# Retiree Plan Administration

## *Effective 1/1/20*

*This document, part of the summary plan descriptions for the retiree plans, provides important information, as required by the Employee Retirement Income Security Act of 1974 (ERISA), about the JPMorgan Chase Health Care and Insurance Program for Retirees, which provides benefits to retirees, certain individuals receiving long-term disability benefits, and their dependents who are not yet eligible for Medicare (pre-Medicare). While ERISA doesn't require JPMorgan Chase to provide you with retiree benefits, it does mandate that JPMorgan Chase clearly communicate to you how the retiree plans subject to the provisions of ERISA operate and what rights you have under the law regarding retiree plan benefits. This document is part of the summary plan description of each of your JPMorgan Chase Health Care and Insurance Plans for Retirees governed by ERISA.*

You'll also find information on the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) in this document. Under COBRA, your covered eligible dependents have the right to continue health care coverage at their own expense for a certain period of time if their JPMorgan Chase-provided health care coverage ends under certain circumstances.

Effective December 31, 2014, JPMorgan Chase generally terminated retiree health coverage (medical, prescription drug, dental and vision) for individuals who are Medicare-eligible and are retired, are receiving benefits under the Long-Term Disability (LTD) Plan, or are covered dependents of these individuals once they are Medicare-eligible. Instead, Medicare-eligible participants have access to individual health care coverage available through Via Benefits, a private Medicare exchange, which is not coverage sponsored by JPMorgan Chase.

The JPMorgan Chase U.S. Retiree Benefits Program is available to individuals who met the applicable retiree benefits age and service criteria when their employment terminated with JPMorgan Chase or a heritage organization. This information does not include all of the details contained in the applicable insurance contracts, plan documents and trust agreements. If there is any discrepancy between this information and the governing documents, the governing documents will control. JPMorgan Chase & Co. expressly reserves the right to amend, modify, reduce, change or terminate its benefits and plans at any time, including its U.S. Retiree Benefits Program. The JPMorgan Chase U.S. Retiree Benefits Program does not create a contract or guarantee of employment between JPMorgan Chase and any individual.

## Questions?

Please refer to each Retiree Summary Plan Description for instructions regarding where to call or how to access the appropriate website or call center for each retiree benefit plan.

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 through Friday, from 8 a.m. to 7 p.m. Eastern Time, except certain holidays.

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

Medicare-eligible individuals should contact Via Benefits for questions about coverage offerings at (844) 448-7300, 8 a.m. to 9 p.m., Eastern Time, Monday through Friday, except certain U.S. holidays.

## About this Document

This document is the Plan Administration section of the summary plan descriptions for the JPMorgan Chase U.S. Retiree Benefits Program. The U.S. Department of Labor requires JPMorgan Chase to routinely provide benefits plan summaries to plan participants. Please retain this information for your records. This document also constitutes the plan document for Retiree Plan Administration. It does not include all of the details contained in the applicable insurance contracts. If there is a discrepancy between the applicable insurance contracts and this document, the insurance contracts will control.

## Table of Contents

# General Information

The following summarizes important administrative information about the JPMorgan Chase Health Care and Insurance Program for Retirees, 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 Information Overview" on page 6 for a listing of official plan names and numbers.

| | |
|---|---|
| **Plan Sponsor** | JPMorgan Chase Bank, NA<br>545 Washington Boulevard<br>12th Floor<br>Mail Code: NY1 – G120<br>Jersey City, NJ 07310<br>(Certain participating companies have adopted some or all of the plans for their eligible employees. See "Participating Companies" on page 7 for participating companies.) |
| **Plan Year** | January 1 — December 31 |
| **Plan Administrator** | JPMorgan Chase U.S. Benefits Executive<br>c/o JPMorgan Chase & Co. Benefits Administration<br>545 Washington Boulevard 12th Floor<br>Mail Code: NY1 – G120<br>Jersey City, NJ 07310 |
| **Claims Administrator** | The contact information for claims administrators for the various benefits plans can be found under "Contacting the Retiree Claims Administrators" on page 16. |
| **COBRA Administrator** | COBRA Payments JPMorgan Chase<br>P.O. Box 27524<br>New York, NY 10087-7524<br>(877) 576-2427 |
| **COBRA Service Provider for Health Reimbursement Arrangement** | Via Benefits<br>National Benefit Services<br>3736 Center Park Dr. #120<br>West Jordan, UT 84084<br>(801) 282-1269 |
| **Benefits Fiduciaries** | Please see "About Plan Fiduciaries" on page 8 for information on benefits fiduciaries. |
| **Agent for Service of Legal Process** | Legal Papers Served:<br>JPMorgan Chase & Co.<br>4 Chase Metrotech Center<br>FL 18, NY1 – C312<br>Brooklyn, NY 11245<br>Service of legal process may also be made upon a plan trustee or the Plan Administrator. |
| **Employer Identification Number** | 13-4994650 |

# Plan Information Overview

The following chart shows the information that varies by plan. All of the following plans are governed by ERISA.

| Retiree Plan Name/ Number | Insurer | Payment of Benefits | Type of Administration |
|---|---|---|---|
| **The JPMorgan Chase Retiree Medical Plan/554** | See "Contacting the Retiree Claims Administrators" on page 16 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug coverage. | See "Contacting the Retiree Claims Administrators" on page 16 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug coverage. | Self-Insured/Trustee |
| **The JPMorgan Chase Retiree Dental Plan/554** | See "Contacting the Retiree Claims Administrators" on page 16 for names and addresses for the Preferred Dentist Program (PDP) Option, the Dental Maintenance Organization (DMO) Option and the Dental Health Maintenance Organization (DHMO) Option | See "Contacting the Retiree Claims Administrators" on page 16 for names, addresses, and telephone numbers for the PDP Option, the DMO Option and the DHMO Option. | Self-Insured/Trustee: PDP Option<br>Fully Insured: DMO Option and DHMO Option |
| **The JPMorgan Chase Retiree Vision Plan/554** | FAA/EyeMed Vision Care<br>P.O. Box 8504<br>Mason, OH 45040-711 | FAA/EyeMed Vision Care<br>P.O. Box 8504<br>Mason, OH 45040-711 | Fully Insured |
| **The JPMorgan Chase Retiree Life Insurance Plan/554** | Metropolitan Life Insurance Company<br>200 Park Avenue<br>New York, NY 10166 | Metropolitan Life Insurance Company<br>200 Park Avenue<br>New York, NY 10166 | Fully Insured |
| **The JPMorgan Chase Retiree Health Reimbursement Arrangement Plan/554** | See "Contacting the Retiree Claims Administrators" on page 16 for name, telephone number and address for the HRA | See "Contacting the Retiree Claims Administrators" on page 16 for name, telephone number and address for the HRA | Self-Insured |

# 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.
- Chase Bank USA, National Association
- Chase BankCard Services, Inc.
- eCast Settlement Corp
- FNBC Leasing Corporation
- Highbridge Capital Mgmt, LLC
- J.P. Morgan Alternative Asset Management, Inc.
- J.P. Morgan Chase Custody Services, Inc.
- J.P. Morgan Electronic Financial Services, Inc.
- J.P. Morgan Institutional Investments, Inc.
- J.P. Morgan Investment Holdings LLC
- J.P. Morgan Investment Management Inc.
- J.P. Morgan Securities, LLC
- J.P. Morgan Treasury Technologies Corporation
- J.P. Morgan Trust Company of Delaware
- JPMorgan Bank and Trust Company, National Association
- JPMorgan Chase Bank, National Association
- JPMorgan Chase Holding LLC
- JPMorgan Distribution Services, Inc.
- Neovest, Inc.
- Paymentech, LLC
- Security Capital Research & Management, Incorporated
- WePay Inc

# Your Rights Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) gives you certain rights and protections while you are a participant in the JPMorgan Chase Retiree Benefits Program described in this document. 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 (e.g., insurance contracts, Form 5500Series, 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, spouse/domestic partner, or eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this document on the rules governing your COBRA continuation coverage rights.

**Keep Your Contact Information Current**

Retirees should update their personal contact information, including mailing address, to receive benefits-related information and correspondence. You can make changes online via My Personal Profile at https://mpp.jpmorganchase.com. You can also call HR Answers. See "Questions?" on page 2 for contact information.

## Enforce Your Rights

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

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

- If you request a copy of the plans' documents or the latest annual report from the Plan Administrator and do not receive it within 30 days, you may file suit in a U.S. federal court. In such a case, the court may require the Plan Administrator to provide the information and pay up to $110 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a U.S. state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If it should happen that the plans' fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a U.S. federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

## 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 participants 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 retiree 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 participants 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.

### U.S. Retiree Health Care and Insurance Plans

For each of the following retiree plans that are governed by ERISA, the Plan Administrator delegates 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:

- Retiree Medical Plan, including Prescription Drug coverage;
- Retiree Dental Plan;
- Retiree Vision Plan; and
- Retiree Life Insurance Plan.

For the Retiree Health Reimbursement Arrangement Plan, the claims administrator renders decisions on initial claims, but the Plan Administrator delegates fiduciary responsibility for appeals of denied claims to the Health Care and Insurance Plans Appeals Committee.

## Assistance with Your Questions

If you have any questions about the JPMorgan Chase Health Care and Insurance Program for Retirees, you should contact HR Answers. For questions on the Health Reimbursement Arrangement, contact Via Benefits. (See "Questions?" on page 2 for contact information.) 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, D.C. 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 regarding 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.

# *Prescription Drug Notice of Creditable Coverage*

JPMorgan Chase will send a Notice of Creditable Coverage to participants who become eligible for Medicare. This notice states that most JPMorgan Chase Retiree Medical Plan options provide a level of prescription drug benefits that is, on average, at least as high as the standard Medicare prescription drug plan benefits. The notice is important because it can help you avoid late enrollment penalties associated with Medicare prescription drug plans that may apply given that JPMorgan Chase benefits-eligible participants would generally wait until retirement to enroll in Medicare Part B and Part D.

If you have a dependent who is eligible for Medicare benefits and you do not receive a Notice of Creditable Coverage, you may contact HR Answers.

# *Claims Related to Eligibility to Participate in the Retiree Plans, Plan Operations and Amount of Retiree Life Insurance*

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 a retiree, dependent or beneficiary who is allowed to obtain benefits under the retiree plans, and whether, as a Medicare-eligible retiree enrolled in medical and prescription drug coverage through Via Benefits, you're eligible for Retiree Health Reimbursement Arrangement Plan funds. In addition, if you have a claim related to the amount of insurance under the Retiree Life Insurance Plan or if you have a type of claim that is not otherwise described in this plan description, 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 Retiree Benefits" beginning on page 11.

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

For questions regarding eligibility to participate in any plans listed in this Guide and to receive benefits or information about general plan operations, please contact HR Answers. (See "Questions?" on page 2 for contact information.)

If you are not satisfied with the response, you may file a written claim with the Plan Administrator at the address provided on page 3. 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 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 due to 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 for any Retiree Health Care and Insurance Plan, 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. The Plan Administrator will generally decide your appeal except for ones involving eligibility for the Retiree Health Care and Insurance Plans. For these appeals, the Plan Administrator delegates that responsibility to the Health Care and Insurance Plans Appeals Committee. 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 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.

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 following your appeal, please see "Filing a Court Action" on page 16.

# Claiming Retiree Benefits

This section explains the retiree benefits claims and appeals process for the JPMorgan Chase Health Care and Insurance Program for Retirees. 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 8 and "Contacting the Retiree Claims Administrators" on page 16. For claims relating to eligibility questions or plan operations please see "Claims Related to Eligibility to Participate in the Retiree Plans, Plan Operations and Amount of Retiree Life Insurance" on page 9.

**Help Pursuing Claims**

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

For the Retiree 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 Retiree Benefits Claims and Appeals Process

### Step 1: Filing Your Initial Claim for Retiree Benefits

In general, when you file a claim for retiree benefits, it is paid according to the provisions of the specific retiree 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 Retiree Claims Administrators" on page 16.

| Retiree Plan | Appropriate Claims Administrator | Timing for Filing Your Initial Claim |
|---|---|---|
| **Medical Plan*** | Claims administrator for your Medical Plan option | No later than December 31 of the year following the year in which services were provided. Please contact your claims administrator for more information. |
| **Prescription Drug Benefit of the Medical Plan** | CVS Caremark | |
| **Dental Plan*** | Claims administrator for your Dental Plan option | |
| **Vision Plan*** | FAA/EyeMed Vision Care | |
| **Life Insurance Plan**** | Metropolitan Life Insurance Company (MetLife) | No deadline for filing a claim, but you are encouraged to file a claim as soon as possible after a death. |
| **Health Reimbursement Arrangement Plan** | Via Benefits | If participant ceases to be eligible for participation in the Plan, claims that occurred prior to the date of coverage loss should be submitted within six months of the date eligibility ceases. |

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

** Please note that MetLife has sole responsibility and discretion to resolve any issues regarding beneficiary designations.

**Life Insurance Claims and 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 Retiree Benefits Is Denied

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

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

**Please Note:** If an extension is necessary because you did not submit necessary information needed to process your health care claim (except in the case of urgent care where the life of a claimant could be jeopardized), life insurance, or health reimbursement arrangement, 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 Retiree 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.

| Retiree Plan | Timing for Notification of a Denial of Benefits Claim |
|---|---|
| **Medical (including the Prescription Drug coverage), Dental and Vision Plans** | • 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.<br>• 15 days for pre-service claims, where approval is required before receiving benefits, plus one 15-day extension due to matters beyond the plan's control.<br>• 30 days for post-service claims, where the claim is made after care is received, plus one 15-day extension due to matters beyond the plan's control. |
| **Life Insurance Plan** | Within 60 days to make a determination once all claim information has been submitted, plus one extension |
| **Health Reimbursement Arrangement Plan** | Within 30 days after the Claims Submission Agent receives your claim |

**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 Retiree 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 Retiree Medical Plan, the explanation must also include:

- If the retiree 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 retiree benefit denial, or a statement that a copy of this information will be provided free of charge upon request.

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

If you have filed a claim for retiree 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:

- Retiree Medical Plan, including Prescription Drug coverage
- Retiree Dental Plans;;
- Retiree Vision Plan; and
- Retiree Life Insurance Plan.

The retiree Plan Administrator delegates all fiduciary responsibility and decisions regarding a claim for a denied benefit under these plans to the applicable claims administrator.

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

The Health Care and Insurance Plans Appeals Committee decides all appeals for the Retiree Health Reimbursement Arrangement Plan. If you would like to file an appeal of a denied claim under the Retiree Health Reimbursement Arrangement Plan, send your appeal to:

JPMorgan Chase U.S. Benefits Executive
c/o JPMorgan Chase & Co. Corporate Benefits
545 Washington Boulevard 12th Floor
Mal Code: NY1-G120
Jersey City, NY 07310

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, following receipt of the claim denial.

| Retiree Plan | Timing for Filing an Appeal of a Denial of Retiree Benefits Claim |
|---|---|
| **Medical Plan (including the Prescription Drug component)** | 180 days |
| **Dental Plan** | |
| **Vision Plan** | |
| **Health Reimbursement Arrangement Plan** | |
| **Life Insurance Plan** | 60 days to appeal. |

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:
  - Were relied upon in denying the retiree benefit.
  - Were submitted, considered or generated in the course of denying the retiree benefit, regardless of whether it was relied on in making this decision.
  - Demonstrate compliance with the administrative processes and safeguards required in denying the benefit.
  - For health care claims only: Constitute 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 benefits, 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, and/or Health Care and Insurance Plans 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 table below.

| Retiree Plan | Timing for Notification of a Denied Benefits Appeal |
|---|---|
| **Medical (including the Prescription Drug component), Dental and Vision Plans** | • As soon as reasonably possible but no more than 72 hours for claims where the life of a claimant could be jeopardized (urgent care)<br>• 15 days where approval is required before receiving benefits (pre-service claims)<br>• 30 days where the claim is made after care is received (post-service claims) |
| **Life Insurance Plan** | 60 days to review and make a determination once all the information has been submitted, plus one extension. |
| **Health Reimbursement Arrangement Plan** | 30 days where the claim is made after care is received (post-service claims) |

Except in the case of urgent care claims related to health care, 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 Appeal

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 Retiree Medical Plan benefits, including the prescription drug component, 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 Retiree 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 retiree benefit denial, or a statement that a copy of this information will be provided free of charge upon request.

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

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

If your appeal of a benefits claim is denied, your final appeal for benefits will be heard by a review panel that is independent of both the company and the Retiree Medical Plan claims administrators. The independent review panel will hear appeals for the Retiree Medical Plan, including the prescription drug coverage.

The independent review panel hears only appeals that involve medical judgment or a rescission of coverage; the panel does not hear appeals regarding 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 commence the court action by the earlier of: (i) one year after the date of the denial of your final appeal; or (ii) three years after the date when your initial claim should have been filed, regardless of any state or federal statutes relating to limitations of actions. If, however, the applicable state or federal law relating to limitations of actions would result in a shorter limitations period within which to start the action, the shorter limitations period will apply. For the health plans, you cannot file a suit unless you have completed two appeals, if required by the claims administrators.

# *Contacting the Retiree Claims Administrators: Plans Subject to ERISA*

This section provides specific contact information for each retiree benefit plan covered by ERISA. Generally, for all U.S. Health Care and Insurance Plans for Retirees, questions related to general plan administration and eligibility to participate in the plans can be addressed by HR Answers. (See “Questions?” on page 2 for contact information.)

## Contact Information for Plans

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 each benefit plan, as listed below. **Please Note:** Retirees and individuals receiving long-term disability benefits and their dependents who are eligible for Medicare are not covered by the JPMorgan Chase U.S. Retiree Medical, Dental, and Vision Plans. Medicare-eligible individuals can sign up for health care insurance coverage through Via Benefits, if desired. (See “Questions?” on page 2 for contact information.)

| Claims Administrators | |
|---|---|
| **Retiree Medical Plan** | |
| ***Aetna*** | Aetna<br>P.O. Box 14079<br>Lexington, KY 40512-4079<br>(800) 468-1266 |
| ***Cigna*** | Cigna<br>P.O. Box 182223<br>Chattanooga, TN 37422-7223<br>(800) 790-3086 |
| ***Prescription Drug Coverage*** | CVS Caremark<br>Attention: Claims<br>P.O. Box 52196<br>Phoenix, AZ 85072-2188<br>(866) 209-6093 |
| **Retiree Dental Plan** | |
| ***Preferred Dentist Program (PDP)*** | MetLife Dental<br>P.O. Box 981282<br>El Paso, TX 79998-1282<br>(888) 673-9582 |
| ***Dental Maintenance Organization (DMO) Option**** | Aetna, Inc.<br>P.O. Box 14094<br>Lexington, KY 40512<br>(800) 843-3661 |
| ***Dental Health Maintenance Organization (DHMO) Option**** | Cigna Dental Health<br>P.O. Box 188046<br>Chattanooga, TN 37422-8045<br>800) 790-3086 |
| **Other Retiree Health Care and Insurance Plans** | |
| ***Vision Plan**** | FAA/EyeMed Vision Care<br>P.O. Box 8504<br>Mason, OH 45040-7111<br>(833) 279-4363 |
| ***Life Insurance*** | Metropolitan Life Insurance Company (MetLife)<br>200 Park Avenue<br>New York, NY 10166<br>(888) 673-9582<br>8 a.m. to 8 p.m. Eastern Time<br>Monday – Friday |
| ***Health Reimbursement Arrangement Plan*** | Via Benefits HRA Services<br>P.O. Box 981156<br>El Paso, TX 79998-1156<br>Fax: (866) 886-0878 |

* Options marked with an asterisk are fully insured

# *If You Are Covered by More Than One Health Care Plan*

The JPMorgan Chase Retiree Medical and Dental Plans 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 Retiree Benefits Program. The following rules do not apply to any private, personal insurance you may have.

## Non-Duplication of Benefits

The JPMorgan Chase Retiree Benefits Program 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 Retiree Benefits Program will ensure that, in total, you receive benefits up to what you would have received with the JPMorgan Chase Retiree Benefits Program 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.

Here's an example of how the JPMorgan Chase Retiree Benefits Program coordinates 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 Retiree Benefits Program (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 Retiree Benefits Program.
- Since your spouse/domestic partner already received $70 from his or her primary plan, he or she would receive the balance ($10) from the JPMorgan Chase Retiree Benefits Program.
- If, however, your JPMorgan Chase Retiree Benefits Program considered the R&C charge to be $80, no additional benefit would be payable, as the JPMorgan Chase Retiree Benefits Program 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 Retiree Benefits Program.

## 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 Retiree Benefits Program 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 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.
- 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.

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.

# Right of Recovery

If the JPMorgan Chase Retiree Benefits Program 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 Retiree Benefits Program has the right to recover these payments from you or from the person or company who is determined to be legally responsible.

Assignment of your claim to a third party does not exempt you from your responsibility for repaying the plan. You must notify the JPMorgan Chase Retiree Benefits Program 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 Retiree Benefits Program making payments on your behalf.

## Subrogation of Benefits

The purpose of the JPMorgan Chase Retiree Benefits Program is to provide benefits for eligible health care expenses that are not the responsibility of any third party. The JPMorgan Chase Retiree Benefits Program has 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 Retiree Benefits Program 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 Retiree Benefits Programs has first priority from any amounts recovered from a third party for the full amount of benefits the plans have paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the JPMorgan Chase Retiree Benefits Program use this right when requested.
- If you fail to help the JPMorgan Chase Retiree Benefits Program 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 Retiree Benefits Program has 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 Retiree Benefits Programs' 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 Retiree Benefits Program is 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.

## Right of Reimbursement

In addition to their subrogation rights, the JPMorgan Chase Retiree Benefits Program is 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 Retiree Benefits Program 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 Retiree Benefits Program 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 Retiree Benefits Program the gross proceeds of a recovery, to be paid to the plans immediately upon your receipt of the recovery. You must reimburse the plans, in first priority and without any set-off or reduction for attorney fees or other expenses. The "common fund" doctrine does not apply to any funds recovered by any attorney you retain, regardless of whether the funds recovered are used to repay benefits paid by the plans.
- If you fail to reimburse the JPMorgan Chase Retiree Benefits Program, 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 Retiree Benefits Program, 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.

# Continuing Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), your covered dependents have the right to continue health care coverage at their own expense for a certain period of time if your JPMorgan Chase Retiree health care coverage ends due to certain circumstances. (For domestic partners, JPMorgan Chase may provide COBRA-like coverage if the domestic partner was covered under the JPMorgan Chase U.S. Retiree Benefits Program at the time that coverage ended.) If continuation coverage is elected, the cost is typically 102% of the Plan's total cost of providing coverage.

Your covered dependents include your spouse and your eligible dependent children who are covered at the time of a qualifying event (as defined below).

HR Answers is the administrator for JPMorgan Chase COBRA coverage. COBRA coverage applies to the:

- Retiree Medical Plan (including the Prescription Drug benefit);
- Retiree Dental Plan; and
- Retiree Vision Plan.

In addition, if your covered spouse is Medicare-eligible and qualified for a Health Reimbursement Arrangement, based on the rules in effect at the time of your retirement, your spouse may qualify for COBRA coverage upon your divorce or legal separation. In this case, Via Benefits is the COBRA administrator for the Health Reimbursement Arrangement.

**Qualified Beneficiary**

Certain individuals eligible for COBRA continuation coverage are called "qualified beneficiaries." A qualified beneficiary includes the covered spouse and eligible dependent children of a covered employee.

In order to be considered a qualified beneficiary, an individual must generally be covered under a group health plan on the day before a qualifying event occurs that causes a loss in coverage (such as a divorce from or death of the covered employee).

## Qualifying Events

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

- You die;
- You divorce your spouse or become legally separated;
- You become eligible for Medicare; or
- Your dependent child loses dependent eligibility status under the terms of the plan (for example, the end of the month in which your dependent child reaches age 26).

**If Your Covered Dependents Lose Coverage.** If your spouse and/or your dependent children lose coverage due to any of the circumstances listed above, they may purchase COBRA coverage for up to 36 months from the date that coverage ends.

**If You or Your Covered Dependents Become Disabled.** If you or one of your covered dependents becomes disabled under the Social Security Administration guidelines within 60 days of a qualifying event, or you are disabled at the time COBRA coverage is initially offered, you and your covered dependents may continue COBRA coverage for an additional 11 months beyond the initial 18 months to a total of 29 months. You must notify Alight Solutions, the COBRA administrator, (or Via Benefits, the COBRA administrator for the HRA) within 60 days after Social Security issues a determination of disability status and before the initial 18-month COBRA coverage period ends. You also must notify the COBRA administrator within 30 days after Social Security determines the end of disability status for you or your covered dependent. If a second qualifying event occurs at any time during this 29-month disability coverage period, your covered dependents (but not you) may continue COBRA coverage for an additional seven months, to a total of 36 months.

## Continuation Coverage for a Domestic Partner Dependent

A domestic partner or the children of a domestic partner who are not your tax dependents are not eligible for COBRA continuation coverage under federal law. However, JPMorgan Chase provides COBRA-like coverage if your domestic partner (and his/her eligible children) was covered under the JPMorgan Chase Retiree Medical Plan, Dental Plan and Vision Plan, at the time coverage ended, and for a Medicare-eligible domestic partner who is eligible to continue a Health Reimbursement Arrangement after a divorce or legal separation.

The rate for domestic partner continuation coverage will be the same as the COBRA rate. Contributions will be made on an after-tax basis and will represent the full value of the coverage plus two percent.

## Giving Notice of a Qualifying Event

If you divorce or become legally separated from your spouse or your dependent child loses dependent status under the terms of the plan, you or one of your covered dependents must contact HR Answers, or Via Benefits if your Medicare-eligible spouse/domestic partner qualifies for a Health Reimbursement Arrangement, within 31 days of any such event. If notice is not received within that 31-day period, your dependents will not be entitled to elect COBRA continuation coverage. Notice must be provided to the COBRA Administrator and must include the following information: the name of the retiree or qualified beneficiaries requesting coverage, and the qualifying event and the date of the qualifying event. In addition, you may be asked to provide supporting documentation such as a divorce decree or separation agreement.

Otherwise, your covered dependents will not be eligible to elect continued coverage under COBRA.

If a qualified beneficiary experiences a second qualifying event that would entitle him or her to additional months of continuation coverage, he or she must notify the COBRA Administrator. Notice must be provided within 31 days from the date of the second qualifying event (or, if later, the date coverage would normally be lost because of the second qualifying event). In addition, the qualified beneficiary may be asked to provide a copy of a death certificate, divorce decree or separation agreement.

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

**Updating Your Personal Contact Information**

Retirees should update their personal contact information, including mailing address, to receive benefits-related information and correspondence. You can make changes online via My Personal Profile at https://mpp.jpmorganchase.com. You can also call HR Answers. See "Questions?" on page 2 for contact information. This will ensure that information needed to enroll in COBRA is received.

## Choosing COBRA Coverage

Your covered dependents must choose to continue coverage within 60 days after the later of:

- The date coverage would be lost as a result of the qualifying event; or
- The date of the COBRA Enrollment Notice.

Elections must be made during the 60-day period, otherwise the right to continue coverage is waived. Each qualifying beneficiary has an independent right to elect COBRA coverage.

COBRA materials will be sent from the JPMorgan Chase COBRA administrator approximately two weeks following the date they are notified of the qualifying event. These materials will describe the enrollment instructions and time frames for making elections. Eligible individuals will have a period of 60 days from the coverage termination date to elect COBRA. **Important Note:** Eligible individuals must make an election at the time COBRA coverage is offered — it is not automatically provided.

## Premium Due Dates

Qualified beneficiaries who elect to continue coverage under COBRA, must pay the first two premiums (including all premiums due but not paid) within 45 days after making the election. Thereafter, COBRA premiums are due on the first calendar day of the month for that month's coverage, and must be paid within 30 days of each due date. If coverage under COBRA is elected, but premium payments are not made timely (even if a bill is not received), coverage will be terminated retroactively to the time frame applicable to the last payment and will not be reinstated.

## Coverage During the Continuation Period

With respect to the Retiree Medical Plan (including the Prescription Drug coverage), Retiree Dental Plan, and Retiree Vision Plan coverage, your covered dependents may choose to continue the coverage you had as a retiree or they may elect a different option at the time they initially enroll for COBRA coverage. (Because the Retiree Vision Plan has only one option, there is no opportunity to change that coverage if you continue it under COBRA.) In addition, covered dependents may change coverage during the annual benefits enrollment, or a Qualified Status Change.

## COBRA Coverage Costs

If your covered dependents choose to continue coverage under COBRA, they will generally pay the full cost of coverage, plus a 2% administrative fee.

## How Continued Coverage Could End

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

- They do not make the required premium payments for coverage on a timely basis;
- They obtain coverage under another group plan that does not exclude or limit coverage for pre-existing conditions. However, if the new plan does have pre-existing conditions or limits, they can continue COBRA coverage for that specific condition up to the end of their original maximum COBRA period;
- They become eligible for Medicare.
- In the case of an extended disability coverage period, your covered dependent is no longer considered disabled under Social Security guidelines;
- JPMorgan Chase terminates the plan.

## Additional Questions About COBRA Coverage

If you have additional questions about COBRA coverage, or you need to contact the COBRA administrator for any reason, please call or write to:

| Medical Dental and Vision | Health Reimbursement Arrangement |
|---|---|
| HR Answers<br>JPMorgan Chase<br>4041 Ogletown Road<br>Newark, DE 19713<br>(877) JPMChase [(877) 576-2427] or<br>(212) 552-5100 | Via Benefits<br>National Benefit Services<br>3736 Center Park Dr. #120<br>West Jordan, UT 84084<br>(801) 282-1269 |

# Other Important Information

In addition to the details provided on other pages, below you'll find more important information.

Your benefits as a participant in the U.S. Health Care and Insurance Benefits Plans for Retirees are provided under the terms of the Summary Plan Descriptions, 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 Administrators for the JPMorgan Chase U.S. Retiree Benefits Program has any authority to interpret the Summary Plan Descriptions (or official plan documents) or to make any promises to you about them. The Plan Administrator for the JPMorgan Chase U.S. Retiree Benefits Program has complete authority in his or her sole and absolute discretion to construe and interpret the terms of the plans and any underlying policies and/or contracts, including eligibility to participate in the plans.

All decisions of the Plan Administrator for the JPMorgan Chase U.S. Retiree Benefits Program, or their delegates, are final and binding upon all affected parties. The Plan Administrator delegates his or her discretion to interpret the plans to the claims administrators, and to decide claims and appeals, including making factual determinations to the claims administrators and to the Health Care and Insurance Plans Appeals Committee, as described in this Guide.

## No Assignment of Benefits

The plans summarized in this Guide 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 reserves the right to amend, modify, 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 document do not represent vested benefits.

If you have any questions about the Retiree Benefits Program, contact HR Answers.