organization that was acquired by JPMorgan Chase. This limit does not apply to the diagnosis of infertility and/or its cause. All procedures and access will be governed by Cigna Global Health Benefits' protocols for determining appropriateness of care. **Please Note:** In order to receive benefits for infertility services, you must contact Cigna Global Health Benefits and receive precertification **before** obtaining services.

Planning Treatments That May Cause Infertility

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

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

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

Infertility Diagnostic Services

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

Coverage Limitations

As mentioned earlier, certain covered services are limited to a specific number of visits or days of limitations, subject to applicable deductibles, coinsurance and/or copayments. These limitations are included in the coverage tables under "Coinsurance Paid by the Expatriate Medical Plan" on page 439.

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

What Is *Not* Covered

While the Expatriate Medical Plan covers a wide variety of medically necessary services, there are some expenses that are not covered. Some of these are listed below.

Expenses ***not*** covered include, but are not limited to:

- Care from a person who is a member of your family or your spouse/domestic partner's family;
- Charges for the difference between a private and semi-private hospital room;
- Correction of weak, unstable, or flat feet; arch supports; corrective shoes; shoe orthotics (except for custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot); or treatment of corns, calluses, or chronic foot strain;
- Cosmetic surgery treatment, except to repair damage from accident or injury; treat a functional birth defect; reconstruct a breast after mastectomy and/or reconstruction of the non-affected breast to produce a symmetrical appearance; or treat an infection or disease;
- Custodial services, including custodial nursing care and group homes;
- Donor expenses with regard to infertility treatment;
- Educational therapy (except for members with a diagnosis of diabetes) and social or marital counseling;
- Expenses for which you're not obligated to pay (for example, if a licensed provider or hospital waives an expense, the Plan will not pay any benefit to you or a licensed provider);
- Expenses in excess of reasonable and customary (R&C) charges;
- Expenses submitted later than December 31 of the year following the year in which services were provided;
- Experimental, investigational, or unproven services, devices, or supplies (see the definition of "Experimental, Investigational, or Unproven Services" in "Defined Terms" on page 465);
- Hospital admissions and other services that began before the participant's effective date of coverage under the Expatriate Medical Plan;
- Inpatient private duty nursing;
- Non-medical charges for care in a nursing or convalescent home or long-term custodial care, even if prescribed by a licensed provider;
- Non-prescription contraceptive devices, unless medically necessary (prescription oral contraceptives are covered under the Expatriate Medical Plan);
- Non-surgical correction of temporomandibular joint (TMJ) syndrome, such as appliances or devices;
- Nutritional support expenses including but not limited to:
  - regular grocery products (including over-the-counter infant formulas such as Similac, Nutramigen, and Enfamil) that meet the nutritional needs of the patient;
  - infant formula that is not specifically made to treat inborn errors of metabolism;

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

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

— Personal hospital services, such as television, telephone, etc.;

— Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments if required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage, or adoption;

— Refractive eye examinations for new lenses or the cost of eyeglasses or contacts. This does not apply to the first pair of contact lenses or the first pair of eyeglasses following either cataract surgery or a diagnosis of Keratoconus;

— Refractive eye surgery including, but not limited to, Lasik or Radial Keratotomy;

— Reproductive education and prevention classes;

— Reversals of sterilization;

— Routine dental care (please see the *Expatriate Dental Plan* section on page 454 for information about services covered under the Expatriate Dental Plan);

— Services, supplies, or treatment for weight loss, nutritional supplements, or dietary therapy;

— Sickness or loss covered by workers' compensation laws or automobile insurance;

— Sickness or loss that is later determined to be the legal responsibility of another person or company;

— Treatments, services, or supplies that are not medically necessary or not approved by a licensed provider or services provided outside the scope of a provider's license;

— Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias (sexual behavior that is considered deviant or abnormal);

— Unbundled medical expenses — charges billed separately when considered by Cigna Global Health Benefits in its sole discretion to be part of a global procedure; and

— A procedure or surgery to remove fatty tissue such as abdominoplasty, brachioplasty, mastopexy, thighplasty, or panniculectomy.

This list is subject to change at any time.

Expatriate Dental Plan

The Expatriate Dental Plan, administered by Cigna Global Health Benefits, offers you and your enrolled dependents coverage for a wide range of dental services, including preventive care, basic and major restorative care, and orthodontia dental services (for children up to age 19).

Key features include:

- **You pay nothing for preventive care** such as oral exams, prophylaxis, X-rays, emergency palliative treatments, and sealants and fluoride treatments for children up to age 19.
- **Other dental expenses are subject to a deductible.** After you satisfy the deductible, the Expatriate Dental Plan generally pays 75% for basic restorative and 50% for major restorative care **up to a $2,000 annual maximum benefit per individual.**
- **50% coverage for orthodontic appliances and treatment up to a $2,500 lifetime** maximum benefit for children up to age 19.
- **You may use any licensed provider,** but if you visit a participating network dentist in the United States, you can realize cost savings while having access to quality care. Participating dentists and other dental providers have agreed to deliver covered dental services at pre-negotiated discounted rates.
- **If you visit a non-network dentist in the U.S. or outside the U.S., you may have to file your own claims** if the dentist will not bill Cigna Global Health Benefits directly.

Pre-Determination of Benefits

If you anticipate that charges will be more than $300 for a proposed treatment, a dental consultant can review the proposed treatment before work begins, and the claims administrator will inform you and your dentist of the amount of the covered charges. That way, you'll understand the benefits that will be paid before treatment begins.

Find a U.S. Dental Provider

You can easily check which U.S. dental providers participate in the Cigna Dental PPO Network in the U.S. by using the Provider Directory available on the Cigna Envoy website at www.cignaenvoy.com or by calling Cigna Global Health Benefits.

Please Note: Before receiving services, you should always check with your dental health care provider to ensure that he or she continues to participate in the network.

How Your Dental Benefits Work

Dental benefits are paid according to the schedule of benefits shown under "Coinsurance" on page 456. If you receive services in the United States, you have to decide whether to receive your care through a Cigna Dental PPO Network provider or through a provider who is not part of the network.

In-Network Care

When you visit a Cigna Dental PPO Network provider in the United States:

- Network dentists cannot charge you more than the negotiated, discounted fee for covered services.
- You may go to any general dentist or specialist in the Cigna Dental PPO Network at any time without a referral.
- At the point of service you pay only your deductible and/or coinsurance expense and you do not need to submit a claim. Participating dentists submit their charges directly to Cigna Global Health Benefits.
- Cigna has screened network providers to ensure that selected providers conform to an expected standard of care. If you don't have a relationship with a dental care provider and are experiencing symptoms, you can visit the Cigna Envoy secure website at www.cignaenvoy.com or call Cigna Global Health Benefits to be referred to the most appropriate provider for your condition and location.

Out-of-Network Care

You may go to any general dentist or specialist at any time without a referral. If you see a non-network dentist, there is no penalty, but you may have to file your own claim if the dentist does not bill Cigna Global Health Benefits directly. (See “Filing a Claim for Benefits” on page 462).

How the Expatriate Dental Plan Pays Benefits

The Expatriate Dental Plan pays the full cost for preventive dental care received inside or outside the U.S. For restorative care, after you satisfy a deductible, you pay your share of dental costs through coinsurance until you reach the annual and/or lifetime maximum benefits.

The Annual Deductible

Restorative care is subject to an annual deductible. The deductible is the amount you must pay “up front” before the Plan begins to pay benefits for covered expenses. After the deductible has been met, you only pay the applicable coinsurance percentage for any subsequent care.

Preventive care is covered in full without a deductible, subject to frequency limitations.

The following table shows the deductibles for restorative care:

Service	Annual Deductible
Preventive care (e.g., cleanings, exams, X-rays, sealants)	No deductible
Restorative services (e.g., fillings, root canals, crowns, bridges, dentures, and orthodontics)	$100 individual $300 family

For restorative care, if you elect coverage for yourself or yourself plus one dependent:

- Each covered person must pay all eligible expenses until the individual deductible is met. Then, eligible expenses are covered at the coinsurance indicated for that expense.
- After a covered person meets the individual deductible amount, that person will pay no further deductible.

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

- All expenses incurred by you and/or your covered dependents combine to meet the family deductible.
- If no one person meets the individual deductible, but combined participant expenses meet the total deductible amount, no further deductible is required.
- The maximum deductible any one covered person must pay is equal to the individual amount. After one person meets the individual deductible, that person will pay no further deductible, but other covered persons must continue to pay deductibles until the total is satisfied.

Example: Amounts Applied Toward Restorative Care Deductible	
On behalf of you	**$100**
On behalf of your spouse/domestic partner	**$100**
On behalf of one child	**$40**
On behalf of a second child	**$60**
Total (meets family deductible)	**$300**

In this example, four people have met the family annual deductible for restorative care. So, any other covered person's restorative care would be reimbursed by the Plan, even if it were on behalf of a person who has not yet met the $100 individual annual deductible. No other covered family members need to meet their restorative care deductible for the rest of the year. **Please Note:** No more than $100 of expenses per individual will be applied towards the family deductible.

Coinsurance

After you meet the applicable deductible, the Expatriate Dental Plan will pay a percentage of in-network dentists' negotiated fees, or, for out-of-network expenses, a percentage of the reasonable and customary (R&C) charges for eligible expenses (see "Defined Terms" on page 465 for the definition of "Reasonable and Customary"). The exact percentage depends on the type of care you receive. You'll pay the remaining amount as coinsurance, plus any amounts above R&C charges. Please see the chart below for the applicable coinsurance rate. The coinsurance amount does not vary based on whether or not the care is received inside or outside of the United States.

Pre-Determination of Benefits

If you anticipate that charges will be more than $300 for a proposed treatment, a dental consultant can review the proposed treatment before work begins, and Cigna Global Health Benefits will inform you and your dentist of the amount of the covered charges.

Preventive Care

Care Received	Coinsurance
Oral exams	• 100% coinsurance • Maximum two per calendar year
Fluoride	• 100% coinsurance • Maximum one per calendar year under age 19
Prophylaxis (cleaning)	• 100% coinsurance • Maximum two per calendar year
Full-mouth X-ray	• 100% coinsurance • Maximum one every 60 months
Bitewing X-ray	• 100% coinsurance • Maximum one per calendar year*
Sealants	• 100% coinsurance • Maximum two treatments per tooth (permanent molars only) per lifetime under age 19

* Two per calendar year for children up to age 19.

Basic Restorative Care

Basic restorative care includes fillings, extractions, periodontics, oral surgery, anesthesia, including non-intravenous conscious sedation when medically necessary.

Care Received	Coinsurance
Basic restorative	75% **after** deductible

Major Restorative Care

Major restorative care includes dentures, crowns, onlays, tooth implants, bridges, root canal.

Care Received	Coinsurance
Major restorative	50% **after** deductible

Orthodontia

Orthodontia care is only covered for your covered children who are under age 19. Please see "Orthodontic Covered Services" on page 457 for additional information.

Care Received	Coinsurance
Orthodontia	50%

Maximum Benefits

Care Received	Maximum Benefit
Combined for preventive and restorative care	Annual maximum of $2,000
For orthodontia	Lifetime per-person maximum of $2,500

Orthodontic Covered Services

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

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

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

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

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

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

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

Maximum Benefits

There are limits on the benefits you can receive from the Expatriate Dental Plan. The maximum benefit is $2,000 per person per year for preventive and restorative care. The lifetime maximum benefit for orthodontia is $2,500 per child. **Please Note:** The maximums reflect a *combined* amount for in- and out-of-network care.

If you were previously enrolled in a U.S. domestic Dental Plan, the benefits you received under that plan will be added to benefits you receive under the Expatriate Dental Plan for purposes of determining benefits provided under the lifetime orthodontia maximum. Any benefits that have been applied to a maximum provision under a U.S. domestic dental plan of your heritage organization will also be applied to the lifetime maximums for the Expatriate Dental Plan.

Lifetime Orthodontia Maximum Includes All Dental Plans

The most you can ever receive in orthodontia benefits under the Expatriate Dental Plan for each eligible child under age 19 is the lifetime maximum benefit of $2,500. This limit includes benefits paid under a U.S. domestic Dental Plan and dental plans of your heritage organization and under the Traditional Indemnity, a former U.S. domestic Dental Plan. If you transfer to a U.S. domestic Dental Plan, or vice versa, you do not gain a new lifetime orthodontia maximum. Any benefits paid under one dental plan will apply against the others.

For example, assume you've received $2,000 in orthodontia benefits for one child under the Expatriate Dental Plan. Then, upon repatriation/transfer to the U.S., you elect coverage under the U.S. domestic PDP Dental Plan. The most the PDP Plan will pay toward that child's orthodontia expenses is the difference between what was paid under the Expatriate Dental Plan ($2,000) and the PDP's lifetime orthodontia maximum — $2,500 for in-network expenses and $2,000 for out-of-network expenses.

In this case, if care is received in-network, the most the PDP Plan will pay for that child's orthodontia expenses is $500 ($2,500 - $2,000 = $500). However, the PDP would not pay anything more for care received out-of-network for that child, since the PDP Plan's lifetime orthodontia maximum has already been met under the Expatriate Dental Plan.

What Is Covered

The Expatriate Dental Plan covers a wide variety of services, as long as the services are necessary and their costs do not exceed reasonable and customary (R&C) charges. (Please see "Defined Terms" on page 465 for the definitions of "Necessary Services" and "Reasonable and Customary Charges.") The following lists include examples of covered services, but the lists are not exhaustive and coverage remains subject to any Plan requirements or limitations. For specific information on covered services and frequency limits, please contact Cigna Global Health Benefits. The list of covered services may change at any time.

Preventive Care Services

Covered preventive care services include the following services (please see the chart under "Preventive Care" on page 456 for age and frequency limitations):

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

Basic Restorative Care Services

Covered basic restorative care services include:

- Consultations (two per calendar year);
- Extractions;
- Fillings;
- Injections of antibiotic drugs;
- Most periodontal or other gum disease treatment;
- Periodontal maintenance (four visits per calendar year, combined with regular cleanings);
- Oral surgery (except as covered by the Expatriate Medical Plan);
- Administration of general anesthesia in conjunction with oral surgery when necessary;
- Periodontal scaling/root planing (one per quadrant per 24 months);
- Periodontal surgery (one per quadrant per 36 months);
- Repair or recementing of crowns, inlays, or onlays; dentures; or bridgework; and
- Relines/rebases (one per denture per 36 months, after six months from installation).

Major Restorative Care Services

Covered major restorative care services include:

- Crowns/inlays/onlays (one per tooth per five calendar years);
- Root canal treatments;
- Only appliances related to temporomandibular joint syndrome (TMJ) and only to a lifetime maximum of $500. Adjustments and diagnostics for TMJ are not separately eligible under the Expatriate Dental Plan. Contact Cigna Global Health Benefits for specific details;
- Initial placement and replacement of dentures and bridges — if the original appliance is at least five years old and cannot be repaired;
- Services necessary to replace teeth lost while coverage is in effect;
- Treatment for harmful habits;
- Treatment for accidental injury (eligible dental expenses are covered under the Expatriate Dental Plan; eligible medical expenses are covered under the Expatriate Medical Plan); and
- Implant(s). Benefits may also be available for the final restoration or prosthesis (crown or partial denture) over the implant. A pre-treatment estimate should be submitted for a dental consultant to evaluate the claim to determine if any benefits are payable. Contact Cigna Global Health Benefits for specific details.

Alternate Benefit Provision

Generally benefits will be limited to the R&C charge for the least expensive method of treatment that is appropriate and that meets acceptable dental standards — as determined by Cigna Global Health Benefits. Pursuant to the Dental Plan's Alternate Benefit provision, if Cigna Global Health Benefits determines that a service less costly than the Covered Service the dentist performed could have been performed to treat a dental condition, the Plan will pay benefits based upon the less costly service if such service:

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

For example:

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

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

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

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

What Is *Not* Covered

While the JPMorgan Chase Expatriate Dental Plan covers a wide range of services, some expenses are not covered.

These include but are not limited to those listed below. This list of excluded services is not exhaustive and may change at any time. For specific information on coverage exclusions and limits, please contact Cigna Global Health Benefits.

The Plan does not cover any of the following services:

- A gold restoration or crown, unless:
  - It is treatment for decay or traumatic injury, and teeth can't be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- An appliance — or modification of one — if an impression for it was made before the person became covered.
- Any of the following services incurred more than 31 days after the date the person's coverage ends:
  - A crown, bridge, or gold restoration for which the tooth was prepared while the person was covered;
  - An appliance — or alteration of one — for which an impression was made while the person was covered; or
  - Root canal therapy for which the pulp chamber was opened while the person was covered.

- Charges in connection with:
  - A service to the extent that it is more than the usual charge made by the provider for the service when there is no insurance;
  - Appliances or restorations needed to alter vertical dimensions or restore occlusion, or for the purposes of splinting or correcting attrition, abrasion, or erosion; or
  - Replacement of lost, missing, or stolen appliances or appliances that have been damaged due to abuse, misuse, or neglect.
- Treatment for problems of the jaw joint, including:
  - Craniomandibular disorder;
  - Temporomandibular joint syndrome (TMJ), other than what is noted in "What Is Covered" on page 458; and
  - Other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves, and other tissues related to that joint.
- Expenses submitted later than December 31 of the year following the year in which services were provided.
- Installation of prosthetic devices (including bridges and crowns) while not covered or which were installed more than 31 days after coverage ends.
- Loss — or portion of a loss — for which mandatory automobile no-fault benefits are recovered or recoverable.
- Partial or full removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth (including congenitally missing teeth) missing before the person became covered under this Plan. The exclusion does not apply if the denture, bridge, or bridgework also includes replacement of a natural tooth that:
  - Is removed while the person is covered; and
  - Was not an abutment to a partial denture, removable bridge, or fixed bridge installed during the prior five years.
- Procedures related to occupational illness or injury.
- Replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for a replacement or modification of a crown or gold restoration or inlay/onlay within five years after that denture, bridgework, crown, inlay/onlay, or gold restoration was installed.
- Expenses or charges with respect to services rendered by hospitals, clinics, laboratories (except dental X-rays are covered), or other institutions.
- Services and supplies included as covered medical expenses under:
  - Any other employer-sponsored plan that covers you, including Medicare;
  - Any other governmental health program, except the U.S. Medicaid program; or
  - The Expatriate Medical Plan.
- Services and supplies rendered in a veteran's facility or government hospital, or services furnished in whole or in part under the laws of the United States or any of its state or political subdivisions.
- Services furnished for cosmetic purposes. Facings on crowns or pontics — which are behind the second bicuspid — will always be considered cosmetic. This limitation does not apply if the service is needed as a result of accidental injuries sustained while a person is covered.
- Services not reasonably necessary as determined by Cigna Global Health Benefits.

- Services to the extent that a benefit for those services is provided under any other program paid in full or in part, directly or indirectly, by JPMorgan Chase. This includes insured and uninsured programs. If a program provides benefits in the form of services, the cash value of each service rendered is considered the benefit provided for that charge.
- Services to the extent that the charges are above the prevailing charge in the area for dental care of a comparable nature. A charge is above the prevailing charge to the extent that it's above the range of charges generally made in the area for dental care of a comparable nature. The area and that range are determined by Cigna Global Health Benefits.
- Treatment by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, a trustee, or a similar person or group.
- Expenses in connection with services, procedures, drugs, or other supplies that are determined by Cigna Global Health Benefits to be experimental, or still under clinical investigation by health professionals.
- Charges for oral hygiene programs, completion of claim forms by the provider on your behalf, and broken appointments.
- Services provided by a relative, or for which a charge would not normally be made.
- Treatment by anyone except a licensed dentist (except for cleaning or scaling of teeth and topical application of fluoride performed by a licensed dental hygienist, if rendered under the supervision and guidance of a licensed dentist).

Other Limitations

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

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

Please contact Cigna Global Health Benefits for more information about services, procedures, charges, and expenses not covered by the Expatriate Dental Plan.

Filing a Claim for Benefits

If you see an in-network provider for a medical or dental service, you will generally be asked to pay only your copayment/coinsurance, if any, at the point of service. In-network providers will typically submit a claim to Cigna Global Health Benefits for the balance, using the information from your ID card. When you visit an out-of-network provider, you should always show the provider your ID card and ask if they will submit the claim for you.

If a provider will not bill Cigna directly you will need to pay at the point of service and file a claim with Cigna Global Health Benefits to be reimbursed. You can submit your claim online or by mail, as described below. (An itemized bill may be submitted in lieu of the attending physician's statement.) Upon filing a claim you will be reimbursed based on the schedule of benefits described under "How the Expatriate Medical Plan Pays Benefits" on page 435 or "How the Expatriate Dental Plan Pays Benefits" beginning on page 455.

Claims Deadline

To have your claim considered for benefits, all claims must be filed by December 31 of the year *following* the year in which services were provided. If you do not meet this deadline, your claim will be denied.

If an In-Network Provider Asks You to Pay in Full at the Point of Service

If you see an in-network provider, you will generally be asked to pay only your copayment /coinsurance, if any, at the point of service. Providers will typically submit a claim to Cigna Global Health Benefits for the balance, using the information from your ID card.

While in-network providers have agreed to submit claims directly to Cigna and **not** ask for full payment at the time of service, occasionally an in-network provider may nevertheless ask you for full payment.

If this happens, you should show your ID card and explain that Cigna needs to review the claim to see what you owe. If you are still required to pay at the time of service, you should do so and get an itemized receipt from your provider. You can then submit a claim to Cigna to be reimbursed for the Plan's share of the expense. Submitting your claims to Cigna Global Health Benefits via the Cigna Envoy website at www.cignaenvoy.com will help to expedite the processing of your claim.

Online Claims Submissions

To expedite the processing of your claims, you can submit claims online at the Cigna Envoy website at www.cignaenvoy.com. Log in with your Cigna ID and password, select "My Claims" on the navigational toolbar at the top of the page, select "File an Online Claim," and follow the instructions to confirm your personal data and enter details of your claim.

Paper Claims Submissions

You can use the same Cigna Global Health Benefits claim form to claim reimbursement for medical, dental, and/or prescription drug expenses. You can download a claim form from the Cigna Envoy website at www.cignaenvoy.com (in 16 different languages).

Completed claim forms, with original itemized bills, should be sent to Cigna Global Health Benefits via:

- Fax: (302) 797-3150 (or ATT access code (800) 243-6998)
- Mail:
  Cigna Global Health Benefits
  P.O. Box 15050
  Wilmington, DE 19850-5050
  U.S.A.
- Courier:
  Cigna Global Health Benefits
  300 Bellevue Parkway
  Wilmington, DE 19809
  U.S.A.
- Email: Email your claim form using the Cigna Envoy website at www.cignaenvoy.com. You will need to scan your receipts and attach the scanned copies to your email.

Claims submitted for payment in U.S. dollars will generally be processed within 10 business days from the date complete information is received by Cigna Global Health Benefits, regardless of the language or currency.

ePayment Plus

Cigna Global Health Benefits offers ePayment Plus (electronic fund transfer (EFT) and international ACH). In most cases, ePayment Plus provides the added feature of depositing funds to your bank account without incurring bank service charges. ePayment Plus also includes automatic notification of payments and an explanation of benefits statement as confirmation.

Employees with a bank account in the following countries may elect to receive claim reimbursements electronically (deposited in local currency):

Australia	Greece	Singapore
Austria	Hong Kong	Spain
Belgium	Ireland	Sweden
Canada	Italy	United Kingdom
Denmark	Netherlands	United States
France	Norway	
Germany	Portugal	

You can quickly and easily enroll in ePayment Plus on the Cigna Envoy website at www.cignaenvoy.com.

New countries may be added from time to time. If your bank is not located in one of these countries, you can receive your claims payments by wire transfer.

If You Have Questions About a Claim

You can check the status of your claim on Cigna Envoy at www.cignaenvoy.com.

You can also call Cigna Global Health Benefits at the telephone number on the back of your ID card.

If you are experiencing difficulty with a claim in the U.S., Health Advocate can also help you resolve benefit claim issues. (See “How the Expatriate Medical Plan Pays Benefits” on page 435 for more information about Health Advocate.)

Appealing a Claim

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

JPMorgan Chase is not involved in deciding appeals for any benefit claim denied under the Expatriate Medical Plan and/or Expatriate Dental Plans. All fiduciary responsibility and decisions regarding a claim for a denied benefit under these Plans rest solely with Cigna Global Health Benefits.

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

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

Defined Terms

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

Alternate Benefits	If Cigna Global Health Benefits determines that a service less costly than the Covered Service the dentist performed could have been performed to treat a dental condition, the Plan will pay benefits based upon the less costly service if such service: ▪ Would produce a professionally acceptable result under generally accepted dental standards; and ▪ Would qualify as a Covered Service.
Before-Tax Contributions	U.S. home-based expatriate employees, and expatriate employees who are assigned to the United States, pay for coverage with before-tax dollars — contributions that are taken from your pay before U.S. federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before U.S. Social Security taxes are withheld. This lowers your U.S. taxable income and your U.S. income tax liability.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Medical and Dental Plan.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue Medical and/or Dental Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. The *Health Care Participation* section provides details on COBRA coverage. Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for COBRA continuation coverage.
Coinsurance	Coinsurance is the way you share costs for certain coverage options after you pay any applicable deductible. The Medical and Dental Plans pay either a percentage of reasonable and customary (R&C) charges or a percentage of the in-network dentist's negotiated fees for covered services, and you pay the remainder. The actual percentage depends on the option you've chosen and the type of covered service.
Coinsurance Maximum	The coinsurance maximum is a "safety net" that protects you from having to pay high expenses in the event of a serious medical situation. The coinsurance maximum is the most you would need to pay in a calendar year in addition to the deductible for medically necessary covered services under the Expatriate Medical Plan. Once the coinsurance maximum is reached, the Expatriate Medical Plan will pay 100% of negotiated rates for medically necessary covered in-network care and 100% of reasonable and customary (R&C) charges for medically necessary covered out-of-network services for the rest of the year. However, amounts that you pay toward your deductibles, copayments, and amounts above R&C charges for out-of-network care do **not** count toward your coinsurance maximum.

Coordination of Benefits	Coordination of benefits rules are the rules that determine how benefits are paid when a patient is covered by more than one group plan. Rules include: ▪ Which plan assumes primary liability; ▪ The obligations of the secondary claims administrator or claims payer; and ▪ How the two plans ensure that the patient is not reimbursed for more than the actual charges incurred. In general, the following coordination of benefits rules apply: ▪ As a JPMorgan Chase employee, your JPMorgan Chase coverage is considered primary for you. ▪ For your spouse/domestic partner or child covered as an active employee and/or retiree of another employer, that employer's coverage is considered primary for him or her. ▪ For children covered as dependents under two plans, the primary plan is the plan of the parent whose birthday falls earlier in the year (based on month and day only, not year). Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee) or covered by U.S. Medicare. These rules do not apply to any private insurance you may have. Please see "If You Are Covered by More Than One Plan" in the *Plan Administration* section for more details.
Copayment	A copayment (also known as a copay) is the fixed dollar amount you pay for certain covered services under the Expatriate Medical and Dental Plans. For example, the Expatriate Medical Plan requires a $150 copayment for an emergency room visit. The actual amount of the copayment will vary based on the services provided.
Covered Expenses	Covered expenses are the in-network negotiated fees or the reasonable and customary (R&C) charges for medically necessary covered services or supplies that qualify for full or partial reimbursement under the Expatriate Medical and/or the Expatriate Dental Plans.
Covered Services	While the Plans provide coverage for numerous services and supplies, there are limitations on what's covered. For example, under the Expatriate Medical Plan, experimental treatments, most cosmetic surgery expenses, and inpatient and outpatient private duty nursing are not covered. Medical procedures are generally reimbursable only if they meet the definition of "Medically Necessary" (see "Medically Necessary," below). Under the Expatriate Dental Plan, a crown, bridge, or gold restoration is not covered if a tooth was prepared for it before the person became covered under the Plan. So, while a service or supply may be necessary, it may not be covered under the Expatriate Dental Plan. Please see "What Is Covered" on page 458 for more details.
Deductible	The deductible is the amount you pay up front each calendar year for covered expenses before the Expatriate Medical Plan and/or Expatriate Dental Plan generally begins to pay benefits for many expenses. Amounts in excess of reasonable and customary (R&C) charges and ineligible charges do not count toward the deductible.

Experimental, Investigational, or Unproven Services

Experimental, investigational, or unproven services are medical, surgical, diagnostic, psychiatric, mental health, substance abuse and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the claims administrator makes a determination about coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The claims administrator, in its judgment, may determine an experimental, investigational or unproven service to be covered under the Medical Plan for treating a "life-threatening" sickness or condition if the claims administrator determines that a service:

- Is safe with promising effectiveness;
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

If services are denied because they are deemed to be experimental, investigational, or unproven, and the service is then considered an approved service by the claims administrator within six months of the date of service, you may resubmit your claim for payment.

Explanation of Benefits

An explanation of benefits (EOB) is a statement that the claims administrator prepares, which documents your claims and provides a description of benefits paid and not paid under the Expatriate Medical Plan and the Expatriate Dental Plan.

Home Health Care

Home health care is an alternative to inpatient hospitalization during a patient's recovery period. If the attending physician believes that part-time care will suffice in treating the sickness or injury, the physician can prescribe a schedule of services to be provided by a state-licensed home health care agency. This schedule may include administration of medication, a regimen of physical therapy, suctioning or cleansing of a surgical incision, or the supervision of intravenous therapy.

In-Network

"In-network" describes a covered service that is performed by a physician, dentist, hospital, lab, or other health care professional who is part of a health care company's network and who has agreed to pre-negotiated fees. When a service is performed in-network, benefits are generally paid at a higher level than they are when a service is performed out-of-network.

Maximum Annual Benefit

The maximum annual benefit is the most the Expatriate Dental Plan will pay for covered preventive and restorative dental services for each participant in a year.

Maximum Lifetime Benefit

The maximum lifetime benefit is he most the Expatriate Medical Plan or Expatriate Dental Plan will pay for covered services in each participant's lifetime.

Maximum Lifetime Orthodontia Benefit

The maximum lifetime orthodontia benefit is the most the Expatriate Dental Plan will pay for covered orthodontia services for each participant's lifetime.

Any benefits that have been applied to a maximum provision under a U.S. domestic dental plan of your heritage organization will also be applied to the lifetime maximum for the Expatriate Dental Plan.

Medically Necessary

Medically necessary health care services and supplies are services or supplies that are determined by the claims administrator to be medically appropriate and:

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

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

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

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

Missing Tooth Exclusion

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

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

Multiple Surgical Procedure Reduction Policy

The multiple surgical procedure reduction policy means that surgical procedures that are performed on the same date of service are subject to the multiple surgical procedure reduction policy. On an in-network basis, 100% of the negotiated charges are reimbursable for the primary/major procedure, 50% of negotiated charges are reimbursable for the secondary procedure, and 50% of negotiated charges are reimbursable for all subsequent procedures. On an out-of-network basis, 100% of the reasonable and customary (R&C) charges are reimbursable for the primary/major procedure, 50% of R&C charges are reimbursable for the secondary procedure, and 50% of R&C charges are reimbursable for all subsequent procedures. Participants undergoing surgery are urged to discuss this policy with their health care provider.

Necessary Services

Necessary services are services or supplies that are accepted and used by the dental community as appropriate for the condition being treated or diagnosed. The services or supplies also must be prescribed by a dentist for the diagnosis or treatment of the condition to be considered necessary. Some prescribed services may not be considered necessary and may not be covered under the Expatriate Dental Plan. Cigna International will determine whether a service or supply is necessary.

Finally, to be considered necessary, a service or supply cannot be cosmetic, educational, or experimental in nature and must be in accordance with generally accepted dental standards

Non-Duplication of Benefits	Non-duplication of benefits is a provision that requires that the 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. You are entitled to receive benefits up to what you would have received under the JPMorgan Chase Expatriate Medical or Expatriate Dental Plan if it were your only source of coverage, but not in excess of that amount. If you have other coverage that is primary to the JPMorgan Chase expatriate plan, the claims administrator will reduce the amount of coverage that you would otherwise receive under this Plan by any amount you receive from your primary coverage. Please see the definition of "Coordination of Benefits" in this section for more information.
Out-of-Network	"Out-of-network" describes a covered service that is performed by a physician, dentist, hospital, lab, or other health care professional who is not part of a health care company's network and who has not agreed to pre-negotiated fees. When a service is performed out-of-network, benefits are generally paid at a lower level than they are when a service is performed in-network and are generally limited to reasonable and customary charges.
Out-of-Pocket Expense	Your out-of-pocket expense is the amount you pay for eligible expenses when you receive treatment. This includes your deductible, coinsurance and copayments.
Pre-Determination	Pre-determination is an itemization of the proposed course of treatment (including recent pre-treatment X-rays), which you should submit before work is begun, if you anticipate that charges will be more than $300. A dental consultant will review the proposed treatment before work begins and the claims administrator will inform you and your dentist of the amount of covered charges. That way, you'll understand the benefits that will be paid before treatment begins. Benefits will be paid according to the Plan provisions in effect when the services are actually rendered. The amount may change if the treatment changes from that which was predetermined or if frequency limits apply. Except in the case of an emergency, you may not want to begin the course of treatment until you know what amount the Expatriate Dental Plan will pay.
Primary Plan	The primary plan is the plan that provides initial coverage to the participant. If the participant is covered under both the JPMorgan Chase Expatriate Medical Plan and/or Dental Plans and another plan, the rules of the primary plan govern when determining the coordination of benefits between the two plans. Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee) or covered by U.S. Medicare. These rules do not apply to any private insurance you may have. Please see "If You Are Covered by More Than One Plan" in the *Plan Administration* section for more details.
Qualified Status Change	The JPMorgan Chase benefits you elect during each Annual Benefits Enrollment will generally stay in effect throughout the plan year, unless you elect otherwise, because of a Qualified Status Change (QSC). If you have a QSC, you have 31 days from the qualifying event to make benefits changes; 90 days from the qualifying event if the event is the birth or adoption of a child. The benefits you elect will be effective the date of the event if you make the elections timely. (**Please Note:** You will have 90 days from the QSC date to add any newly eligible dependents to the JPMC Medical Plan should that dependent pass away within this 90-day period.) **Please Note:** Any changes you make during the year must be consistent with your QSC. Please see "Changing Your Coverage Midyear" on page 426.
Reasonable and Customary Charges	Reasonable and customary charges ("R&C charges," also known as "eligible expenses") are the actual charges that are considered for payment when you receive medically necessary care for covered services from an out-of-network provider under the Expatriate Medical and/or Expatriate Dental Plans. R&C means the prevailing charge for most providers in the same or a similar geographic area for the same or similar service or supply, as determined in the sole discretion of the claims administrator. These charges are subject to change at any time without notice. Reimbursement is based on the lower of this amount and the provider's actual charge. If your provider charges more than the R&C charges considered under the Expatriate Medical Plan and/or Expatriate Dental Plans, you'll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered eligible expenses. Therefore, they don't count toward your deductible, benefit limits, or coinsurance maximums.

Self-Insured	A self-insured plan is a plan where the sponsor (in the case of the Expatriate Medical Plan and the Expatriate Dental Plan, JPMorgan Chase) is responsible for the payment of medical and dental claims under the Plans. This makes these plans self-insured.
Spouse	The term “spouse” refers to any person to whom you are legally married as recognized by U.S. federal law. If JPMorgan Chase employs your spouse, domestic partner, or child, he or she can enroll in coverage as an employee or as your dependent, but not as both. If you want to cover your eligible child(ren), you or your spouse/domestic partner may provide this coverage. If you are covering a spouse/domestic partner who is also a JPMorgan Chase employee (i.e., company couple), you should update the “dependent is also an employee” indicator on the Dependent Enrollment page of the Benefit Web Center, available through **Expatriate Health Benefits Resources**.

Your JPMC Benefits Guide

Effective 1/1/22

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

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

Print and Web Versions

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

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

How This Guide Is Organized

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

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

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

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

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

Retirement Savings

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

Questions?

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

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

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About This Guide

Effective 1/1/22

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

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

About This Summary

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

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

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

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

Additional Plan Information

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

Your benefits as a participant in the plans are provided under the terms of this document and insurance contracts, if any, issued to JPMorgan Chase. If there is a discrepancy between the insurance contracts and this document, the insurance contracts will control.

Please Note: No person or group (other than the plan administrator for the JPMorgan Chase U.S. Benefits Program) has any authority to interpret the plans (or official plan documents) or to make any promises to you about them. The plan administrator for the JPMorgan Chase U.S. Benefits Program has complete authority in his or her absolute discretion to construe and interpret the terms of the plans and any underlying insurance policies and/or contracts, including the eligibility to participate in the plans, and to make factual determinations.

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

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

No Assignment of Benefits

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

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

Right to Amend

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

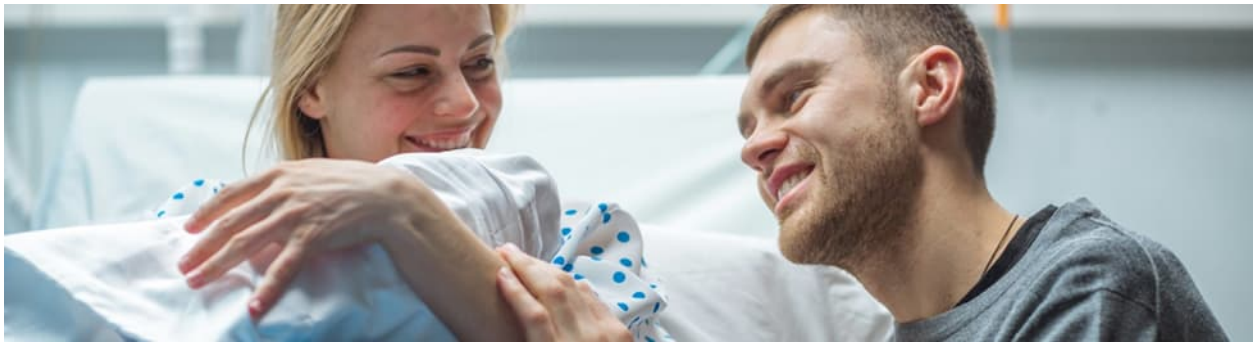
JPMorgan Chase also reserves the right to amend any of the plans and policies, to change the method of providing benefits, to curtail or reduce future benefits, or to terminate at any time for any reason, any or all of the plans and policies described in this Guide.

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

Not a Contract of Employment

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

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



What Happens If …

Effective 1/1/22

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

New Dependents Must Be Verified

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

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

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Qualified Status Changes (QSCs)

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

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

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

If You Have an Event …

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

31-Day Deadline

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

Retroactive Payroll Contribution Changes

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

QSCs for Health Benefits — Medical, Dental, Vision

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

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

*QSCs for Spending Accounts**

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

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

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

QSCs for Supplemental Term Life Insurance Benefits

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

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

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

You Get Married

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

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

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

You Have or Adopt a Child or Become a Legal Guardian

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

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

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

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

A Covered Dependent Becomes Ineligible

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

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

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

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

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

You and/or Your Dependents Lose Other Coverage

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

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

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

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

You and/or Your Dependents Gain Other Coverage

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

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

You Move

If you move out of your Medical or Dental Plan option service area and your current option is no longer available, you can change Medical and/or Dental Plan option for yourself and your covered dependents. (**Please Note:** In this situation, you will be assigned new coverage by JPMorgan Chase based on your new service area. However, you will have the ability to change this assigned coverage within 31 days of the qualifying event.)

You Divorce, Separate or Terminate a Domestic Partner Relationship

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

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

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

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

If you divorce or become legally separated, certain court orders could require you to provide health care benefits to covered child(ren). JPMorgan Chase is legally required to recognize qualified medical child support orders within the limits of the JPMorgan Chase plans. If you're a party in a divorce settlement that involves the JPMorgan Chase plans, you should have your attorney contact HR Answers to make sure the appropriate documents are filed and that the court order in question is actually a qualified medical child support order that complies with governing legislation. Please see "Qualified Medical Child Support Orders" in the *Health Care Participation* section for more information.

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

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

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

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

You Pass Away

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

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

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

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

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

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

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

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

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

Other Events or Changes

Change in Scheduled Work Hours

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

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

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

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

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

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

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

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

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

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

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

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

You Go on Short-Term Disability Leave

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

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

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

You Go on Long-Term Disability

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

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

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

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

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

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

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

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

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

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

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

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

You Are on LTD and Become Eligible for Medicare

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

You Become Eligible for Medicare

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

You Go on a Military Leave

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

Paid Military Leave

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

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

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

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

Unpaid Military Leave

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

Making Contributions While on Unpaid Leave

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

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

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

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

You Go on a Parental Leave

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

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

You Go on Approved Family and Medical Leave

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

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

Special Rules for Health Care Spending Account

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

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

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

You Go on Unpaid Leave

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

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

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

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

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

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

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

You Return from a Leave of Absence

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

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

For the Health Care Spending Account (HCSA):

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

For the Dependent Care Spending Account (DCSA):

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

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

For LTD Benefits:

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

Total Annual Cash Compensation (TACC)

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

You Leave JPMorgan Chase

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

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

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

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

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

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

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

If You Port or Convert

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

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

Porting Versus Converting Insurance Policies

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

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

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

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

Your Expatriate Assignment Ends

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

You Retire from JPMorgan Chase

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

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

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

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

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

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

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

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

If You Port or Convert

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

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

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

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

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

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

You Work Past Age 65

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

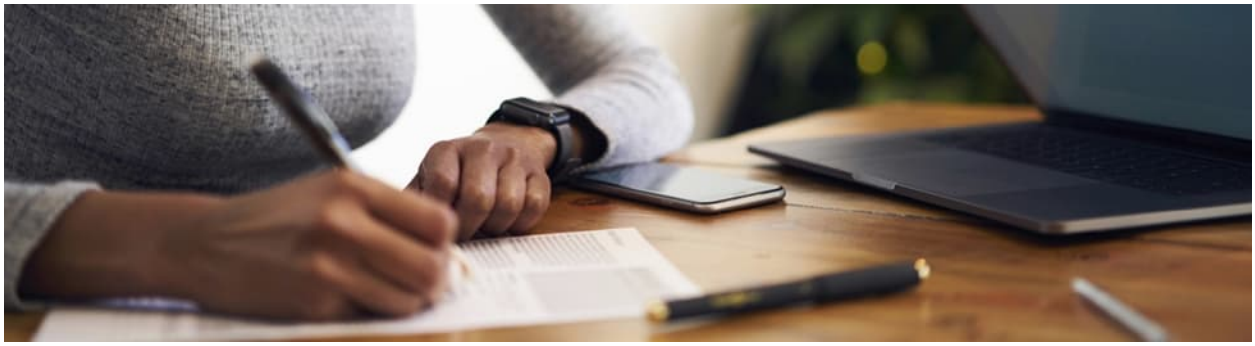
For Life and Accident Insurance Plans: If you continue to work for JPMorgan Chase after you reach age 65, you may continue to participate in the Life and Accident Insurance Plans, as long as you are actively employed and meet all eligibility requirements.

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

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

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

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



Plan Administration

Effective 1/1/22

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

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

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

About This Section

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

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

Questions?

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

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

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

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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 361 for a listing of official plan names and numbers.

Keep Your Information Current

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

Plan Sponsor

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

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

Plan Year

January 1 – December 31

Plan Administrator

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

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

For the Business Travel Accident Insurance Plan:

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

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

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

Claims Administrator

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

COBRA Administrator

COBRA questions should be directed to JPMorgan Chase HR Answers.

COBRA payments should be directed to:

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

(877) 576-2427

Benefits Fiduciaries

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

Agent for Service of Legal Process

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

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

Employer Identification Number

13-4994650

Plan Administrative Information

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

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

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

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

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

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

Participating Companies

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

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

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

Your Rights Under ERISA

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

ERISA provides that all plan participants are entitled to:

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

An Important Note

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

Enforce Your Rights

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

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

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

Keep Your Contact Information Current

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

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

About Plan Fiduciaries

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

Prudent Actions by Plan Fiduciaries

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

Health Care and Insurance Plans for Active Employees

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

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

Assistance with Your Questions

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

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

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

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

Privacy Information

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

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

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

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

Privacy Notice

JPMorgan Chase is committed to maintaining the highest level of privacy and discretion about your personal compensation and benefits information.

However, federal legislation under the Health Insurance Portability and Accountability Act (HIPAA) legally requires employers—like JPMorgan Chase—to specifically communicate how certain "protected health information" under employee and retiree health care plans may be used and disclosed, as well as how plan participants can get access to their protected health information.

What Is Protected Health Information?

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

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

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

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

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

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

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

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

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

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

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

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

Help Pursuing Claims for Eligibility

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

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

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

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

If Your Claim Is Denied

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

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

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

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

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

Claiming Benefits: Plans Subject to ERISA

An Important Reminder

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

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

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

Help Pursuing Claims

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

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

Steps in the Benefits Claims and Appeals Process

Step 1: Filing Your Initial Claim for Benefits

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

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

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

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

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

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

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

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

Life Insurance Claims & Appeals

Life insurance claims and appeals are divided between two parties.

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

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

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

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

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

What Qualifies as a "Denied Benefit"?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Send your written appeal to:

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

Telephone: (609) 292-6135

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

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

In your appeal, you have the right to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Filing a Court Action

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

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

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

Contacting the Claims Administrators: Plans Subject to ERISA

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

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

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

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

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

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

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

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

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

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

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

Contacting the Claims Administrators: Plans Not Subject to ERISA

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

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

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

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

If You Are Covered by More Than One Health Care Plan

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

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

Non-Duplication of Benefits

The JPMorgan Chase health care plans do not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. The non-duplication provisions of the JPMorgan Chase health care plans will ensure that, in total, you receive benefits up to what you would have received with the JPMorgan Chase plans as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount.

A summary of coordination rules (that is, how JPMorgan Chase coordinates coverage with another group plan to ensure non-duplication of benefits) follows. If you have questions, please contact your health care company for help. (Please see contact information in the *Contacts* section.)

Here's an example of how the JPMorgan Chase health care plans coordinate benefits with other group health care plans:

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

Determining Primary Coverage

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

- If you are enrolled in the JPMorgan Chase plan and another plan and your other health care plan doesn't have a coordination of benefits provision, that plan will be considered primary, and it will pay first for you and your covered dependents.
- If your covered dependent has a claim, the plan covering your dependent as an employee or retiree will be considered primary to this plan.
- If your claim is for a covered child who is enrolled in coverage under both parents' plans, the plan covering the parent who has the earlier birthday in a calendar year (based on the month and date of birthday only, not the year) will be considered primary. In the event of divorce or legal separation, and in the absence of a qualified medical child support order, the plan covering the parent with court-decreed financial responsibility will be considered primary for the covered child. If there is no court decree, the plan of the parent who has custody of the covered child will be considered primary for the covered child. (Please see "Qualified Medical Child Support Orders" in the *Health Care Participation* section.)
- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

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

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

Coordination with Medicare

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

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

Right of Recovery

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

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

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

Subrogation of Benefits

The purpose of the JPMorgan Chase health care plans is to provide benefits for eligible health care expenses that are not the responsibility of any third party. The JPMorgan Chase plans have the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plans making payments on your behalf or on behalf of a covered dependent. This is known as subrogation of benefits. The following rules apply to the plan’s subrogation of benefits rights:

- The JPMorgan Chase plans have a first priority equitable lien from any amounts recovered from a third party for the full amount of benefits the plans have paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the JPMorgan Chase plans use this right when requested.

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

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

Right of Reimbursement

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

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

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

Special Notice for Employees Who Have Been Rehired by JPMorgan Chase

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

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

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

Contacts

Effective 1/1/22

My Health, My Rewards and HR Answers for More Information

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

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

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

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