Your JPMC Benefits Guide

Effective 1/1/21

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

This Guide provides a detailed summary of the Health Care and Insurance Plans for Active Employees of the JPMorgan Chase U.S. Benefits Program. To access the Retirement Savings Plans, you must be on the website at www.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 1/1/21

This Guide serves as the summary plan description (SPD) for the following plans of the JPMorgan Chase U.S. Benefits Program, effective as of January 1, 2021:

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

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

Additional Plan Information

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

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

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

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

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

No Assignment of Benefits

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

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

Right to Amend

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

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

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

Not a Contract of Employment

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

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

What Happens If…

Effective 1/1/21

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

New Dependents Must Be Verified

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

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Qualified Status Changes (QSCs)

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

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

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

If You Have an Event…

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

31-Day Deadline

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

Retroactive Payroll Contribution Changes

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

QSCs for Health Benefits — Medical, Dental, Vision

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

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

*QSCs for Spending Accounts**

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

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

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

QSCs for Supplemental Term Life Insurance Benefits

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

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

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

You Get Married

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

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

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

You Have or Adopt a Child or Become a Legal Guardian

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

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

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

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

A Covered Dependent Becomes Ineligible

If your dependent becomes ineligible (such as when a dependent child reaches age 26, for health care coverage), the dependent's coverage will end on the last day of the month in which he or she no longer meets the eligibility requirements. For Supplemental Term Life and AD&D, once your dependent is no longer eligible, it is your responsibility to remove the dependent from your coverage.

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

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

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

You and/or Your Dependents Lose Other Coverage

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

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

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

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

You and/or Your Dependents Gain Other Coverage

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

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

You Move

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

You Divorce, Separate or Terminate a Domestic Partner Relationship

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

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

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

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

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

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

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

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

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

You Pass Away

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

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

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

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

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

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

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

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

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

Other Events or Changes

Change in Scheduled Work Hours

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

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

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

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

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

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

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

- **For the Basic Life Insurance Plan, Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan:** Your coverage and eligibility will end on the date of your status change and you are then scheduled to work less than 20 hours per week. For more information on when you increase work hours to more than 20 hours, please see the *Life and Accident Insurance* section.
  - — You can convert your basic life insurance to an individual policy within 31 days of your status change date by contacting MetLife, the claims administrator, for a conversion application.
  - — You can port or convert your employee supplemental term life insurance and/or port your AD&D — up to the lesser of five times your eligible compensation or $1 million — through a direct billing arrangement with MetLife. Contact MetLife, the claims administrator, within 31 days of your change in status. If you port your coverage, you may also port dependent coverage. For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

- **For the Business Travel Accident Insurance Plan,** you remain eligible for coverage regardless of your scheduled work hours, if you are otherwise eligible for coverage.

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

- **Your Group Legal Services Plan coverage** will end on the date your work status changes and you are then scheduled to work fewer than 20 hours per week. However, you can continue coverage for additional 12 months by contacting the MetLife Legal Group.
- **Your Group Personal Excess Liability Insurance Plan coverage** will end on the date your work status changes and you are then scheduled to work fewer than 20 hours per week. However, you may continue coverage through the end of year by contacting Arthur J. Gallagher Risk Management.

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

You Go on Short-Term Disability Leave

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

- **For the Medical Plan, the Dental Plan, the Vision Plan, the Health & Wellness Centers Plan, the Group Legal Services Plan, and the Group Personal Excess Liability Insurance Plan:** For the approved period of your disability leave, you'll remain eligible to be covered under the Medical Plan, the Dental Plan, the Vision Plan, the Health & Wellness Centers Plan, the Group Legal Services Plan, and the Group Personal Excess Liability Insurance Plan, and you will remain eligible to participate in the Health Care Spending Account. JPMorgan Chase will deduct any required contributions for medical coverage from the pay you receive during this period on a before-tax basis for the health care plans and the Health Care Spending Account and on an after-tax basis for the Group Legal Services Plan and the Group Personal Excess Liability Insurance Plan.
  - This medical and dental coverage continuation includes expatriate medical and dental coverage. If you are not receiving pay via Expat Payroll during your leave, JPMorgan Chase will bill you directly for any required contributions.
- **For the Dependent Care Spending Account**, your participation is suspended during a period of paid or unpaid leave.
- **For the Transportation Spending Account**, your participation is terminated during a period of paid or unpaid leave and any unused credits in your account(s) will be forfeited if you do not return to work and reenroll in the Transportation Spending Account. If you know you will be going on a leave, you should change your contribution amount to zero approximately one month before your leave begins in order to avoid forfeiting any contributions. Expenses incurred after your leave begins will not be eligible for reimbursement or payment from your account(s). If you wish to continue participation after you return to active service, you must re-enroll. However if you participated in the "Pay Me Back" option, you have 180 days following the end of any particular benefit month you participated in the program to file claims for reimbursement from your "Pay Me Back" account.
- **For the Basic Life Insurance Plan, Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan:** For the approved period of your disability leave, you'll remain eligible to be covered under the Basic Life Insurance Plan (including Identity Theft (ID) Assistance Program, Travel Assistance and Emergency Evacuation services, funeral concierge services, and SurvivorSupport® financial counseling services), Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan.
  - In the case of the Basic Life Insurance Plan, your eligible compensation is updated as changes occur throughout the year.
- **For the Business Travel Accident Insurance Plan:** While you are on disability leave, your business travel accident insurance will be suspended.

You Go on Long-Term Disability

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

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

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

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

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

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

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

Please Note: If you became disabled before January 1, 2011**,** your coverage will continue at active employee rates while you receive benefits under the Long-Term Disability Plan. If you do not make the required contributions to continue your coverage, your coverage will be canceled.

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

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

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

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

You Are on LTD and Become Eligible for Medicare

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

You Become Eligible for Medicare

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

You Go on a Military Leave

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

Paid Military Leave

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

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

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

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

Unpaid Military Leave

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

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

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

Making Contributions While on Unpaid Leave

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

You 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 when you return to work.

Special Rules for Health Care Spending Account

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

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

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

You Go on Unpaid Leave

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

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

For the Health Care Spending and Dependent Care Spending Accounts: During an approved unpaid leave of absence, you may continue to make monthly contributions to the Health Care Spending Account on an after-tax basis, via your benefits invoice. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on a leave and you may not receive reimbursement for any health care expenses you incur after your coverage terminated. You may not make contributions to a Dependent Care Spending Account during an unpaid leave. For the Dependent Care Spending Account, you may use your account balance only for eligible expenses incurred prior to the date of your approval to go on unpaid leave, and must 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.
- If your TACC is equal to or greater than $60,000, generally, you have to re-enroll for LTD coverage within 31 days of your return from your leave, and you may be required to provide evidence of insurability (EOI). Your coverage will resume on the first pay cycle after EOI is approved. If you don't re-enroll within 31-days, your next opportunity to enroll will be Annual Benefits Enrollment. Contact HR Answers for specific questions.
  - If you are on an approved medical leave, your LTD coverage remains in effect throughout your leave
  - If you are on a paid parental leave, your LTD coverage ends after 16 weeks
  - If you are on an unpaid leave, your LTD coverage ends after 16 weeks
  - If you are on any other type of nonmedical, paid or unpaid leave, coverage ends after 16 weeks

Total Annual Cash Compensation (TACC)

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

You Leave JPMorgan Chase

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

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

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

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

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

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

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

If You Port or Convert

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

- **For Supplemental Term Life**, within 31 days of your termination date, you have the option to convert your employee and/or dependent life insurance coverage to an individual life policy or port that coverage following your termination of employment as follows:

  — Employee Supplemental Life Insurance:

  - You may convert the coverage to an individual policy; OR
  - You may port the lesser of your total life insurance in effect at date of termination or up to $2 million (in increments of $25,000)
  - You must provide MetLife evidence of insurability for the additional coverage amount
  - If you are already at the $2 million maximum you may not increase your coverage.

— Dependent Spouse Supplemental Life Insurance:

- You may convert the coverage to an individual policy; OR
- You may port the minimum of $2,500 ($10,000 when porting Dependent Spouse life insurance alone) to a maximum of the lesser of your total dependent spouse life insurance in effect at date of termination, or $300,000.

— Dependent Child Supplemental Life Insurance:

- You may convert the coverage to an individual policy; OR
- You may port your dependent child supplemental life insurance coverage at a minimum of $1,000 to a maximum of the lesser of the total amount in effect at the date of termination or $20,000.

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

Porting Versus Converting Insurance Policies

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

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

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

For the Group Personal Excess Liability Plan, if your employment with JPMorgan Chase terminates, participation for you and your covered dependents usually ends on your termination date. While you cannot convert or port your coverage, you may continue your current coverage through the end of the calendar year by paying the balance of the remaining premium in full directly to Arthur J. Gallagher Risk Management Services.

Your Expatriate Assignment Ends

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

You Retire from JPMorgan Chase

For medical, dental, and vision coverage: You need to meet minimum age and service requirements at the time of retirement to be eligible for retiree medical and dental coverage. For vision coverage, you may enroll for retiree vision coverage even if you were not covered under the Vision Plan at the time of your retirement.

- **For expatriate medical and dental coverage**, you must be a U.S. home-based expatriate employee and meet minimum age and service requirements and have active medical coverage at the time of retirement to be eligible for U.S. retiree medical coverage.
- For more information, please see the **As You Leave Guide** on **me@jpmc**.

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

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

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

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

- **Retiree Life Insurance Coverage may be available.** You need to meet minimum age and service requirements at the time of retirement to be eligible for retiree medical and dental coverage. For details on the eligibility requirements, please see the **As You Leave Guide** on **me@jpmc**.

- **For Basic Life**, upon receipt of the MetLife conversion package at your home mailing address, and within 31 days of your retirement date, you may convert any portion of your Basic Life Insurance (over the first $10,000) to an individual policy by contacting Metropolitan Life Insurance Company (MetLife), the plan administrator. Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will be able to address any questions on how much to convert to an individual policy. MetLife will bill you directly after you retire.

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

You Work Past Age 65

For the spending accounts: If you continue to work for JPMorgan Chase after you reach age 65, you can continue participating in the spending accounts, as long as you meet all the other eligibility requirements to participate.

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

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

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

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

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

Health Care Benefits

Effective 1/1/21

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

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

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

How This Section Is Organized

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

- The Medical Plan (including prescription drugs, the Medical Reimbursement Account (MRA), the U.S. Fertility Benefits Program, and wellness benefits);
  - For eligible employees in the United States, the plan has two options: the Simplified Medical Plan for employees in Arizona and Ohio and the Core Medical Plan for all other U.S. employees.
- The Dental Plan; and
- The Vision Plan.

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

COBRA Continuation

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

Health Care Participation

Effective 1/1/21

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

Be Sure to See *What Happens If…*

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

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

About This Summary

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

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

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

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Who's Eligible?

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

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

Who's Not Eligible

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

Examples of such individuals include an:

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

When You Become Eligible

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

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

Eligible Dependents

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

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

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

* Newly hired employees wishing to enroll their disabled dependent who is over the age of 26 in the medical plan can do so by contacting HR Answers for assistance in completing the disabled dependent enrollment process.

Please Note: You may continue coverage beyond age 26 for an unmarried child who is enrolled at the time of turning age 26 in that benefit and is deemed unable to support himself or herself because of a mental or physical disability that began before age 26 and who depends on you for financial support. Contact your health care company* for more information and specific requirements before your dependent turns 26. To continue coverage for a disabled dependent, that dependent must be enrolled in the Plan prior to turning age 26.

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

Important Note on Dependent Eligibility

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

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

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

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

Spouse

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

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

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

Children

"Children" include the following:

- Your natural children;
- Your stepchildren (children of your current spouse);
- Children of your domestic partner (if your domestic partner is also enrolled in the Plan);
  - If you are covering the child of a domestic partner who is not your tax dependent, imputed income for that child will be applied.

- Your legally adopted children;
- Your foster children;
- Children under your legal guardianship (as established by a court order) whom you claim on your income tax return as dependents or for whom you provide more than 50% of their financial support;
- A child under age 18 who lives with you and 1) for whom adoption proceedings have already begun, and 2) whom you have the legal obligation to support (in whole or in part);
- Children who are alternate recipients under a Qualified Medical Child Support Order (QMCSO), as required by law; and
- A disabled child dependent who is over age 26 and meets the following criteria:
  - Is an unmarried, eligible child dependent
  - Is deemed not capable of supporting themselves due to a mental or physical disability that began prior to age 26
  - Is dependent on the employee for financial support
  - Is enrolled in the JPMC Medical plan prior to turning 26 or is the dependent of a newly hired employee who has enrolled in the Medical Plan during their new hire enrollment period

Domestic Partners

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

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

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

OR

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

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

Please Note: If you are covering a domestic partner who is not a tax dependent, imputed income for that domestic partner will be applied. Information about domestic partner coverage and the various tax consequences can be found on **My Health >Benefits Enrollment > 2021 U.S. Benefits Resources** > Covering a Domestic Partner Tip Sheet.

Qualified Medical Child Support Orders

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

Enrolling

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

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

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

Elections a la Carte!

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

Medical and Dental Plan Options

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

The Medical Plan

The Dental Plan

Coverage Levels

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

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

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

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

An Important Note on Dependent Coverage

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

Tax Treatment of Domestic Partner Coverage

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

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

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

Enrolling a Domestic Partner

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

How to Enroll

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

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

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

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

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

Enrolling if You Are an Employee

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

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

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

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

Enrolling if You Are a Newly Hired Employee

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

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

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

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

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

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

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

If You Do *Not* Enroll

Coverage if You Do Not Enroll and You Are an Employee

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

Re-enrollment May Differ for Other Plans

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

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

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

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

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

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

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

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

When Coverage Begins

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

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

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

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

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

When Payroll Contributions Begin

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

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

Retroactive Contributions as Necessary

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

Changing Your Coverage Midyear

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

Important Note About Providers Leaving Networks

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

Qualified Events

Qualified Status Changes (QSCs) include:

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

Making the Changes

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

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

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

Allowable Changes

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

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

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner ("DP") Child
Marriage	Add	Add	Add
Domestic Partner Commitment	Add	Add	Add
Divorce, Legal Separation, or termination of DP commitment	Add	Drop	Drop
Death of Spouse/DP	Add*	Drop	Drop
Birth/Adoption/Legal Guardianship	Add	Add	Add
Child Gains Eligibility	Add	Add	Add
DP's Child becomes eligible	Add	Add	Add
Child Gains Eligibility due to QMCSO	Add	N/A	Add
Child/DP child no longer eligible	N/A	N/A	Drop
Death of Child/DP child	N/A	N/A	Drop
You or covered dependent gains other coverage	Drop/reduce # 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
If you are enrolled in the Simplified and move out of AZ or OH	You will remain in the Simplified plan for the rest of the calendar year. You will be offered the appropriate Medical plan options during the next Annual Enrollment	You will remain in the Simplified plan for the rest of the calendar year. You will be offered the appropriate Medical plan options during the next Annual Enrollment	You will remain in the Simplified plan for the rest of the calendar year. You will be offered the appropriate Medical plan options during the next Annual Enrollment

* Call HR Answers

HIPAA Special Enrollment Rights

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

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

- You and/or your eligible dependents lose other health care coverage because you no longer meet the eligibility requirements (because of legal separation, divorce, death, termination of employment, or reduced work hours);
- If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption (90 days for birth/adoption). If you are eligible for coverage but do not enroll, your dependent cannot enroll;
- Employer contributions for other coverage ends; or
- The other coverage was provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the COBRA coverage period ends.

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

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

When Coverage Ends

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

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

When Dependent Coverage Ends

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

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

Continuing Health Coverage Under COBRA

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

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

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

COBRA coverage applies to the:

- The Medical Plan, including the Prescription Drug Plan, the MRA (see "The MRA and COBRA" on page 46 for more information), Wellness Screenings at your doctor's office or qualifying labs and Tobacco Cessation program;
- Dental Plan;
- Vision Plan;
- Health Care Spending Account (through the end of the year in which the qualifying event occurs); and
- Onsite Health and Wellness Centers access, wellness screenings, tobacco cessation program and Employee Assistance Program as a bundled election, even if not electing any other benefits under COBRA.

What's Included with COBRA Medical Plan Coverage

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

- The Medical Plan which you were enrolled in as an active employee, including the Prescription Drug Plan and the MRA (see "The MRA and COBRA" on page 46 for more information);
- Wellness Screenings at your doctor's office or qualifying labs; and
- Tobacco cessation program.

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

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

If you elect COBRA coverage for these services, you are eligible to earn Wellness Rewards (a taxable incentive payable through payroll) by completing the Initial Wellness Activity(ies) during the annual designated timeframe. This maximum amount of Initial Wellness Rewards you can earn is determined by your Medical Plan eligibility: JPMC Core Medical Plan $200, JPMC Simplified Medical Plan $100. Additionally, your covered spouse/domestic partner is not eligible to earn any Additional Wellness Activities.

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

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

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

Qualified Beneficiary

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

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

Qualifying Events

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

- **If Your Employment Terminates or Your Work Hours Are Reduced.** If you lose coverage because your employment terminates (for any reason other than gross misconduct) or your work hours are reduced, you and/or your covered dependents may purchase COBRA coverage for up to 18 months. Certain events may extend this 18-month COBRA continuation period:
  - If your covered dependents experience any second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).

- If you become eligible for Medicare while employed (even if this is not a qualifying event for your covered dependents because they do not lose coverage) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your covered dependents may elect COBRA continuation for up to 36 months from the date that you become eligible for Medicare.

- **If Your Covered Dependents Lose Coverage.** If your spouse and/or your dependent children lose coverage because of any of the circumstances listed below, they may purchase COBRA coverage for up to 36 months from the date that coverage ends because:
  - You pass away;
  - You divorce your spouse or become legally separated;
  - You become eligible for Medicare; or
  - Your dependent child loses dependent eligibility status under the terms of the plan (for example, the end of the month in which your dependent child reaches age 26).
- **If You or Your Covered Dependents Become Disabled.** If you or one of your covered dependents becomes disabled under the Social Security Administration guidelines within 60 days of a qualifying event, or you are disabled at the time COBRA coverage is initially offered, you and your covered dependents may continue COBRA coverage for an additional 11 months beyond the initial 18 months, to a total of 29 months. You must notify HR Answers, the COBRA Administrator, within 60 days after Social Security issues a determination of disability status and before the initial 18-month COBRA coverage period ends. You also must notify the COBRA Administrator within 30 days after Social Security determines the end of disability status for you or your covered dependent.

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

Continuation Coverage for a Domestic Partner Dependent

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

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

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

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

Giving Notice of a COBRA Qualifying Event

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

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

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

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

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

Updating Your Personal Contact Information

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

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.

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

Choosing COBRA Coverage

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

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

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

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

Premium Due Dates

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

Coverage During the Continuation Period

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

COBRA Coverage Costs

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

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

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

Company-Subsidized COBRA Coverage

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

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

How Continued Coverage Could End

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

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

The MRA and COBRA

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

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

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

If you do not enroll in COBRA medical coverage, you cannot earn additional Wellness Rewards beyond your termination of employment. You can use your existing MRA funds to pay for out-of-pocket costs incurred prior to the end of the month of your termination date. For example, if you terminate as of January 5, 2021, any out-of-pocket medical and prescription drug expenses incurred through January 31, 2021, are eligible, but you must submit an MRA Claim Form by December 31, 2022, to receive a reimbursement. Any remaining MRA balance will be forfeited (unless you are retirement eligible in which case the balance remains intact and can be used to offset medical and prescription drug expenses until the account is depleted; administrative fees may be incurred).

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

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

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

Special Rule for Health Care Spending Account Participants

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

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

Additional Questions About COBRA Coverage

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

Defined Terms

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

Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical, Dental, Vision and Spending Accounts Plans payroll contributions are generally taken on a before-tax basis.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Medical, Dental and Vision Plans. JPMorgan Chase is not involved in deciding appeals for any benefit claim denied under the Medical, Dental and Vision Plans. All fiduciary responsibility and decisions regarding a claim for a denied benefit under the Plan rest solely with the claims administrator. **Please Note**: Claims and appeals relating to eligibility to participate in the Medical, Dental and Vision Plans are decided by the plan administrator. Consult the *Plan Administration* section for details.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise end. This *Health Care Participation* section provides details on COBRA coverage. Publications 502, 503 and 15B are Internal Revenue Service (IRS) publications that can be used as a guide to determine eligible and ineligible expenses under the Health Care Spending Account, Dependent Care Spending Account and Transportation Spending Accounts. You can request a copy by calling the Internal Revenue Service (IRS) at (800) 829-FORM ((800) 829-3676), or you can view these publications by logging on to www.irs.gov.
Medical Reimbursement Account	A Medical Reimbursement Account ("MRA," also known as a Health Reimbursement Account" or "HRA") is a tax-free account established on your behalf at your health care company when you enroll in the Medical Plan. You (and your covered spouse/domestic partner) can earn Wellness Rewards for your MRA by completing Initial Wellness Activities and Additional Wellness Activities. This account is JPMC-funded only; you cannot contribute to your MRA. You can use the funds in your MRA to pay for eligible out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments).

Medicare	Medicare is Health Insurance for the Aged and Disabled provisions of Title XVIII of the Social Security Act of the United States, as enacted or later amended. Coverage is available to most U.S. residents age 65 and older, those with a disability for at least 29 months, and those with end-stage renal disease (ESRD). Generally, Medicare is the primary coverage for individuals who are age 65 and older, unless those individuals are actively working.
Qualified Status Change	The JPMorgan Chase benefits you elect during each Annual Benefits Enrollment will generally stay in effect throughout the plan year, unless you elect otherwise, because of a Qualified Status Change (QSC). If you have a QSC, you have 31 days from the qualifying event to make benefits changes; 90 days from the qualifying event if the event is the birth or adoption of a child. The benefits you elect will be effective the date of the event if you make the elections timely. (**Please Note:** You will have 90 days from the QSC date to add any newly eligible dependents to the Medical Plan, should that dependent pass away within this 90-day period.) **Please Note:** Regardless of whether you experience a qualified change in status, you cannot change your health care company during the year.

The Core Medical Plan

Effective 1/1/21

In addition to providing coverage in the event of illness, the Core Medical Plan (also referred to Medical Plan throughout this document) offers full coverage for eligible preventive care and eligible preventive generic prescription drugs, along with an integrated Wellness Program to help you and your family stay healthy and a Medical Reimbursement Account (MRA) to help you pay for eligible out-of-pocket costs. You can earn funds for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in wellness activities.

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

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

About this Summary Plan Description

This section is the summary plan description (SPD) and the plan document for the Core Medical Plan. Please retain this section for your records. Other sections may also constitute the complete SPD/plan document, including the *Plan Administration* and the *Health Care Participation* sections.

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.

Two Options

The Medical Plan offers two “Consumer Driven Health Plan” options, and you choose whether your coverage is provided through Aetna or Cigna. Both options offer the same coverage for medically necessary services and supplies, including prescription drugs. The key difference between the two options is the level of payroll contributions versus deductibles and coinsurance maximums.

Here’s how the two Medical Plan options compare:

- Option 1 — Higher medical payroll contributions; lower annual deductibles and annual coinsurance maximums.
- Option 2 — Lower medical payroll contributions; higher annual deductibles and annual coinsurance maximums.

Both Aetna and Cigna have networks of selected health care providers, and you are strongly encouraged to go to in-network providers, as this saves both you and the Medical Plan money. However, you have the option to use out-of-network providers if you choose. The Prescription Drug Plan is part of the Medical Plan and is administered by CVS Caremark — regardless of which option or health care company you choose.

The Medical Reimbursement Account

When you enroll in Option 1 or Option 2 through Aetna or Cigna, you will automatically be set up with a Medical Reimbursement Account (MRA). The MRA is a company-funded account that you can use to help pay for eligible out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments). You can earn Wellness Rewards for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in certain wellness activities.

For Eligible U.S. Employees in Arizona and Ohio, the Simplified Medical Plan

If you are an eligible U.S. employee living in Arizona or Ohio, your JPMorgan Chase medical coverage is available via the Simplified Medical Plan, not the Core Medical Plan. For details, see the Simplified Medical Plan overview.

Our Health Care Companies

JPMorgan Chase has selected Aetna and Cigna to administer our Medical Plan. Both are large, established companies that offer broad nationwide provider networks.

They also offer strong, well-established clinical programs and provide tools and resources to help you research and understand your health treatment alternatives. You can choose to have one of these health care companies administer your Medical Plan, regardless of whether you choose Option 1 or Option 2.

Provider Directories

You can easily check which health care providers participate in the various JPMorgan Chase Medical Plan options by accessing your health care company's website at **My Health**.

Please Note: You should always check with your health care provider to ensure that he or she plans to continue participating in the network of the Medical Plan option you choose. **If your health care provider decides to leave the network, it does not qualify as an event that allows you to change your health care company during the year.**

Questions?

For questions or concerns regarding the Medical Plan, please contact your health care company (Aetna or Cigna) or the prescription drug plan administrator, CVS Caremark:

Aetna
(800) 468-1266
8 a.m. to 8 p.m. all times zones

Cigna
(800) 790-3086
24/7

CVS Caremark
(866) 209-6093
24/7

For additional specialty 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 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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Medical Coverage Highlights

My Health

My Health is your central internal online resource for our health care plans. From **My Health**, you can easily connect to the Medical Plan carriers' websites to find in-network provider directories, access treatment cost estimators, check claims status, view Explanations of Benefits (EOBs), track your Medical Reimbursement Account balance, access your electronic ID card and much more. **My Health** also has benefits materials, tip sheets and other information on health and wellness.

Your Medical Plan Options

Option 1 and Option 2 of the Medical Plan, each offered through Aetna and Cigna, are "Consumer Driven Health Plan" options. Both options cover the same medically necessary services and supplies, including prescription drugs and pre-existing conditions.

However, Option 1 has higher payroll contributions but generally lower annual deductibles and annual coinsurance maximums, while Option 2 has lower payroll contributions but generally higher annual deductibles and annual coinsurance maximums.

Option 1 and Option 2 benefits are offered through a network of participating health care providers (for example, doctors, hospitals, labs, and outpatient facilities that belong to Aetna and Cigna's networks). You can visit any provider each time you need care, even if it's not in the network. However, the most cost-effective care will always be available through in-network providers who have agreed to accept pre-negotiated rates.

- Eligible in-network preventive care (including physical exams and recommended preventive screenings) and eligible preventive generic drugs are covered at 100% with no deductible, coinsurance, or copayments.
- **Important**: In-network primary care office visits are covered at 90% with no deductible. Primary care physicians include doctors who practice family medicine, internal medicine (and are contracted with Aetna or Cigna as Primary Care Physicians), obstetricians/gynecologists, and pediatricians. Visits to convenience care clinics, such as CVS Minute Clinic®, are also considered primary care visits.
- Virtual doctor visits provide on-demand 24/7/365 access to non-urgent primary care services at 90% with no deductible through a national network of licensed, board-certified, U.S.-based doctors, including pediatricians. Virtual doctor visits with mental health providers are covered at 80% after the deductible.
- When you receive non-primary care medical services, you'll need to satisfy an annual deductible — a set amount that you pay out-of-pocket — before the Plan shares in the cost for care. There are separate deductibles for in- and out-of-network care and for prescription drugs.
- After you satisfy the deductible, the Plan pays a percentage (generally 80% in-network and 50% out-of-network) of the cost. Your share — called coinsurance, the amount you and the Plan pay for certain expenses — after the deductible is typically 20% of the cost of in-network care and 50% of the cost for out-of-network care. The amount of coinsurance you have to pay each year is limited by separate annual in-network and out-of-network coinsurance maximums, which act as a financial "safety net." In-network charges do not apply toward the out-of-network deductible or coinsurance maximum — and vice versa. Benefits for out-of-network care are limited to reasonable and customary (R&C) charges. These charges are based on average claims data in your area and are determined by your health care company to be appropriate fees. Out-of-network charges are typically higher than the pre-negotiated rates for in-network care. You are responsible for paying any amount above R&C charges.
- If you see an in-network provider, you will generally not have to pay anything at the point of service, and you will not have to file a claim. Your provider will typically submit your claim electronically to your health care company using the information on your ID card.
- Prescription drug benefits are part of your coverage. The Prescription Drug Plan has a different plan design than other Medical Plan features and is subject to a separate deductible and a separate safety net in the form of per-prescription maximums and an annual out-of-pocket maximum.

Your Coverage Level	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).
Contribution Rates	Contribution rates vary by the types of dependent whom you choose to cover — for example, 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 meet eligibility requirements.) Contributions will also vary based on your Total Annual Cash Compensation, geographical location, the Medical Plan option you select, you and your covered spouse's/domestic partner's tobacco user status, and you and your covered spouse's/domestic partner's Initial Wellness completion status. The amount you pay does not differ depending on whether you choose Aetna or Cigna as your health care company.
Covered Services	Covered services will generally include: ▪ Hospitalization; ▪ Surgical procedures; ▪ Physician's office visits; ▪ Lab services/X-rays; ▪ Emergency room services; ▪ Maternity care; ▪ Mental health and substance abuse care; and ▪ Prescription drugs. The Medical Plan also covers various preventive care services. Services and procedures must be considered medically necessary to be covered.
Resources	Resources to help you make health care decisions include: ▪ NurseLine; ▪ Expert Medical Advice; ▪ Health Advocate; ▪ Condition Management; ▪ Treatment Decision Support; and ▪ Maternity Support Program.

Medical Plan Options

The Medical Plan, a "consumer driven health plan" provides two options — Option 1 and Option 2 — offered through Aetna and Cigna. Both options cover the same medically necessary services and supplies, including prescription drugs.

Here's how the two Medical Plan options compare:

- Option 1 — Higher medical payroll contributions; lower annual deductibles and annual coinsurance maximums.
- Option 2 — Lower medical payroll contributions; higher annual deductibles and annual coinsurance maximums.

JPMorgan Chase uses a "flat-dollar subsidy" approach, which means that JPMorgan Chase will generally contribute the same dollar amount (or "subsidy") to the cost of your coverage regardless of which Medical Plan option you choose.

Cost of Coverage

You and JPMorgan Chase share the cost of coverage under each of the Medical Plan options. You pay for coverage through payroll contributions with before-tax dollars.

The amount you pay via payroll contributions depends on several factors:

- The Medical Plan option you choose (described under "Medical Plan Option" on page 54);
- The number and type of eligible dependents you cover (described under "Eligible Dependents" in the *Health Care Participation* section;
- The level of your Total Annual Cash Compensation (see "Total Annual Cash Compensation" on page 56);
- You and your covered spouse's/domestic partner's Initial Wellness Activity completion status (see "Initial Wellness Activity (New Activity for 2021; Applies to Wellness Activity Completed in 2020)" on page 61);
- Your and/or your covered spouse's/domestic partner's tobacco user status (see "Tobacco User Status" on page 57), and
- Your regional cost category (geographic location) (see "Regional Cost Categories" on page 57).

If you cover your children, 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 meet eligibility requirements).

The amount you pay does not differ depending on whether you choose Aetna or Cigna as your health care company.

You will have a higher cost for coverage if your Total Annual Cash Compensation (TACC) is higher, you elect Option 1, you cover more dependents, you and/or your covered spouse/domestic partner are a tobacco user, you and/or your covered spouse/domestic partner do not complete the Initial Wellness Activity and/or costs in your geographic area are higher than average.

Tax Treatment of Domestic Partner Coverage/Gross-Up Policy

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 medical 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.

Enrolling a Domestic Partner

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

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

Total Annual Cash Compensation

Under the Medical Plan, Total Annual Cash Compensation (TACC) is used to determine your Medical Plan contribution pay tier, the annual deductible and the annual coinsurance maximum.

Your TACC is:

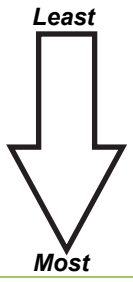
- Your annual rate of base salary plus applicable job differential pay (for example, shift pay) as of each August 1, plus
- Any cash earnings from any incentive plans (for example, annual incentive compensation, commissions, draws, overrides, and special recognition payments or incentives) that are paid to or deferred by you for the previous 12-month period ending each July 31.
- Overtime is not included.

For purposes of determining the Medical Plan contribution pay tier that applies to you, your TACC is recalculated as of each August 1 to take effect the next January 1 and will remain unchanged throughout the year. For most employees hired on or after August 1, TACC will be equal to base salary plus job differentials.

Separate definitions may apply to employees in certain positions who are paid on a draw-and-commission basis. If this situation applies to you, you will be notified by your Line of Business.

Your TACC in effect for the plan year is available on the Benefits Web Center via **My Health.**

Please Note: Your TACC is measured as of August 1 and remains unchanged for purposes of determining Medical Plan contributions and the coinsurance maximum for the next calendar year.

Tier	Total Annual Cash Compensation	Employee Pays
1	< $45,000	
2	$45,000–$59,999	
3	$60,000–$79,999	
4	$80,000–$149,999	
5	$150,000–$249,999	
6	$250,000–$349,999	
7	$350,000 and above	

Initial Wellness Activity

By completing the Initial Wellness Activity during the annual specified time frame, you can save $500 in your annual medical payroll contributions. If you cover your spouse/domestic partner, you can save an additional $500 if your spouse/domestic partner also completes their Initial Wellness Activity during the annual specified time frame. In addition to savings on medical payroll contributions, timely completion of this activity will also earn employees Wellness Rewards in their Medical Reimbursement Account (MRA). There are special provisions for newly eligible members or employees on a leave of absence. For the 2021 plan year, the Initial Wellness Activity is the online Wellness Assessment only. Please see “Initial Wellness Activity (New Activity for 2021; Applies to Wellness Activity Completed in 2020)” on page 61 for more information about the 2021 Initial Wellness Activity and other ways to earn Wellness Rewards for your MRA.

Tobacco User Status

Employees and their covered spouses/domestic partners who do not use tobacco products pay less for medical coverage. Each year, employees must verify their status as a non-tobacco user or tobacco user, as well as the status of their covered spouse/domestic partner. To be considered a non-tobacco user and pay lower, non-tobacco user rates under the Medical Plan for a plan year, you and/or your covered spouse/domestic partner must either:

- Be tobacco-free for at least 12 months as of January 1 of that plan year; or
- Complete an approved tobacco cessation program.

If you continue to use tobacco, you will need to complete the Quit for Life tobacco cessation program offered free of charge by JPMorgan Chase annually to continue to qualify for the lower, non-tobacco user rates. If you and/or your covered spouse/domestic partner meet the definition of a tobacco user but fail to declare your tobacco user status, you may be subject to disciplinary action.

Please Note: In your first calendar year of employment, you will be assigned non-tobacco user rates for you and your covered spouse's/domestic partner's coverage. This assignment applies even if you declare yourself and/or your covered spouse/domestic partner as tobacco users, because you may not have had an opportunity to complete a tobacco cessation course to qualify for the lower non-tobacco user rates. In subsequent years, however, you will be eligible for non-tobacco user rates only if you have been tobacco-free for 12 months (as of January 1) or if you complete the Quit for Life tobacco cessation program, as described in the preceding paragraph.

If you were hired on or after September 1, for the current plan year and in the next plan year, you will be assigned non-tobacco user rates for you and your covered spouse's/domestic partner's coverage even if you declare yourself and/or your covered spouse/domestic partner as a tobacco user. This assignment applies because you may not have had an opportunity to complete a tobacco cessation program to qualify for the lower non-tobacco user rates.

You'll receive more information about the opportunity to update your tobacco user status during each Annual Benefits Enrollment.

For more information on the Tobacco Cessation Program, go to **My Health**.

How Tobacco User Is Defined

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

Regional Cost Categories

Costs for medical care differ across the United States. To ensure equity in how the Medical Plan options are priced, JPMorgan Chase applies the concept of geographic cost differences to the Medical Plan. Under the Plan, each state or region is assigned to a "Regional Cost Category" based on the cost of health care for that region in relation to the national average.

The Regional Cost Category for your home state or region will be a factor in determining your medical payroll contributions, along with the other factors described in "Cost of Coverage" on page 55.

The following chart shows the different Regional Cost Categories for Medical Plan coverage (categories are the same for Option 1 and Option 2).

Regional Cost Category*	Locations
Category 1 (lowest cost category)	California; Colorado; Evansville and Jeffersonville, Indiana; Kansas; Nebraska; New York (excluding Metro New York); Utah; Washington
Category 2	Arizona; Arkansas; Delaware; Georgia; Illinois (excluding Chicago); Iowa; Kentucky; Maryland; Missouri; Nevada; North Carolina; Oklahoma; Oregon; Pennsylvania; South Carolina; Austin and San Antonio, Texas; Virginia; Washington, D.C.
Category 3	Alabama; Alaska; Florida; Hawaii; Idaho; Chicago, Illinois; Gary, Indiana; Maine; Massachusetts; Michigan; Minnesota; Mississippi; Montana; New Hampshire; New Mexico; North Dakota; Ohio; Rhode Island; South Dakota; Tennessee; Houston, Texas; Vermont; Wyoming
Category 4	Connecticut; Indiana (excluding Evansville, Gary and Jeffersonville); New Jersey; Metro New York; Dallas, Texas
Category 5 (highest cost category)	Louisiana; West Virginia; Wisconsin

*Category numbers range from 1-5 (with 1 being the lowest cost; and 5 being the highest cost)

The Medical Reimbursement Account (MRA) and Wellness

The Medical Plan includes a health reimbursement account, which we call the Medical Reimbursement Account (MRA). This tax-free account will automatically be established on your behalf at your health care company — Aetna or Cigna. Your MRA is completely company-funded; you are not permitted to contribute.

To Check Your MRA Balance

Go to **My Health** > My MRA Balance.

You can earn funds, called Wellness Rewards, for your MRA when you take action for your health by completing certain wellness activities. You can also earn Wellness Rewards for your MRA when your covered spouse/domestic partner also completes certain wellness activities.

Wellness Rewards are available through the Wellness Program, which gives you and your covered spouse/domestic partner ways to get and stay healthy. The program provides tailored, personal support to help you make educated health care decisions when you need treatment. In addition to earning Wellness Rewards, you can also save money on your medical payroll contributions by completing the Initial Wellness Activity See “Wellness Activities within the MRA” on page 59 for more information.

You can access all the Wellness Program offerings easily through **My Health > Wellness Activities & Services** or by calling your health care company.

The MRA

You can use the MRA to help pay for covered out-of-pocket medical and prescription drug expenses, such as deductibles, coinsurance, and copayments incurred by you and your covered dependents. **Please Note:** MRA funds cannot be used to pay for dental or vision expenses. However, you can be reimbursed for these expenses from a Health Care Spending Account (HCSA), if you choose to participate in that plan. Please see the *Spending Accounts* Summary Plan Description on **My Health** for more information.

Unused funds left in your MRA at year-end automatically carry over for use in future years, as long as:

- You remain a JPMorgan Chase employee enrolled in the Medical Plan*; or
- You leave JPMorgan Chase and you are eligible for retiree medical plan coverage or you elect to continue your medical coverage through COBRA (see "What Happens to Your MRA If Your Employment with JPMorgan Chase Ends" on page 66).

* If you are an active employee who previously enrolled in the Medical Plan and had an MRA balance but you currently choose not enroll in the Medical Plan, any unused MRA funds will be placed on hold for you by your health care company and will be available to you if you re-enroll in the Medical Plan in a subsequent year.

You can earn up to $1,000 ($1,400 if your covered spouse/domestic partner also participates) in Wellness Rewards for your MRA by completing certain wellness activities in a given year. The following sections summarize the opportunities for 2021 to earn Wellness Rewards.

See "MRA Payment Elections" on page 65 and "Using Your MRA and HCSA to Pay for Services" on page 90 for more information.

Your MRA and/or Spending Accounts (HCSA, DCSA) are administered by your health care company (PayFlex, an Aetna Company or Cigna), or Cigna if you are not enrolled in the JPMC Medical Plan. If you change health care companies (from Aetna to Cigna or vice versa) during Annual Benefits Enrollment, your balance will automatically be transferred to your new health care company (generally the April timeframe).

However, if you change health care companies (from Aetna to Cigna or vice versa) because you are a late hire, late year COBRA enrollee or in certain other limited circumstances on or before January 31, of any given year, your associated MRA, HCSA and/or DCSA accounts may transition to your new health care company. If you change health care companies after February 1, your MRA, HCSA and/or DCSA accounts will remain with the health care company you were enrolled with as of January 1 of that year automatically. Your new health care company will also create an MRA for you to store incentives earned for completing wellness activities. You may carry over **only** your MRA balance to your new health care company, however it is incumbent upon you to request this transfer from your health care company.

Wellness Activities within the MRA

This is a summary of the wellness activities that are eligible for Wellness Rewards. Be sure to review the more detailed information about each activity to understand it better, especially when to complete the Initial Wellness Activity to save money on your medical payroll contributions. See the following table for list of activities and amount of MRA funds you can earn.

2021 Wellness Activity	Amount of MRA Funds That Can Be Earned* for Employee's MRA by:		Earn funds up to this many times for each activity in 2021
	You	Your Covered Spouse/ Domestic Partner	
Initial Wellness Activity(see "Initial Wellness Activity (New Activity for 2021; Applies to Wellness Activity Completed in 2020)" on page 61) Complete online Wellness Assessment between Nov 23, 2019 and Nov. 20, 2020 in order to earn MRA funds, see **My Health** for details.			
Online Wellness Assessment	$200 **AND** $500 savings on your medical payroll contributions	$100 **AND** an additional $500 savings on your medical payroll contributions	Once

2021 Wellness Activity	Amount of MRA Funds That Can Be Earned* for Employee's MRA by:		Earn funds up to this many times for each activity in 2021
	You	Your Covered Spouse/ Domestic Partner	
Additional Wellness Activities (between Jan. 1 and Dec. 31)			
	Receive up to a maximum of $800	Receive up to a maximum of $300	
Preventive Care (see page 62)	$200	$100	Once
Achieve a Healthy Body Mass Index (BMI) < 25 OR make progress toward a healthy BMI** (see "Healthy BMI/Progress Toward Healthy BMI*" on page 62)	$200	$100	Once
Achieve a Healthy Blood Pressure of 120/80 or less OR complete an alternative activity** (see "Healthy Blood Pressure or Alternative Activity" on page 62)	$200	$100	Once
Personal Action Call (see page 62)	$50	$50	Once
Health Coaching Programs (telephonic or online) (see page 62)			
Online coaching	$100	$50	Once
Telephonic Coaching	$200	$100	Twice
Maternity Support (see "Maternity Support Program" on page 63)	$200	$100	Once
Condition Management (see page 63)	$300	$150	Twice
Expert Medical Advice (see page 64) Receive funds for completing an expert second medical opinion on a documented diagnosis	$300	$150	Once
Treatment Decision Support (see page 64)	$200	$100	Once
Online Learning Programs			
Choosing Care Wisely (see "Online Learning Programs" on page 64)	$50	$50	Once
Planning Your Finances Wisely (see "Online Learning Programs" on page 64)	$50	$50	Once
meQuilibrium (see page 64)	$100	Not Applicable	Once
Maximum MRA Funds $1,400 if employee and covered spouse/domestic partner complete Initial + Additional Wellness Activities within required timeframes.	$1,000 ($200*** + $800)	$400 ($100*** + $300)	

* Assumes that Wellness Activities are completed as noted above and you are actively employed when MRA funds are distributed

** If it is unreasonably difficult because of a medical condition for you and/or your covered spouse/domestic partner to achieve the standards for the reward under this program, contact your health care company to work with you (and, if you wish, with your doctor) on an alternative.

*** The $200 and $100 amounts shown assumes the online Wellness Assessment was completed between Nov. 23, 2019 and Nov. 20, 2020.

Initial Wellness Activity (New Activity for 2021; Applies to Wellness Activity Completed in 2020)

Online Wellness Assessment

The online Wellness Assessment is an online survey that asks you questions about your biometric values, current health conditions and lifestyle. The Wellness Assessment can be completed at mycigna.com (even if you are enrolled with Aetna).

You and your covered spouse/domestic partner (if applicable) must complete the Wellness Assessment between November 23, 2019 and November 20, 2020 at 11:59 pm Eastern time in order to:

- Earn Wellness Rewards in your MRA for 2021 ($200 for you and $100 if covering a spouse/domestic partner); and
- Save $500 in medical payroll contributions ($1,000 if covering a spouse/domestic partner) in 2021.

Employees who become eligible for benefits coverage — and/or add a spouse/domestic partner to medical coverage — after September 1, 2020 will automatically save $500 (or $1,000 if covering a spouse/domestic partner) on both 2020 and 2021 medical payroll contributions without completing the Initial Wellness Activity in 2020. They will have until the 2021 Initial Wellness Activity deadline (to be communicated in 2021) to earn 2021 MRA dollars for completing the Initial Wellness Activity; however, if they complete the Initial Wellness Activity by November 20, 2020, they not only earn Wellness Rewards for their 2020 MRA, but for their 2021 MRA, too.

The **2021** medical payroll contributions (payroll deductions for Medical Plan coverage) shown when you enroll on the Benefits Web Center assume you and your covered spouse/domestic partner completed the Wellness Assessment between November 23, 2019 and November 20, 2020. This means the $500 savings (or $1,000 if you cover a spouse/domestic partner) will be reflected in your 2021 medical payroll contributions. If you and/or your covered spouse/domestic partner didn't complete the Wellness Assessment by the deadline, your medical payroll contributions will increase in February 2021. The $500 or $1,000 increase will be applied in equal installments to each pay from the first effective pay in February 2021 through December 2021.

Note: You have until June 30, 2021, to open a case with your health care company if you believe your online Wellness Assessment was completed by the deadline and not reflected in your medical payroll contributions.

For employees currently on an approved Leave of Absence: You and your covered spouse/domestic partner are encouraged to participate in the Initial Wellness activity. However, if you are on an approved Leave of Absence for at least 45 consecutive days between September 1 and November 20, 2020, and do not complete your online Wellness Assessment during that period, you will not lose the $500 in 2021 medical payroll contribution savings ($1,000 if covering a spouse/domestic partner). Other provisions of the Medical Plan and Wellness Program will continue to apply, including the opportunity to earn MRA funds by completing Additional Wellness Activities.

Additional Wellness Activities

Complete Additional Wellness Activities between January 1 – December 31 and earn up to $800 in your MRA. Your covered spouse/domestic partner can complete Additional Wellness Activities during the same time period, and you will receive up to an additional $300 in your MRA.

Preventive Care

The Medical Plan covers eligible in-network preventive care at 100% with no deductible, coinsurance, or copayments. Out-of-network preventive care is also covered but generally at a higher cost. You and/or your covered spouse/domestic partner can earn Additional Wellness Rewards for completing any of the following age and gender appropriate preventive care services:

- Wellness physical;
- Cervical or prostate screening;
- Mammogram; and
- Colonoscopy.

Healthy BMI/Progress Toward Healthy BMI*

Body mass index (BMI) is one of the numbers that is measured in the Wellness Screening. BMI can be an indicator of overall health. Achieve a BMI under 25 or a weight loss of at least 5% since your last screening and earn $200 in Wellness Rewards.

* If it is unreasonably difficult because of a medical condition for you and/or your covered spouse/domestic partner to achieve the standards for the reward under this program, contact your health care company to work with you (and, if you wish, with your doctor) on an alternative.

Healthy Blood Pressure or Alternative Activity

A Healthy blood pressure is a reading of 120/80 or less.

If your blood pressure is 120/80 or less, you earn $200 in Wellness Rewards.

If your blood pressure is greater than 120/80 but less than 160/100, you can earn $200 in Wellness Rewards in one of two ways:

- You can make an appointment at an onsite JPMC Health & Wellness Center for in-person health coaching regarding your risks for high blood pressure. After completion of your coaching session, the JPMC nurse will notify your health care company that the coaching took place and the health care company will authorize Wellness Rewards for Blood Pressure.
- You can call your health care company (Aetna/Cigna) and complete a Telephonic Health Coaching that will be focused on your blood pressure or a related topic, such as Heart Health. Your health care company will authorize your Wellness Rewards. **Note:** The incentive for completing this Blood Pressure activity will be recorded under Telephonic 'Health Coaching', not Blood Pressure

If your blood pressure is 160/100 or greater, you can still earn $200 in Wellness Rewards by calling your health care company (Aetna/Cigna) to obtain the “Wellness Screening Outcomes Exemption Form” and taking it to your personal health care provider. Your health care provider can determine if medication adjustment or information regarding your blood pressure risks is appropriate for you. They can then complete the form and fax it to your health care company as evidence that you are currently under medical care for your blood pressure. Your health care company will then award Wellness Rewards for Blood Pressure.

Personal Action Call

After you complete a Biometric Wellness Screening (even though not a part of 2021 Initial Wellness Activities), and/or an Online Wellness Assessment you can call your health care company to discuss the results and to learn what tools and resources are available to improve your results.

Health Coaching

Aetna and Cigna offer access to health coaches who can answer questions about your Wellness Screening and/or Wellness Assessment, as well as help you set and achieve your health goals, assess treatment options, navigate the Wellness Program, and remind you about prescription refills and preventive tests. You have your choice of receiving telephonic or online support.

You May Be Contacted by Your Health Care Company

If your health care company (Aetna or Cigna) feels you could benefit by working with a health coach based on its review of your Wellness Screening numbers, Wellness Assessment responses, and/or claims data, a health care company representative (not JPMorgan Chase) may contact you directly.

Please Note: Aetna and Cigna have access to your medical, prescription drug, and lab claims. So even if you do not get a Wellness Screening or complete a Wellness Assessment, you may still be contacted by your health care company to inform you of health programs available to you. Keep in mind that you do not have to participate in these programs, but if you don't, you'll miss earning Additional Wellness Rewards.

You don't have to wait to receive a call to participate; you can contact your health care company directly at the number on the back of your medical card.

Listed below are the most common health topics addressed by the health coaches at Aetna and Cigna. However, you can contact them on any health topic.

- Emphysema and chronic bronchitis;
- Depression and anxiety;
- Diabetes/pre-diabetes;
- Healthy eating;
- High blood pressure;
- High cholesterol;
- Physical activity;
- Stress management; and
- Weight management.

Please see the mycigna.com website through **My Health** (even if you are with Aetna) for a more comprehensive list of the topics that Aetna and Cigna can address through their telephonic and online programs.

Maternity Support Program

The Maternity Support Program provides expectant mothers with help throughout their pregnancy. If you or a covered spouse/domestic partner are pregnant and enroll in the program within the first trimester of a pregnancy, or within 31 days of the effective date of your Medical Plan coverage, you and your covered spouse/domestic partner can earn Additional Wellness Rewards. **Please Note:** You can enroll in the program anytime throughout your pregnancy to receive support from a health coach, however you will not be incented upon completion of the program if your enrollment is after your first trimester or after 31 days of your enrollment into the Medical Plan. This is a confidential program and JPMorgan Chase will not be notified of your individual enrollment. This program is available only if you are enrolled in the Medical Plan. You will not receive your incentive reward until after you complete your post-partum call.

Contact your health care company to learn more.

Condition Management

The Condition Management program provides you with personal support from a registered nurse to help you find practical ways to manage chronic conditions. Condition Management offers support for asthma, coronary artery disease, COPD, diabetes, and heart failure. This program is available only if you are enrolled in the Medical Plan.

Contact your health care company to learn more.

Expert Medical Advice

An expert second medical opinion through Grand Rounds allows you to receive medical guidance from a national leading expert on a documented diagnosis — without leaving your home. Leading experts are available to review documentation on treatment plans, complex medical conditions, scheduled surgeries or major procedures and medications you are taking. This program is available only if you are enrolled in the Medical Plan. You or your covered spouse/domestic partner must complete the entire expert second medical opinion process — from medical collection to a written report by the expert — to be eligible for Wellness Rewards in your MRA. Visit www.grandrounds.com/jpmc or call (888) 868-4693.

Treatment Decision Support

The Treatment Decision Support program offers access to registered nurses, or in the case of Grand Rounds, staff clinicians who can help you deal with conditions that have multiple treatment options, such as breast cancer and prostate cancer. The Treatment Decision Support program provides detailed information to help you choose the best treatment option(s), along with names of high-quality, cost-effective physicians near you and questions to ask your doctor. This program is available only if you are enrolled in the Medical Plan.

- **Cigna:** Treatment Decision Support offers support for benign uterine conditions, breast cancer, coronary artery disease, hip osteoarthritis/replacement, knee osteoarthritis/replacement, low back pain, and prostate cancer.
- **Aetna:** Treatment Decision Support offers support for a variety of medical and surgical conditions including but not limited to angina, benign prostate disease, breast cancer, dysfunctional uterine bleeding, endometriosis, fibroids, hip replacement, knee replacement, low back pain, and prostate cancer.
- **Grand Rounds:** Treatment Decision Support offers support for coronary artery disease/heart disease, hyperlipidemia, metabolic disease, hypertension, obesity, low back pain, shoulder pain, knee pain, hip pain, other chronic joint pain, migraines, anxiety, depression, benign uterine conditions, prostate cancer, and breast cancer.

Contact your health care company or Grand Rounds to learn more.

Online Learning Programs

You can take advantage of health and financial Online Learning Programs:

- Choosing Care Wisely — learn how to become a good health care purchaser. Go to www.mycigna.com (even if you are enrolled with Aetna)
- Planning Your Finances Wisely — learn more about how to be financially well by using tools and resources that JPMorgan Chase provides. Go to www.mycigna.com (even if you are enrolled with Aetna)

meQuilibrium

meQuilibrium is an online and mobile program designed to help you manage stress, feel your best, and become more resilient. It targets your individual stress triggers based on your personalized stress profile. In addition, the program provides a specific set of skills to help you practice behavior changes to stay calm and focused, boost self-confidence, sleep better, work well under pressure, better handle life's competing demands and more. Go to www.mymeQ.com/jpmc. Only employees are eligible to participate in the meQuilibrium program.

Wellness Program If You Do Not Enroll in JPMC Medical Coverage

Employees who do not enroll in the Medical Plan have access to a Wellness Program designed to provide ways to get and stay healthy. The program, which is administered by Cigna, provides tailored, personalized support.

The Wellness Rewards component of the program allows you to earn up to $600 per year by completing certain wellness activities. The Wellness Rewards are paid to you in cash through JPMorgan Chase payroll (this is considered taxable income and will be reported as such).

If you completed an online Wellness Assessment during the annual required time frame, you will earn $200, payable in January if you are actively employed at that time. If you completed the Wellness Assessment but your employment subsequently terminates before the January payroll deposit, you will forfeit the funds.

The Additional Wellness Activities you can complete are:

- Personal Action Call;
- Biometric Guidelines for Body Mass Index and Blood Pressure;
- Preventive Care;
- Telephonic Health Coaching;
- Online Health Coaching;
- Planning Your Finances Wisely
- meQuilibrium.

Wellness Rewards are not available to spouse/domestic partners of employees who do not enroll in the JPMorgan Chase Medical Plan.

Special Rules for Company Couples

If you are covering a spouse/domestic partner who is also a JPMorgan Chase employee (i.e., company couple), they will be incented as a covered spouse/domestic partner and the Wellness Rewards they earn for completing Wellness Activities will be deposited into your MRA. They will not be incented as a waiver (i.e., an employee who chooses not to enroll in the JPMorgan Chase Core Medical Plan).

MRA Payment Elections

During Annual Benefits Enrollment or when you first enroll in Option 1 or Option 2, you must choose how claims will be paid from your MRA when you have a covered expense. There are two ways claims can be paid:

- Through automatic claim payment default option for new Medical Plan enrollees or
- With a debit card.

Your choice will also apply to your Health Care Spending Account (HCSA), if you elect to participate in that plan. If you do not make an election when you first enroll in the Medical Plan, you will be enrolled in the automatic claim payment method. Your election will remain in effect for future plan years, unless you make a change during a subsequent Annual Benefits Enrollment. (Annual Benefits Enrollment is the only time during the year that you can change your MRA payment election*.) **Please Note:** During 2020, all Aetna enrollees were defaulted to the debit card option and those enrollees will remain in the debit card option unless they elect automatic claim payment during Annual Benefits Enrollment.

* You are eligible for a mid-year payment method change (from automatic claim payment to debit card) if you or your dependent is eligible for a prescription drug co-payment or discount program.

Your MRA payment election determines how in-network claims are processed by your health care company. If an out-of-network provider agrees to submit a claim to your health care company on your behalf, your election would also apply to the processing of that claim. The claims payment process takes into account whether there is money in your MRA (and/or HCSA, if applicable) available to pay for all or part of your share of the covered medical or prescription drug expense. Please see "Using Your MRA and HCSA to Pay for Services" on page 90, which contains detailed instructions about payments at in-network and out-of-network providers.

Remember, your MRA can be used to pay for eligible medical and prescription drug out-of-pocket expenses, and your MRA account must be exhausted before you can use your HCSA for medical and prescription drug out-of-pocket expenses. Further, your MRA cannot be used for vision or dental expenses — only your HCSA can be used for those expenses. (For information about the HCSA, please see the Spending Accounts Summary Plan Description, at **My Health**. Also see the "Automatic Claim Payment vs. Debit Card" tip sheet on **My Health**.)

What Happens to Your MRA If Your Employment with JPMorgan Chase Ends

If your employment with JPMorgan Chase ends and you do not enroll in COBRA or retiree medical coverage you:

- Cannot earn additional Wellness Rewards beyond your termination of employment;
- Can use your remaining MRA balance for covered out-of-pocket medical and prescription drug expenses incurred before the end of the month in which your employment ends. Claims for these costs must be submitted no later than one year following the end of the plan year in which you were enrolled. For example, if you terminated employment on September 23, 2021, you would have until December 31, 2022, to submit an MRA claim for covered expenses incurred during 2021. You will forfeit any remaining MRA funds.
- Will also forfeit any rewards for completing an online Wellness Assessment during the annual required time frame if you don't elect COBRA and remain on COBRA through the January award cycle or enroll in Retiree Medical coverage.

If your employment with JPMorgan Chase ends and you enroll in COBRA or retiree medical coverage:

- Your account balance will be available if you elect COBRA medical coverage (see "Continuing Coverage Under COBRA" in the *Health Care Participation* section). While you remain enrolled in COBRA medical coverage, you can use the remaining balance in your MRA to pay for your covered out-of-pocket costs related to covered medical and prescription drug expenses. You can also continue to earn Wellness Rewards for your MRA as if you were an active employee up to the full annual amount of $1,000 (or $1,400 if you are covering a spouse/domestic partner).
- You qualify as "retired" from JPMorgan Chase (that is, at the time your employment ends with JPMorgan Chase, you are age 55 or older with at least 15 years of service, or age 50 or older with at least 20 years of service in the case of severance). If you retire from JPMorgan Chase, you can continue to access your MRA regardless of what medical coverage you have in retirement, whether it is through COBRA, the JPMorgan Chase Retiree Medical Plan, or another plan. However, you can no longer earn additional Wellness Rewards to increase your MRA balance.
- If you are enrolled in COBRA or in the JPMorgan Chase Retiree Medical Plan, the MRA can be used to pay for eligible out-of-pocket medical and prescription drug expenses. You will have to submit your claims for reimbursement.

- If you are covered by another plan, the covered expenses eligible for reimbursement from the MRA will be determined by the expenses covered by that plan. You will need to file an MRA and/or HCSA Claim Form for reimbursement of your covered out-of-pocket medical and prescription drug expenses (see “Filing a Claim for Benefits” on page 92).
- If you are enrolled in JPMorgan Chase Retiree Medical Plan, administrative fees for your MRA will apply, and will be automatically deducted from your MRA each month.
- Your MRA will be managed by the last health care company in which you were enrolled while you were an active employee.

For more information, please see the **As You Leave Guide** on **me@jpmc** or **My Rewards**.

Please see the *Health Care Participation* section for more information on COBRA.

Covered MRA Expenses

You can use the funds in your MRA to pay for covered out-of-pocket medical and prescription drug expenses (out-of-network deductibles, coinsurance, and copayments) under the Medical Plan. Please see “What Is Covered” on page 96 for a list of covered expenses.

Expenses that are not covered under the Medical Plan are not eligible to be reimbursed by the MRA. Please see “What Is Not Covered” on page 107 for a list of excluded expenses. **Please Note**: While the MRA cannot be used to pay for expenses that are not considered covered expenses under the Medical Plan, such as charges above reasonable and customary levels for out-of-network care, or for dental or vision expenses, you can be reimbursed for these expenses from a Health Care Spending Account, if you choose to participate in that Plan. Please see the *Spending Accounts* Summary Plan Description on **My Health** for more information.

Other Wellness Programs

In addition to the Wellness Activities and Programs that are associated with the MRA, JPMorgan Chase offers other wellness related benefits to give you and your family more ways to stay healthy. These programs are provided to benefits-eligible employees, regardless of whether you enroll in the Medical Plan, and coverage under these programs does not begin or end with participation in the Medical Plan.

Employee Assistance Program (EAP) and Work-Life Program

The Employee Assistance and Work-Life Program (EAP) is available to provide professional, confidential counseling, consultation and referral services to help you and your eligible dependents find solutions to the many challenges faced in managing work and personal lives. The EAP is available to active U.S. benefits-eligible employees (that is, U.S. employees who are regularly scheduled to work 20 hours or more a week). That means you and your dependents can participate in the EAP even if you’re not enrolled in a JPMorgan Chase Medical Plan. As part of the EAP, you have access to referrals for free professional counseling for topics related to stress, anxiety, depression, marriage, family, relationship issues and more.

Employee Assistance Program Counselors are professionally trained, licensed, or certified mental health professionals.

Employees can receive up to five counseling sessions a year per issue. All services provided by the EAP are free, confidential, and available 24 hours a day, seven days a week. If referral to some other professional is made and fees are involved, the counselor will help you determine whether your Medical Plan benefits will offset some of the costs.

Use of the Employee Assistance Program is voluntary and completely confidential as required by law and JPMorgan Chase policy.

When Employee Assistance Program coverage ends for you and/or your eligible dependents, you may be able to continue coverage for a certain period of time under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please see the *Health Care Participation* section for more information on COBRA.

For additional information about the EAP and Work-Life Program, go to me@jpmc > Health, Life & Parenting > Employee Assistance and Work Life Program > U.S. or call (877) 576-2007 or access the Employee Assistance Program on **My Health >** Wellness Activities & Services.

Tobacco Cessation Program

JPMorgan Chase offers tobacco cessation through Optum's Quit For Life® Program. By enrolling in this program, you and/or your covered spouse/domestic partner can obtain experienced help in committing to a tobacco-free lifestyle.

The program provides, at no cost:

- Telephone coaching and online support;
- A Quit Guide; and
- Quitting aids (for example, patches and gum).

Upon completion of the program, you may be eligible for lower "non-tobacco user" rates for certain benefits, including the Medical Plan (see "Tobacco User Status" on page 57 for more information).

Call 866-QUIT-4-LIFE ((866) 784-8454) or access the program at **My Health**.

Onsite Health & Wellness Centers

At certain large locations, JPMorgan Chase provides fully staffed Health & Wellness Centers. These Centers provide:

- Basic medical services;
- Wellness Screenings (see "Wellness Activities within the MRA" on page 59 for more information) and other health evaluations; and
- Help understanding health information and guidance on resources available to you.

You pay nothing for these services. These Centers are for benefits-eligible employees (not just those enrolled in the JPMorgan Chase Medical Plan) and are not available for use by spouses/domestic partners or children.

For a list of the locations of the JPMorgan Chase Health & Wellness Centers, visit **My Health**.

Please see the Health & Wellness Centers Summary Plan Description for more information.

How Your Medical Plan Works

Option 1 and Option 2 pay the same percentage for the same covered expenses (the Plan's "coinsurance" rate). What differs between the two options are the payroll contributions required for each option and the annual deductible and coinsurance maximum values, as explained in the following sections.

The prescription drug plan is the same, regardless of whether you choose Medical Plan Option 1 or Option 2. For a description of coverage for prescription drugs, please see "The Prescription Drug Plan" on page 81.

The Annual Deductible

Under Options 1 and 2, certain expenses are subject to an annual deductible. The annual deductible is the amount you must pay "up front" each calendar year before the Plan begins to pay benefits for most covered expenses.

Under Options 1 and 2, there are certain services that are provided **before** the deductible (meaning the Plan begins paying immediately):

- Eligible preventive care that is received from in-network providers is covered in full without having to satisfy the deductible;
- In-network primary care is covered at 90% without having to satisfy the deductible; and
- Virtual doctor visits are covered for approximately $5, before the deductible for primary care services. Mental health virtual visits are covered at 80% after the deductible.
- For more information on what is considered "eligible preventive care" and "primary care," please see the chart under "Coinsurance Paid for Covered Benefits" beginning on page 74.

Out-of-network care has a higher deductible that is separate from the in-network deductible. Amounts in excess of reasonable and customary (R&C) charges do not count toward the out-of-network deductible. As a reminder, the Prescription Drug Plan has a separate plan design and has separate deductibles from those listed in the following table.

In addition to separate deductibles for in-network and out-of-network medical care, the annual deductible you are subject to also varies by (1) your Total Annual Cash Compensation (TACC), and (2) your coverage level.

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

In- and Out-of-Network Deductibles (Medical Only)				
Coverage Level	**Option 1**		**Option 2**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Total Annual Cash Compensation: less than $60,000				
Employee*	$1,000	$2,750	$2,000	$4,750
Employee + spouse/domestic partner or Employee + child(ren)	$1,875	$4,125	$3,375	$7,125
Family (employee + spouse/domestic partner + child(ren))	$2,750	$5,500	$4,750	$9,500
Total Annual Cash Compensation: $60,000 or more				
Employee*	$1,750	$2,750	$2,750	$4,750
Employee + spouse/domestic partner or Employee + child(ren)	$2,625	$4,125	$4,125	$7,125
Family (employee + spouse/domestic partner + child(ren))	$3,500	$5,500	$5,500	$9,500

* Also functions as a "per person" deductible under the other coverage levels.

If you elect coverage for yourself, you must pay up front for all eligible expenses (except for preventive care and primary care) until you meet the per-person deductible. After you meet the annual per-person deductible, the Plan will begin to pay its portion of covered expenses — known as the coinsurance rate (please see chart under "Coinsurance Paid for Covered Benefits" beginning on page 74 for the Plan's coinsurance for various expenses).

If you cover dependents, all eligible expenses paid by you and/or your covered dependents combine to meet the deductible amount for the coverage level.

However, no individual must satisfy more than the per-person deductible amount. This means that once an individual's expenses meet the per-person deductible, the Plan will begin to pay benefits for that person, even if the family has not yet met the full deductible for the coverage level. Please see "The Per-Person Deductible and Coinsurance Maximum Provision" on page 71.

The Annual Coinsurance Maximum

Under Options 1 and 2, the annual coinsurance maximum is the maximum amount you must pay in coinsurance in a plan year toward eligible covered expenses.

The coinsurance maximum does not include the deductible, and there are separate coinsurance maximums for in-network and out-of-network charges.

The coinsurance maximum varies based on coverage level and TACC (see definition under "Defined Terms" on page 109), which provides greater financial protection for lower-paid employees, as shown in the following table.

The coinsurance maximum functions as your "financial safety net." It prevents you from having to pay very high health care expenses in the event of a serious medical situation. Once the coinsurance maximum is reached, the Medical Plan will pay 100% of negotiated fees for covered in-network care and 100% of the reasonable and customary charges for covered out-of-network services for the rest of the year.

Amounts that you pay toward your medical deductible and amounts above reasonable and customary charges for out-of-network care do not count toward your coinsurance maximum. In addition, prescription drug benefits are subject to a separate out-of-pocket maximum, as explained under "How the Prescription Drug Plan Works" on page 82.

In- and Out-of-Network Coinsurance Maximums (Medical Only, Excludes Deductible and Prescription Drugs)				
	Option 1		Option 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Total Annual Cash Compensation: less than $60,000				
Employee*	$1,000	$6,000	$2,750	$6,000
Employee + spouse/domestic partner or Employee + child(ren)	$1,500	$8,000	$4,125	$8,000
Family (employee + spouse/domestic partner + child(ren))	$2,000	$12,000	$5,500	$12,000

In- and Out-of-Network Coinsurance Maximums (Medical Only, Excludes Deductible and Prescription Drugs)				
	Option 1		Option 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Total Annual Cash Compensation: $60,000-$149,999				
Employee*	$1,500	$6,000	$3,050	$6,000
Employee + spouse/domestic partner or Employee+ child(ren)	$2,250	$8,000	$4,575	$8,000
Family (employee + spouse/domestic partner + child(ren))	$3,000	$12,000	$6,100	$12,000
Total Annual Cash Compensation: $150,000+				
Employee*	$2,250	$6,000	$3,050	$6,000
Employee + spouse/domestic partner or Employee + child(ren)	$3,375	$8,000	$4,575	$8,000
Family (employee + spouse/domestic partner + child(ren))	$4,500	$12,000	$6,100	$12,000

* Also functions as a “per person” coinsurance maximum under the other coverage levels.

The Per-Person Deductible and Coinsurance Maximum Provision

The prior sections describe the deductible and coinsurance maximums — outlining services that are and are not subject to the deductible, as well as the portion the Plan pays in coinsurance and coinsurance maximums established within the Medical Plan.

If you have elected Employee Only coverage, then the deductible and coinsurance descriptions and amounts shown in the chart will apply.

If you cover dependents, the charts under “The Annual Deductible” on page 70 and “The Annual Coinsurance Maximum” on page 70 depict the deductible level and coinsurance maximum levels that apply for that coverage level (i.e., employee plus adult, or family coverage).However, there is also a “per person” rule that allows any single individual (for example, 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 individual.

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 individual 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.

An Example: Amounts Applied Toward In-Network Family Coinsurance Maximum for Medical Plan Option 1 After Deductibles Were Met (Total Annual Cash Compensation < $60,000)	
On behalf of you	$1,000
On behalf of your spouse/domestic partner	$100
On behalf of one child	$50
On behalf of a second child	$50
TOTAL	**$1,200**
In this example, one person has met the $1,000 per-person coinsurance maximum (the employee), and combined coinsurance costs for the family have reached $1,200. Any charges for eligible medically necessary covered services for the employee's care would therefore be reimbursable at 100% for the remainder of the year, even though the family as a whole has not yet met the family coinsurance maximum for the Total Annual Cash Compensation < $60,000 tier ($2,000).	

Note: If your coverage level changes during a calendar year as a result of Qualified Status Change, your annual deductible and/or annual coinsurance maximum increases or decreases accordingly. For example, your deductible will go back to the individual amount if you move from Employee + spouse/domestic partner or Employee + child(ren) to Employee only during the year as a result of a Qualified Status Change.

Maximum Lifetime Benefits

There is no dollar limit on the amount Options 1 and 2 would pay for essential benefits while you and your covered dependents are enrolled in the Medical Plan.

However, there is a $10,000 lifetime infertility services maximum provided by the Medical Plan ($30,000 if you and/or your covered spouse/domestic partner receive your care in a Center of Excellence, as explained under "Centers of Excellence (COEs)" on page 80). These amounts do not include the infertility benefit provided by the Prescription Drug Plan.

There is also a lifetime limit of 365 days for in- or out-of-network care in a skilled nursing facility. The infertility services and skilled nursing facility lifetime maximum benefits apply to both in-network and out-of-network care.

An Important Note on the Option 1 and Option 2 Benefit Maximums

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

- Medical Plan Option 1.
- Medical Plan Option 2.

You do not gain a new benefit maximum if you switch your coverage between options or health care companies.

Choosing Between In- and Out-of-Network Care

Under Options 1 and 2 of the Medical Plan, you can choose to see any provider, but you'll pay less when you receive your care through your health care company's network of physicians and facilities because network providers have agreed to charge negotiated discounted fees for their services. In addition, the Plan pays a higher rate of coinsurance for in-network care, so your share of charges, if any, is less for in-network care. Lastly, the deductible is lower for in-network care than it is for out-of-network care, so you have to incur less expense before the Medical Plan begins to pay coinsurance for covered expenses.

Forgot Your ID Card?

Not to worry. You can access an electronic version of your medical coverage ID card online at your health care company's website or on their apps.

When you receive in-network care:

- You usually don't have to file any claim forms; your network provider will usually file claims for you.
- Your out-of-pocket expenses will be lower compared to your expenses for the same type of care on an out-of-network basis. In-network doctors have agreed with Aetna and Cigna to charge pre-negotiated fees that are on average lower than the fees charged by doctors outside the network. You cannot be billed for any amounts above those pre-negotiated fees.

When you receive out-of-network care:

- You may need to file a claim form to receive out-of-network benefits. Please see "Filing a Claim for Benefits" on page 92 for more information.
- Your out-of-pocket costs for medically necessary covered services generally will be higher than if you received in-network care.

Covered services performed by providers not participating in the network 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 your health care company to be appropriate fees for medical services. Out-of-network charges are typically higher than the pre-negotiated fees that are covered for in-network care. **Please Note:** You will be responsible for paying any charges by your out-of-network provider above the R&C amount. Charges in excess of reasonable and customary levels are not considered a covered expense under the Plan, and they therefore do not count toward the deductible or coinsurance maximum.

The Shared Savings Program is a program in which Aetna and Cigna may obtain a discount to an out-of-network provider's billed charges. This discount is obtained by the non-Network provider agreeing to a reduced charge either directly with Aetna or Cigna or with a third party on behalf of Aetna or Cigna. When this happens, you may share in the savings because your out-of-pocket costs (i.e., coinsurance and deductible) are determined using the reduced charge. In addition, the out-of-network provider should not bill you for any amount above the agreed upon reduced charge. If this happens, however, you should call the number on your ID card for either Aetna or Cigna. In some instances, Aetna or Cigna may not obtain a discount. In this case the out-of-network provider may bill you not only for the deductible and coinsurance applicable to the allowed amount determined by Aetna or Cigna under the terms of the Plan, but for all charges above that allowed amount. Out-of-network providers that agree to reduced charges are not credentialed by Aetna or Cigna and are not Network Providers.

Out-of-Area Network Participants

The JPMorgan Chase Medical Plan vendors, Aetna and Cigna, offer broad national networks. However, in certain extremely limited situations, participants may be in an area without access to the expected level of Aetna's or Cigna's network coverage. In those rare circumstances, and effective as of each Annual Benefits Enrollment period, participants impacted by this are offered coverage during Annual Benefits Enrollment through Cigna's "Out of Area" program and are offered participation in Option 1. Out-of-Area participants can use any provider and the services are covered as in-network. Typically, eligibility for Out-of-Area participation is based on the number of Aetna and Cigna network primary care physicians and hospitals within a certain mileage radius of your home zip code. Out-of-Area eligibility can change, as more physicians or hospitals are added in your area.

Coinsurance Paid for Covered Benefits

The following table shows the coinsurance percentage paid by the Medical Plan on an in-network and out-of-network basis for covered expenses. Please also see "What Is Covered" on page 96 for a more detailed list of covered expenses under the Medical Plan.

Please Note

When you visit an in-network facility for a scheduled surgery, Options 1 and 2 will cover care provided by radiologists, anesthesiologists, and/or pathologists (RAPs) at the in-network percentage of the billed charges, 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. The Plan will reimburse you 80% of the reasonable and customary (R&C) amount; if the R&C amount is $500 you would be reimbursed $400; you will be responsible for payment of the remaining $100. 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.

Covered Benefits: Eligible Preventive Care

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
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 your health care company, as preventive medical care rather than as a diagnostic service. Additional lab or other services performed during a preventive care visit that are not considered preventive in nature may not be covered at 100% with no deductible.		
Fecal Occult Blood Test	• 100% before deductible • One test per year	• 50% coverage after deductible • One test per year
Immunizations (routine adult and child) (includes immunizations related to travel)	• 100% before deductible	• 50% coverage after deductible
Preventive Sigmoidoscopy/Colonoscopy	• 100% before deductible • One baseline screening and one follow-up screening every five years	• 50% coverage after deductible • One baseline screening and one follow-up screening every five years
Routine Gynecological Exams and Pap Smears	• 100% before deductible • One exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines	• 50% coverage after deductible • One exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Routine Mammography, Prostate Specific Antigen (PSA) Test, and Digital Rectal Exam	• 100% before deductible • Age 40 and over: one exam per year based on age and gender	• 50% coverage after deductible • Age 40 and over: one exam per year based on age and gender
Routine Physical Exams	100% before deductible**	50% coverage after deductible**
Routine Screenings Provided During Pregnancy (For example, gestational diabetes and bacteriuria screenings, as well as items such as certain breast pumps)	100% before deductible	50% coverage after deductible

* Covered 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.

** Your health care company determines the preventive care services covered at 100% under the Plan based on guidelines and clinical recommendations for the general population developed 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. For a list of preventive services that are covered at 100%, go to your health care company's website accessible via **My Health > My Medical Plan Website.**

Covered Benefits: Outpatient Services

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Outpatient Services		
Acupuncture Services	80% coverage after deductible	50% coverage after deductible
Cognitive Rehabilitation Therapy (combined in-network and out-of-network limit of 60 visits/calendar year)	80% coverage after deductible	50% coverage after deductible
Convenience Care Clinics	90% coverage before deductible	50% coverage after deductible
Home Health Care (may require precertification; limited to maximum of 200 visits/calendar year; one visit = four hours) See "Mental Health Benefits" on page 80 for more information.	80% coverage after deductible	50% coverage after deductible

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Infertility Services (available to covered members with a medical diagnosis of infertility, as defined by your health care company) Limited to combined in-network and out-of-network maximum of $10,000/lifetime for each covered member** ($30,000 lifetime maximum if a Center of Excellence is used for your treatment, as described under "Infertility Treatment Procedures" on page 105) Separate $10,000 prescription drug benefit; see "What's Covered and Not Covered" on page 86.	80% coverage after deductible; coverage requires you to contact your health care company and receive precertification before obtaining services	50% coverage after deductible; coverage requires you to contact your health care company and receive precertification before obtaining services
Mental Health Care	80% coverage after deductible	50% coverage after deductible
Primary Care Office Visits (to family practitioners, internists, pediatricians, OB/GYNs, and convenience care clinics). Internists must be contracted with Aetna or Cigna as a Primary Care Physician (PCP). Go to Aetna or Cigna's websites through **My Health** to search for PCPs/primary care. (includes tests, injection drugs, supplies, and other services authorized by the Plan and provided during the visit and billed by the Primary Care Physician)	90% coverage before deductible	50% coverage after deductible
Routine eye exams	Not covered	Not covered
Specialist's Office Visits (includes tests, injection drugs, supplies, and other services authorized by the Plan and provided during the visit, consultations, specialist referrals, and second surgical opinions)	80% coverage after deductible	50% coverage after deductible

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Speech, Physical, or Occupational Therapy (combined in-network and out-of-network limit of 60 visits/calendar year per therapy type**; unlimited for those with a mental health diagnosis) See "Mental Health Benefits" on page 80 for more information.	80% coverage after deductible	50% coverage 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 including initial consultation**	80% coverage after deductible	50% coverage after deductible
Substance Use Disorder Services	80% coverage after deductible	50% coverage after deductible
Urgent Care Center	80% coverage after deductible	80% coverage after the ***in-network deductible***
Virtual Doctor Visit for medical (non-mental health) services delivered through Teladoc (Aetna) and MDLive (Cigna)	Approximately $5 (90% coverage) before deductible for primary care services. Mental health services are covered at 80% after the deductible.	Not covered

* Covered 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.

** Combined in-network and out-of-network. 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.

Covered Benefits: Inpatient Services

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Inpatient Services (precertification recommended, please see "Prior Authorization" on page 79)		
Acute Hospital Care (based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases)	80% coverage after deductible	50% coverage after deductible
Hospice Care	80% coverage after deductible	50% coverage after deductible
Mental Health Care	80% coverage after deductible	50% coverage after deductible

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Skilled Nursing Facility (includes charges for services and supplies provided while patient is under continuous care and requires 24-hour skilled nursing care and room and board; limited to combined in-network and out-of-network maximum of 365 days/lifetime for each covered individual**)	80% coverage after deductible	50% coverage after deductible
Substance Use Disorder Services	80% coverage after deductible	50% coverage after deductible

* Covered 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.

** Combined in-network and out-of-network. 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.

Covered Benefits: Other Services

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Other Services		
Ambulance Services (for sudden and serious medical conditions approved by your health care company as required for emergency care — also see "If You Need Emergency Care" on page 80)	80% coverage after deductible	80% coverage after the ***in-network deductible***
Emergency Room (for sudden and serious medical conditions approved by your health care company as required for emergency care — also see "If You Need Emergency Care" on page 80) In accordance with applicable regulations, true emergency is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors.	• 80% coverage after deductible for true emergencies**; • 50% coverage after deductible for non-emergencies	• 80% coverage after in-network deductible for true emergencies; • 50% coverage after in-network deductible for non-emergencies; • **Note:** the in-network deductible applies for true emergencies**, rather than the out-of-network deductible

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Durable Medical Equipment and Prosthetics (includes certain*** glucose monitors, insulin pumps and related pump supplies)	80% coverage after deductible	50% coverage after deductible
Prescription Drugs	Please see "The Prescription Drug Plan" on page 81.	
X-rays and Labs (when performed to diagnose a medical problem or treat an illness or injury)	80% coverage after deductible	50% coverage after deductible

* Covered 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.

** True emergency as determined based on what a prudent person would consider an emergency, not on the final diagnosis reached by doctors.

*** Some glucose monitors and insulin pumps are available under the Prescription Drug Plan. For information on which insulin pumps are covered under the Medical and/or Prescription Drug Plan, please contact the appropriate provider (Aetna/Cigna and/or CVS Caremark)

Additional Plan Provisions

Prior Authorization

Prior authorization is required for many services and procedures, such as hospital stays and some surgical procedures.

In general, in-network providers are responsible for obtaining prior authorization before providing these services to you. Before receiving these services, you may want to contact your health care company to verify that the hospital, physician and other providers are in-network providers and that they have obtained the required prior authorization. In-network facilities and providers cannot bill you for services if they fail to obtain prior authorization as required.

If you are using an out-of-network provider, you are responsible for obtaining prior authorization before you receive these services. **Note:** You must obtain prior authorization when an out-of-network provider intends to admit you to an in-network facility or refers you to other in-network providers.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs.

Hospital Notification

You should contact your health care company at least 48 hours before all scheduled hospital admissions. You should also contact your health care company if a maternity stay will exceed 48 hours for the mother and/or newborn child following a vaginal delivery, or 96 hours for the mother and/or newborn child following a cesarean section delivery.

To provide notification, please contact your health care company at the number on the back of your ID card. You will not be penalized under the Plan if you do not notify the claims administrator.

Mental Health Benefits

Mental health care or benefits, in accordance with the Mental Health Parity and Addiction Equity Act, are items or services for mental health or substance use disorder conditions, as determined solely within the discretion of the plan administrator, consistent with generally recognized independent standards of current medical practice. Conditions affecting physical health that are related to a mental health condition or substance use disorder are medical/surgical benefits rather than mental health care benefits under the Medical Plan. However, for those individuals with a mental health diagnosis, associated medical treatments subject to visit limits (such as physical, occupational and speech therapy) will not be subject to an annual visit limitation.

If You Need Emergency Care

If you have a medical emergency that's sudden, urgent, and serious or life-threatening, you should go to the nearest physician, hospital emergency room, or other urgent care facility. Your emergency care will be covered at 80% (assuming you have met the in-network annual deductible) under both Option 1 and Option 2 as long as your health care company approves the care as being required for a true emergency.

Care will be approved for local emergency ambulance service or air ambulance to the nearest hospital qualified to treat the condition if medically necessary and confirmed by a licensed provider.

If your health care company determines that you did not have a true emergency, the Plan will pay benefits at 50% rather than 80% after meeting the in-network deductible. Non-emergency transportation is covered if it is provided by a licensed professional ambulance (either ground or air ambulance as determined appropriate) when the transport is:

- from an out-of-network hospital to the nearest in-network hospital with capabilities to care for the condition;
- to a hospital that provides a higher level of care that was not available at the original hospital, when medically necessary for the patient's care; or
- to a more cost-effective acute care facility (as authorized by the Plan) from an acute facility to the nearest most appropriate sub-acute facility.

Note: The determination of whether the visit was a true emergency and thus whether coverage is at the 50% or 80% level is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors. True emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Centers of Excellence (COEs)

Organ transplants, bariatric surgery, and infertility treatment are complex procedures and services that require highly specialized or quality care. As a result, the Medical Plan has in-network hospitals that have been designated as Centers of Excellence because of the high-quality care they consistently provide for these procedures and services.

You must contact your health care company in advance of an organ transplant, bariatric surgery or receiving infertility treatment to receive instruction on any required precertification. This applies whether or not you choose a Center of Excellence.

The Medical Plan contains incentives designed to encourage use of COEs for infertility services. Your infertility medical benefit maximum will be increased from $10,000 to $30,000 if you choose a COE for treatment. (**Please Note**: There is a separate $10,000 prescription drug benefit for infertility services.)

To locate a Center of Excellence, visit your health care company's website at **My Health** or call your health care company.

NurseLine

You can call Aetna and Cigna and speak to a registered nurse at any time. You can get help with health advice 24 hours a day, seven days a week — even on weekends and holidays. There are no limitations on how many times you might use the NurseLine. Examples include:

- Recognize urgent and emergency symptoms;
- Understand medication interactions;
- Locate in-network doctors and hospitals; and
- Research treatment costs.

Contact your health care company to learn more:

- **Aetna:** Call (800) 468-1266 and select the prompt, "24-hour NurseLine."
- **Cigna:** Call (800) 790-3086 and select the prompt, "24-Hour Health Information Line."

Virtual Doctor Visits

Virtual doctor visits through Teladoc (an Aetna partner) and MDLive (a Cigna partner) allow you to connect to a doctor in minutes — anytime, anywhere — using a smartphone, tablet, or computer, for approximately $5 per virtual visit (before the deductible) for primary care services. Mental health services are covered at 80% after the deductible. Doctors can make diagnoses, provide advice and call in prescriptions to your local pharmacy. Register before you need care: Go to **My Health**.

The Prescription Drug Plan

The Prescription Drug Plan is the same under Option 1 and Option 2 of the Medical Plan and is administered by CVS Caremark. Prescription drug coverage has a separate plan design from the other Medical Plan features, with a separate deductible, copayments, and coinsurance, and a separate "safety net" in the form of per-prescription maximums and an annual prescription drug out-of-pocket maximum. You will receive a separate prescription drug identification (ID) card from CVS Caremark in addition to your Medical Plan ID card.

For Help with the Prescription Drug Plan

You can reach a Caremark Customer Service Representative 24 hours a day, seven days a week at (866) 209-6093. In addition, once you are enrolled, you can visit CVS Caremark's website accessible via **My Health** or directly at www.caremark.com. The site allows you to:

- View the covered and excluded drug lists;
- View your personal prescription drug history;
- Estimate drug costs and identify prescription drug cost saving opportunities;
- Order/refill/check the status of mail order prescriptions;
- Look for network retail pharmacies;
- Research drug information;
- Set up personal email reminders for refills; and
- Print temporary CVS Caremark ID cards.

How the Prescription Drug Plan Works

Highlights of the Prescription Drug Plan are listed below; detailed information follows.

- Free preventive generic drugs. Eligible preventive generic medications are covered at 100% with no deductible, copayments or coinsurance at network pharmacies.
- Separate deductibles and coinsurance maximums than the Medical Plan;
- MRA funds can be used to pay for covered out-of-pocket prescription drug costs;
- Discounted prices that are available at network pharmacies (you'll generally pay more at an out-of-network pharmacy); if you use an out-of-network pharmacy that does not accept your prescription drug ID card, you will generally pay more and will need to file a claim for eligible reimbursement;
- Option of having maintenance prescriptions filled through a convenient mail-order program or at a pharmacy;
- Traditional (non-specialty) and specialty lists of preferred/covered and excluded drugs; the most recent lists can always be found on the CVS Caremark website; and
- Mandatory Generic Drug Program; if you fill a prescription for a brand-name medication when a generic equivalent is available, you will pay the difference in cost between the brand-name drug and generic drug, plus the generic copay.

Here is how the Plan generally pays for different types of drugs:

- Free preventive generic drugs. Eligible preventive generic medications are covered at 100% with no deductible, copayments, or coinsurance at network pharmacies.
- Preventive drugs are medications that can help prevent the onset of a condition if you are at risk or help you manage your health if you have a condition. CVS Caremark determines which drugs are considered "preventive generic" drugs. To see a list of drugs in this category, visit CVS Caremark's website accessible via **My Health**.

Please Note: Generic prescription contraceptives are also fully covered with no deductible (as are brand-name, contraceptive drugs for which a generic is not available)

- $10 copayment for non-specialty generic drugs (up to 30-day supply). You pay $10 for non-specialty generic drugs not considered preventive purchased at a network pharmacy. Non-specialty generic drugs are not subject to a deductible. If the cost of a generic drug is less than the $10 copayment, you'll pay the lower amount.
- Annual retail deductible for brand-name and specialty generic drugs. An annual deductible of $100 per individual (with a maximum of $300 per family) applies to brand-name and specialty generic prescriptions filled at retail pharmacies. There is no deductible for non-specialty generic drugs or for 90-day supplies purchased at a CVS retail pharmacy or by mail.
- Coinsurance for brand-name and specialty generic drugs. After you satisfy the retail deductible, you and the Plan share the cost of brand-name and specialty generic drugs through coinsurance.

When a generic prescription drug is not available, there are often many different brand-name alternatives. CVS Caremark has reviewed these alternatives and determined which are clinically appropriate and cost-effective. These are called "preferred brand-name prescription drugs," and are covered at a higher level than "non-preferred brand-name drugs." To see a list of preferred drugs, visit CVS Caremark's website.

- Per-prescription maximum. The amount you pay for brand-name and specialty generic drugs each time you fill a prescription is capped by a per-prescription maximum, a safety net that protects against the cost of very expensive drugs. If the coinsurance amount is greater than the per-prescription maximum, you will pay only the amount of the maximum.
- Cost savings for long-term maintenance medications. Maintenance Choice® offers advantageous pricing when you receive 90-day supplies of maintenance medication by mail or pick up your prescription at CVS retail pharmacies, where the same discounts are available. There is no deductible for maintenance medications received through Maintenance Choice®.
- Annual out-of-pocket maximum. The annual out-of-pocket maximum is the overall "safety net" of your prescription drug coverage. The maximum caps your annual cost for covered prescriptions at $1,150 per individual (with a maximum of $2,300 per family), not including the deductible. Once an individual reaches this limit (or once the family meets the family limit), that individual (or family) does not have to pay anything further for covered drugs for the calendar year, regardless of coverage level.
- The out-of-pocket maximum covers all copayments and coinsurance for covered drugs. It does not include the annual deductible for retail prescriptions or costs for non-covered drugs. **Please Note:** The prescription drug out-of-pocket maximum is separate from the Medical Plan's out-of-pocket maximum.
- If you have money in your Medical Reimbursement Account (MRA), those funds are available to offset your share of the cost of your eligible covered medication.
- If you have elected or were assigned automatic claim payment, at the time of purchase, your MRA funds will automatically be used to offset your out-of-pocket cost after the Plan pays its share of the cost of your medication. If you elected the debit card, you may pay your out-of-pocket costs by using the card or your own funds. If you pay out-of-pocket, you can submit a claim form for reimbursement from the MRA.
  - If you elected autopay during enrollment and subsequently receive a prescription drug coupon or prescription drug copay assistance card, you have the option to switch to debit card mid-year.
- Once your MRA funds are depleted, you can use your HCSA for eligible prescription drug expenses if you elected to participate in the HCSA and have available funds.

A Note about Generic vs. Brand-Name Drugs

Many popular brand-name drugs are expected to have a generic version available. Shortly after generic equivalents are introduced, the equivalent brand-name drug will move from preferred to non-preferred status. If you choose to continue to take the brand name drug when the generic is available, you may be subject to a significantly higher cost. Please see "Mandatory Generic Drug Program" on page 88 for more information. You should talk to your doctor to determine whether a generic equivalent is suitable.

How Prescription Drug Benefits Are Paid Under the Medical Plan

Prescription drug coverage has a separate plan design from the other Medical Plan features, with a separate deductible, copayments, and coinsurance, and a separate "safety net" in the form of per-prescription maximums and an annual prescription drug out-of-pocket maximum.

Category	Provisions
Preventive Generic Drugs	100% coverage (deductible does not apply)
Non-preventive Generic Drugs (non-specialty)	30-day supply: $10 or the actual cost of the drug if less than $10; not subject to the deductible 90-day supply: You pay $20 or actual cost of the drug if less than $20; not subject to the deductible

Category	Provisions	
Annual Retail Deductible (retail pharmacy only; waived for non-specialty generic drugs)	Employee only (also serves as a per-person maximum**)	$100
	Employee + spouse/domestic partner or Employee + child(ren)	$200
	Family (employee + spouse/domestic partner + child(ren))	$300
Retail Pharmacy Benefit (up to a 30-day supply) The Retail Pharmacy benefit covers up to a 30-day supply of medication purchased from a network pharmacy.		
• Preferred brand-name and specialty generic coinsurance/per-prescription maximum*	You pay 30% after the deductible, up to a $200 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $200 maximum)	
• Non-preferred brand-name coinsurance/per-prescription maximum*	You pay 45% after the deductible, up to a $250 maximum per-prescription payment (the Plan pays 55% coinsurance plus costs above the $250 maximum)	
Mail Order Pharmacy or CVS Retail Pharmacy/ Maintenance Choice® (up to a 90-day supply; opt-out available)* The deductible does not apply if you fill maintenance medications through Maintenance Choice®. Please see “Details about Maintenance Choice®” on page 85 for more information.		
• Preferred brand-name and specialty generic coinsurance/per-prescription maximum**	You pay 30% up to a $500 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $500 maximum)	
• Non-preferred brand-name coinsurance/per-prescription maximum**	You pay 45% up to a $625 maximum per-prescription payment (the Plan pays 55%coinsurance plus costs above the $625 maximum)	
Annual Out-of-Pocket Maximum (covers copayment/coinsurance expenses for covered eligible prescription drugs; does not include the deductible)	Employee only (also serves as a per-person maximum**)	$1,150
	Employee + spouse/domestic partner or Employee + child(ren)	$1,750
	Family (employee + spouse/domestic partner + child(ren))	$2,300
• **CVS Caremark Excluded Drugs** (Traditional and Specialty)	Not covered; you will pay the full cost for these drugs.	
• **Non-Sedating Antihistamines** (also known as NSAs)	Not covered; you will pay the full cost for these drugs.	

* The Maintenance Choice® program covers 90-day supplies of maintenance medication. There is no deductible for maintenance medications. Maintenance Choice® allows you to: 1) send your 90-day prescription to CVS Caremark and have your medicine delivered by mail to your home; or 2) fill your 90-day prescription at any CVS retail pharmacy. If you “opt out” out of Maintenance Choice®, your prescription will be subject to the deductible and your costs will generally be higher. Please see “Details about Maintenance Choice®” on page 85.

** CVS Caremark determines which drugs are considered “generic,” “brand,” “preventive generic,” “preferred,” “non-preferred,” “maintenance,” and “specialty,” etc. We use CVS Caremark’s lists of covered and excluded drugs. An independent committee made up of pharmacists, physicians and medical ethicists reviews and approves the drug lists (also known as formularies). These lists are subject to change quarterly by CVS Caremark. If you continue to take a noncovered drug, you will pay the full cost of the drug. To see a list of drugs in these categories, visit CVS Caremark’s website at **My Health**.

*** For both the retail deductible and the annual out-of-pocket maximum, the “per person” rule allows the employee or any covered dependent(s) [for example, spouse/domestic partner or child(ren)] to reach an individual deductible or out-of-pocket maximum, after which the deductible or out-of-pocket maximum is satisfied for the year for that person. Covered individuals who have not met the deductible or out-of-pocket maximum may combine to meet the remainder of the deductible or out-of-pocket maximum for that particular coverage level. If no one person has met the individual deductible or out-of-pocket maximum, the expenses of all covered individuals can combine to meet the deductible or out-of-pocket maximum for that coverage level.

Details about Maintenance Choice®

The Maintenance Choice® program provides discounted pricing for 90-day supplies of long-term maintenance drugs. Some examples of long-term maintenance drugs are those taken for:

- Asthma;
- Diabetes;
- High blood pressure; and
- High cholesterol.

To see a list of maintenance drugs and to compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS retail network pharmacy, visit CVS Caremark's website.

With Maintenance Choice®, a 90-day supply of maintenance medicine can be delivered by mail to your home, or you can fill your 90-day prescription at any CVS retail pharmacy, where the same discounts are available.

You may also "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy (see "Opting Out of Maintenance Choice®" on page 85).

Before filling a long-term prescription through Maintenance Choice®, you can obtain two 30-day supplies at a network pharmacy by paying retail pharmacy rates. This "trial period" gives you and your doctor the ability to confirm that the medication and dosage is right for you. After that, you will need to use Maintenance Choice® to obtain the most advantageous pricing (or you may opt out of the program, but you may pay more).

A CVS Caremark Mail Order Form is available on the CVS Caremark site. Mail your prescriptions with your completed order form to the address noted on the form.

Opting Out of Maintenance Choice®

You will generally pay the lowest price for maintenance medications if you use Maintenance Choice® to obtain a 90-day supply by mail or at a CVS retail pharmacy. However, you may "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy. You will be subject to the annual retail deductible, and, for 90-day supplies of medication, your per-prescription maximum will be higher, as shown in the following table.

Comparing Per-prescription Maximums Under Maintenance Choice® to Opting Out of Maintenance Choice®

	Maximum per-prescription charge	
	Maintenance Choice® (obtain through mail or at a CVS retail pharmacy)	***Opt Out (obtain prescription at a non-CVS retail in-network pharmacy*)***
Annual Deductible	Not Applicable	$100
Generic non-specialty 90-day supply	$20	$30, after satisfying annual deductible
Preferred brand-name and specialty generic 90-day supply	$500	$600, after satisfying annual deductible
Non-preferred brand-name 90-day supply	$625	$750, after satisfying annual deductible

* Or picking up three 30-day supply prescriptions at a CVS retail pharmacy.

To compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS retail in-network pharmacy, visit CVS Caremark's website.

To continue to fill your maintenance medication prescription at a non-CVS retail in-network pharmacy after your two 30 days' supplies at a network pharmacy, you must opt out of Maintenance Choice® by calling CVS Caremark. If you order maintenance medications through a non-CVS retail in-network pharmacy without calling CVS Caremark first, your claim will be rejected and you will pay the full cost of the medication. **Please Note:** Your "opt out" status will apply to all maintenance medications that you fill through the Plan.

Filing a Paper Prescription Drug Claim

If you purchase your prescription drugs through a non-network pharmacy or do not show your CVS Caremark ID card at a network pharmacy, you will have to pay for the prescription drug and then file a CVS Caremark Claim Form to be reimbursed for the Plan's share of the eligible expense. If you have funds in your MRA and/or HCSA, you can be reimbursed for your share of the expense by filing an MRA and/or HCSA Claim Form (see "If You Paid Out-of-Pocket for a Prescription Drug" under "Filing a Claim for Benefits" on page 92.) Reminder, you can only be reimbursed from your HCSA once your MRA is depleted.

Forgot Your ID Card?

Not to worry. You can access an electronic version of your prescription drug ID card online at the CVS Caremark website or by downloading the CVS Caremark app.

What's Covered and Not Covered

The following chart shows common prescription drugs and their coverage status. **Please Note:** This list does not show every drug covered under the Plan. For the most current information and a full list of covered medications, visit CVS Caremark's website, accessible through **My Health** or directly at caremark.com.

Prescription Drugs Covered by the Prescription Drug Plan

Drug	Coverage Status
Allergy Serums (oral immunotherapy drugs)	Covered but requires prior authorization
Aspirin	Covered — generic aspirin (81mg only) is fully covered without a deductible as prevention medication 1) after 12 weeks of gestation in women who are at high risk for preeclampsia (Age limit: 12 or older, quantity limit: 100 units per fill); 2) for primary prevention of cardiovascular disease and colorectal cancer (Age limit: 50 to 59 years, quantity limit: 100 units per fill) OTC products require prescription
Breast Cancer Drugs	Covered — generic anastrozole, exemestane, raloxifene, and tamoxifen are fully covered without a deductible as part of a treatment therapy for women at risk for breast cancer and/or diagnosed with breast cancer for age 35 or older

Drug	Coverage Status
Contraceptives	Covered — generic prescription contraceptives are fully covered without a deductible, as are brand-name prescription contraceptives for which a generic is not available, such as Lo Loestrin® 24 Fe.* * **Please Note:** If a generic prescription becomes available for a brand-name contraceptive, the generic form of the contraceptive will be fully covered without a deductible, while the brand-name version of the contraceptive would be covered according to the provisions for other brand-name medications (see chart under "How Prescription Drug Benefits Are Paid Under the Medical Plan" on page 83).
Diabetic Supplies (includes certain glucose monitors, insulin pumps and related pump supplies)*	Covered - except alcohol wipes
Diet Medications (anorexiants and anti-obesity)	Covered but requires prior authorization
Fluoride Supplements	Covered — generic fluoride supplements are fully covered without a deductible for children age 5 or younger
Infertility Drugs (exclusive of treatment)	Covered up to a $10,000 lifetime maximum (combined Retail Pharmacy Benefit and Maintenance Choice® program) per person
Legend Vitamins	Covered
Male Impotency Drugs	Covered at 8 units per 30 days (24 units per 90 days through Maintenance Choice®).
Prescription Tobacco Cessation Products	Covered
Proton Pump Inhibitors (PPIs) (such as Prilosec, Tagamet, and Nexium)	Covered subject to preauthorization, as described under "Coverage for Proton Pump Inhibitors" on page 88
Respiratory Therapy Supplies	Covered — except nebulizers.
Solaraze (Diclofenac sodium gel 3%)	Covered but requires prior authorization.
Solodyn	Covered but requires prior authorization.

* Some glucose monitors and insulin pumps are available under the Medical Plan. For information on which insulin pumps are covered under the Medical and/or Prescription Drug Plan, please contact the appropriate provider (Aetna/Cigna and/or CVS Caremark)

Prescription Drugs Not Covered by the Prescription Drug Plan

Drug	Coverage Status
Allergy Serums (injectable)	Not covered
Blood Plasma/ Blood Transfusion Agents	Not covered
Botox and Myoblock	Not covered — for cosmetic purposes; requires prior authorization for other uses.
Bulk Powders & Topical Analgesic (compounds)	Not covered*
Cosmetic Products (such as depigmenting agents, hair growth stimulants, hair removal agents)	Not covered

Drug	Coverage Status
Mifeprex	Not covered
Non-Sedating Antihistamines (NSAs) (such as Clarinex and Allegra)*	Not covered
Nutritional Supplements (injectable or oral)	Not covered
Over-the-Counter Drugs	Not covered (but still may be less expensive than related prescription drugs)
Renova	Not covered
Rx Devices Other Than Respiratory (such as elastic bandages and supports, GI-guostomy and irrigation supplies, other Rx devices)	Not covered
Select Medical Devices and Artificial Saliva products	Not Covered
Vaccines/Toxoids	Not covered (except seasonal flu and COVID-19 vaccines, which are covered)

* Your physician and/or pharmacist may contact CVS Caremark to seek exception approval for specific medical reasons.

** Although non-sedating antihistamine (NSA) drugs are not covered under the Prescription Drug Plan, you can still obtain these and other non-covered prescription drugs (versus the over-the-counter alternative) at discounted prices through Maintenance Choice®. You pay 100% of the discounted price for non-covered drugs obtained through Maintenance Choice®.

Coverage for Proton Pump Inhibitors

If you are prescribed a brand-name proton pump inhibitor (PPI) prescription medication, you must have previously tried a generic proton pump inhibitor to receive coverage for the brand-name PPI. You should talk to your doctor to see if a generic alternative is appropriate for you. If your physician has a medical reason for you to take a brand-name PPI prescription medication rather than a generic alternative, your physician will need to contact CVS Caremark for preauthorization and a determination will be made. If the brand-name prescription is not authorized and you opt not to obtain the generic alternative available, you will be responsible for the entire cost of the prescription under the terms of the JPMorgan Chase Prescription Drug Plan.

Additional Plan Provisions

Mandatory Generic Drug Program

The Plan contains a **mandatory generic drug program,** in which generic drugs are substituted for certain brand-name* prescription drugs. If you fill your prescription with a brand-name drug when a generic equivalent is available, you pay the entire cost difference plus the generic drug copay. **Please Note:** These cost differences will not be limited by per-prescription maximums or annual out-of-pocket maximum limits. Your physician can contact CVS Caremark to seek a medical exception review for possible approval for specific clinical reasons.

*For this purpose, brand drugs refer to those brand drugs with a direct generic equivalent produced by at least two manufactures.

Step Therapy Program

Step Therapy is a program that lets members get the treatment they need affordably. It also helps the Plan maintain affordable prescription drug coverage. In step therapy, medicines are grouped in categories based on treatment and cost.

- First-line medicines are the first step. First-line medicines are typically generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.
- Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who don't respond to first-line medicines. Second-line drugs are the most expensive options.

Prior Authorization

Certain medications may only be covered by the Plan under certain conditions with a prior authorization (PA) from CVS Caremark prior to purchasing the medicine. To find out if a drug requires a PA, log in to www.caremark.com and click on "Check Drug Cost & Coverage" on the "Plan & Benefits" tab, or call CVS Caremark.

Quantity Restrictions on Covered Medications

There may be quantity limits on certain medicines. Quantity limits are based on the Food and Drug Administration's (FDA) recommended dosing guidelines for each medication and are reviewed regularly by CVS Caremark to ensure clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions.

Certain prescriptions may also be limited to less than the standard days supply, which is a thirty (30) day supply. For specific medicine limitations, please log in to www.caremark.com or call CVS Caremark at (866) 209-6093. Quantity limits may change periodically based on updates from the FDA's recommended dosing guidelines.

To determine whether your medication is subject to CVS Caremark's utilization management program such as Step Therapy, Prior Authorization or Quantity limit, etc., please contact CVS Caremark.

Pharmacy Advisor

The Plan also offers **Pharmacy Advisor**, a voluntary counseling program offered through CVS Caremark to help employees (and covered spouses/domestic partners) with certain conditions — such as diabetes or heart disease — adhere to their prescription regimen, manage their medications and make sure their medications don't conflict with each other. When you pick up your prescription at a CVS retail pharmacy, the pharmacist will automatically offer to provide onsite counseling.

Coverage for Specialty Drugs

Certain conditions such as asthma, growth hormone deficiency, hepatitis C, immune disorders, infertility, multiple sclerosis, and rheumatoid arthritis may be treated with specialty drugs. These drugs may be oral or self-injectable, include biological drugs, often require special handling, such as refrigeration, and are generally not available at the majority of pharmacies. CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides specialty drugs directly to covered individuals along with supplies, equipment, and care coordination.

Certain specialty drugs require further clinical review and prior authorization before coverage will be approved. The "CVS Specialty Drug List" can be found on CVS Caremark's website. The CVS Caremark Specialty Guideline Management Program evaluates the appropriateness of drug therapy with specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. This clinical program helps ensure patient safety, efficacy, and optimal therapeutic benefit.

If you submit a prescription for a specialty drug that requires preauthorization, CVS Caremark will undertake a review. The provider who prescribed the medication will be required to call (866) 814-5506 as part of the review process. After the review is complete, you and your physician will receive a letter confirming whether coverage has been approved or denied (usually within 48 hours after CVS Caremark receives the information it needs).

In certain cases, a first-line specialty drug may be required. This is a step therapy program that encourages the use of a preferred drug before using a non-preferred drug. Preferred drugs under this program are well-supported treatment options and represent the most cost-effective drug for a given condition. Before a non-preferred specialty drug is covered, an established evidence-based protocol must be met.

If coverage is approved, you'll pay your normal copay or coinsurance amount for your prescription. If coverage is not approved, you have the right to appeal (please see the *Plan Administration* section).

You may contact CVS Caremark Specialty Customer Care at (800) 237-2767 from 7 a.m. to 7 p.m. Central time, Monday – Friday, to arrange for expedited, confidential delivery of your specialty drug to the location of your choice. You will also have access to a pharmacist-led or nurse-led Care Team that can provide customized care, counseling on how to best manage your condition(s), patient education, and evaluation to assess your progress and to discuss your concerns.

Using Your MRA and HCSA to Pay for Services

When you need to use the Plan for covered services and expenses — whether at a doctor's office or other health care facility or at the pharmacy to purchase a covered prescription drug — you should present your Medical Plan ID card or your separate CVS Caremark prescription drug ID card. With your ID card, the provider can start the claims payment process with your health care company.

If You See an In-Network Provider

When you see an in-network provider, you will generally not be asked to pay at the point of service. Providers will typically submit a claim to your health care company, Aetna or Cigna, using the information from your ID card. Your claim for medical care will be processed as follows.

Using the Automatic Claim Payment Method

When you use the automatic claim payment method, your health care company will automatically use your MRA funds first, then HCSA funds, to pay for your portion of eligible medical and prescription drug expenses.

You generally will not be asked to pay anything during a visit to an in-network provider. Your health care company will pay the provider first from the Plan, then for your share of the cost using your MRA funds. Once your MRA funds are depleted, your HCSA funds (if applicable) will be used to pay the remaining balance. This will happen automatically through your health care company (either Aetna or Cigna). Any bill you receive from your provider will be after your MRA funds and any available HCSA funds are applied. You should pay the bill after comparing it to the statement you receive from your health care company.

For covered prescription drug expenses, the Plan will pay for its portion of the cost at the time of purchase, and your MRA funds will automatically be applied to your portion of the cost. Once your MRA funds are depleted, your HCSA funds (if applicable) will be applied, as described above. The pharmacy will tell you what amount, if any, you will need to pay.

Using the Debit Card Payment Method

With the debit card payment method, you have the option of using your debit card or paying out-of-pocket for covered expenses. Keep in mind that you will need to keep your receipts and be prepared to substantiate any debit card claims, as required by the IRS. The same debit card accesses funds from both your MRA and HCSA, if applicable.

When you have a covered medical expense, your in-network provider will generally not require payment at the time of service.

After your medical claim is processed by your health care company or at the time of a prescription drug purchase, you can either pay with your debit card or pay out-of-pocket. (You will have to pay out-of-pocket if your provider does not accept the debit card as a form of payment.) When you use your debit card, your MRA funds will be used first. Once your MRA funds are depleted, your HCSA (if applicable) will then be applied. If you pay using personal funds and later decide you wish to be reimbursed from your MRA or HCSA, you must submit a paper claim form (via mail or fax) or an online claim form for reimbursement from your MRA or HCSA. The form can be found on your health care company's website (Aetna or Cigna) or on **My Health** > Medical, Rx, MRA & Spending Accounts > Claims and Other Forms.

If Your In-Network Provider Asks You to Pay at the Point of Service

While in-network providers have been asked by Aetna and Cigna to submit claims for JPMorgan Chase employees directly to the health care companies and not to ask for payment at the time of service, occasionally an in-network provider may nevertheless ask you to pay at the time of service.

If this happens, you should show your provider your ID card and explain that your health care company needs to review the claim first to see what you owe. If you are still required to pay at the time of service, you should do so and get a receipt from your provider. For instructions on how to file for reimbursement, see "How to Submit a Claim," on page 94, under "Filing a Claim for Benefits" on page 92.

If You See an Out-of-Network Provider

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 they agree to do so, your claim will be processed as explained in "If You See an In-Network Provider" on page 90 (your health care company will see if funds are available — first from your MRA and then from your HCSA, if applicable).

If an out-of-network provider will not file a claim for you, you will need to pay for the service at the time of your visit and submit a Medical Claim Form to your health care company to be reimbursed for the Plan's share of the expense. You can file a claim online at mycigna.com or medical claim forms can be found on **My Health** or on your health care provider's website. You can also be reimbursed from your MRA/HCSA, if applicable, for your out-of-pocket share of the expense. Please see "How to Submit a Claim," on page 94, under "Filing a Claim for Benefits" on page 92 for instructions.

The MRA/HCSA and Your Prescription Drug Expenses

You must pay for your share of prescription drug expenses at the time of purchase. The payment process differs according to whether you elected or were assigned automatic claim payment or whether you elected the debit card method of payment for your MRA/HCSA. Your health care company manages both your MRA and HCSA accounts.

If You Elected or Were Assigned Automatic Claim Payment	If You Elected the Debit Card
Your network pharmacy will submit the claim through your prescription plan with CVS Caremark. After CVS Caremark pays its share of the cost, your health care company will pay your share of the expense first from your MRA and then from your HCSA, if applicable. Your MRA balance will be used first to cover your share of the cost; you won't need to pay anything. If your MRA has been exhausted, your health care company will use your HCSA balance, if any, to pay the pharmacy; you won't need to pay anything if the HCSA covers your remaining amount due. If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost, your health care company will inform your pharmacy. You will need to pay the amount you owe out-of-pocket at the time of your pharmacy visit.	Your network pharmacy will submit the claim through your prescription plan with CVS Caremark. After CVS Caremark pays its share of the cost, you can decide whether to use your debit card to pay your share of the cost or pay out-of-pocket at the pharmacy. If you use your debit card, the card would first use funds from your MRA and then from your HCSA, if applicable, to pay the pharmacy. You should keep your receipt in case you are asked to substantiate your expense. If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost, you will need to pay the remaining balance out-of-pocket. If you choose not to use your debit card and instead pay out-of-pocket, you may request reimbursement for your share of the expense from your MRA/HCSA, if applicable, later. You will need to provide a receipt if you file for reimbursement from your MRA/HCSA (see "If You Paid Out-of-Pocket for a Prescription Drug" under "Filing a Claim for Benefits" on page 92).

Filing a Claim for Benefits

When you receive in-network care, your network doctor or other provider will file the claim for you; you will generally not be asked to pay at the time of service. However, there may be instances in which you paid out-of-pocket for an expense. In these cases, you would need to file a claim form to receive reimbursement from the Medical Plan and from your MRA and/or HCSA, if applicable. After the Plan pays its share of the expense, reimbursement to you is made first from your MRA, followed by your HCSA, if applicable.

How to file a claim and determine which claim form to use depends on the services you received and whether you paid out-of-pocket, as detailed in the following sections. Always keep your receipt for any out-of-pocket expense for which you intend to file for reimbursement. Instructions for accessing claim forms, if necessary, and mailing addresses are in "How to Submit a Claim" on page 94.

If You Saw an In-Network Provider and Paid Out-of-Pocket

While in-network providers have been asked by Aetna and Cigna to submit claims for JPMorgan Chase employees directly to their health care companies and not to ask for payment at the time of service, occasionally an in-network provider may nevertheless ask you to pay at the time of service.

- If you elected or were defaulted to automatic claim payment, you will typically be reimbursed automatically by your health care provider. However, if reimbursement is not made automatically, you will need to call your provider when you receive your Explanation of Benefits (EOB). The EOB will show that your health care company made payment to your provider. You should explain to the provider's billing office that they have been paid twice: once by you at the time of service, and again when the Plan paid them from your MRA/HCSA. (On the Cigna EOB, the "What My Accounts Paid" section shows the amount paid; on the Aetna EOB, this information is in the "You may owe" section.) If you need additional assistance, you can call your health care company at the number on the back of your ID card or the JPMorgan Chase Health Advocate for help in getting reimbursed for amounts paid out-of-pocket (see "If You Have Questions about a Claim" on page 95).
- If you elected the debit card, use the MRA and/or HCSA Claim Form to request reimbursement from your accounts (see "How to Submit a Claim" on page 94).

If You Saw an Out-of-Network Provider and Paid Out-of-Pocket

Out-of-network providers may require payment at the point of service. In these circumstances, you should submit a Medical Claim Form to your health care company (see "How to Submit a Claim" on page 94) to be reimbursed for the Plan's share of the expense. Be sure **not** to sign the box on the Medical Claim Form or check the box when submitting the claim online on aetna.com or mycigna.com that authorizes your health care company to make payment directly to your provider, as the payment should be made to you.

Your health care company will process your claim to determine your and the Plan's responsibility, based on whether you have satisfied your deductible and the amount of coinsurance applicable.

- If you elected or were defaulted to automatic claim payment, in addition to processing the claim to determine the amount the Plan should have paid, your health care company will determine what amount can be paid directly to you by available MRA funds first, and then from your HCSA, if applicable.
- If you elected the debit card, you will receive an EOB showing the amount paid by the Plan. You can then submit an MRA and/or HCSA Claim Form to request reimbursement if you paid with your personal funds (see "How to Submit a Claim" on page 94).

If You Paid Out-of-Pocket for a Prescription Drug

If you paid out-of-pocket for a prescription drug at a network pharmacy because you have a debit card but chose not to use it, use the MRA/HCSA Claim Form to be reimbursed for your share of the expense (see "How to Submit a Claim" on page 94).

If you paid out-of-pocket for a prescription drug because you purchased your drugs through a non-network pharmacy or did not show your ID card at a network pharmacy, use the CVS Caremark Claim Form to be reimbursed for the amount owed by the Prescription Drug Plan (see "How to Submit a Claim" on page 94). If you have funds in your MRA/HCSA, you can be reimbursed for your out-of-pocket costs by filing a MRA and/or HCSA Claim Form (see "How to Submit a Claim" on page 94).

If You Paid Out-of-Pocket Because Your MRA/HCSA Was Depleted (But You Have Since Earned MRA Funding)

If you paid out-of-pocket for an expense because you had no funds left in your MRA/HCSA, but you have since earned MRA funds, use the MRA and/or HCSA Claim Form to be reimbursed (see "How to Submit a Claim," on page 94).

How to Submit a Claim

The Medical Claim Form and the MRA and/or HCSA Claim Form are available on **My Health**. The forms are also available on the health care company's websites.

Please Note: You can elect to have your MRA reimbursement directly deposited into an account of your choice by accessing your health care company at **My Health**.

You need to file your Medical and MRA reimbursement claims by December 31 of the year after the one in which you received the service or purchased the prescription. For example, if you incur an expense on July 1, 2021, you must file your claim for reimbursement by December 31, 2022. If you fail to meet this deadline, your claim will be denied.

Be sure to attach itemized receipts to your claim form and keep copies for your records.

You can submit an MRA/HCSA reimbursement request online or via the app (Cigna or PayFlex, an Aetna Company).

Mail your claim form to the address printed on the forms:

Medical Claim Forms

Aetna:

Aetna
P.O. Box 14079
Lexington, KY 40512- 4079

(800) 468-1266

Cigna:

Cigna
P.O. Box 182223
Chattanooga, TN 37422-7223

Customer Service: (800) 790-3086

Remember: If you have already paid your medical provider, be sure not to sign the box on the Medical Claim Form or check the box when submitting the claim online on aetna.com or mycigna.com that authorizes your health care company to make payment directly to your provider, as the payment should go to you.

Generally, Medical Claim Forms are processed in 10–12 business days and mailed with an Explanation of Benefits (EOB). Payment (if any) is sent about two weeks after the claim is processed.

MRA and/or HCSA Claim Forms

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:

Cigna
P.O. Box 182223
Chattanooga, TN 37422-7223

Customer Service: (800) 790-3086

CVS Caremark Claim Forms

The CVS Caremark Claim Form is available at **My Health**. The form is also available on the CVS Caremark website. Please mail your completed claim form to:

CVS Caremark Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196

Member Services: (866) 209-6093

Generally, prescription claims are processed weekly and mailed with payment (if any) in about two to three weeks.

You can also submit your prescription claim through the CVS Caremark website or mobile app. To do so, please visit the CVS Caremark website and click on “Submit Prescription Claim” on the Plan & Benefits tab. On the mobile app, click “Submit Claims” on the main screen. Your prescription information and receipt are required for claim submission with CVS Caremark.

If You Change Health Care Companies during Annual Benefits Enrollment

If you change health care companies during Annual Benefits Enrollment, you will also be changing the company that administers your MRA and HCSA. The transition of your MRA and HCSA accounts will happen automatically—you do not need to take any action.*

It is important to note that there will be a delay in transferring your unused MRA funds (if any) from the prior year to your MRA at your new health care company (generally occurs in the April time frame). This delay is designed to allow your prior health care company continued access to funds in your MRA to pay prior year medical and prescription drug claims that are processed in the first four months of the new year. However, if this policy creates a financial hardship, you may contact your new health care company to accelerate the transition of your MRA/HCSA account, which will allow you to access your prior year unused MRA funds more quickly.

* Any balance of up to $550 remaining in your Health Care Spending Account (HCSA) at the end of the 2020 calendar year will be automatically carried over to the next year. Any amount over $550 in your HCSA, after processing claims for the 2020 year, will be forfeited. If you were previously enrolled in the HCSA and decide not to participate in 2020, any unused amounts under $25 will be forfeited. Even if you do not participate in 2020, amounts of $25 or more will remain available for future eligible health care expenses. If you do not enroll in the JPMorgan Chase Medical Plan your balance will be managed by Cigna.

If You Have Questions about a Claim

You can check the status of your claim by accessing your health care company’s website, or you can call your health care company at the number on the back of your ID card.

If you are experiencing difficulty with a claim, the JPMorgan Chase Health Advocate program, available at **My Health**, can also help you resolve benefit claim issues.

Appealing a Claim

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

Help Pursuing Claims

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

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

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

What Is Covered

Each of the Medical Plan options cover a wide variety of services, as long as the services are medically necessary (please see the definition of “Medically Necessary” under “Defined Terms” on page 109) and their costs do not exceed reasonable and customary (R&C) charges. (Please see “Defined Terms” on page 109 for the definitions of "Necessary Services" and "Reasonable and Customary Charges.") Covered services and frequency limits may vary slightly across the health care companies — Aetna and Cigna. The lists on the pages that follow include examples of covered services, but the lists are not exhaustive, and coverage remains subject to any Plan requirements or limitations and clinical policies. For specific information on the Medical Plan's covered services and frequency limits, please contact the appropriate claims administrator (Aetna or Cigna) directly, using the telephone numbers provided under "Where to Submit Claims." The list of covered services may change at any time.

Important Note

While the services listed in this section are covered by the Medical Plan, they must be “medically necessary.” Please see the definition of “Medically Necessary” under “Defined Terms” on page 109.

Quality Providers

The health care companies (Aetna and Cigna) designate a select number of their participating providers to be “quality” providers. This is a special designation for physicians and other medical providers who have been proven to provide high-quality and cost-effective care. If you choose to use these providers, you may have better outcomes, lower medical costs, or both. Visit your health care company’s website for more information.

Preventive Care Services

The preventive care services covered at 100% in-network are determined by your health care company 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. For a list of preventive services that are covered at 100%, go to your health care company’s website. Age and frequency limits apply. Please contact your health care company for further information.

These services generally include:

- Routine care including:
  - — PAP tests (one per year, includes related laboratory fees);
  - — Prostate exams (one exam per year);
  - — Flexible sigmoidoscopy (one baseline screening, and one follow-up screening every five years;
  - — Screening colonoscopy (one baseline screening and one follow-up screening every five years);

- — Fecal occult blood test (one test per year);
- — Routine physical exams (one office visit per year with appropriate laboratory and radiology services);
- — Mammography screenings (one mammogram per year);
- — Routine screenings during pregnancy (for example for gestational diabetes and bacteriuria);
- — Breast pumps (please contact your health care company for details about which breast pumps are fully covered);
- — Travel immunizations; 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

This list is subject to change at any time.

Please Note: An in-network medical service will only be covered at 100% if it is 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 the claims administrator, as preventive medical care rather than as a diagnostic service.

Outpatient Services

Outpatient services under the Medical Plan include, but are not limited to, the following services, subject to any limitations or requirements of the Plan and based on medical necessity:

- Acupuncture, is covered when it's used:
  - — as a form of pain control, or
  - — for treatment of nausea because of chemotherapy, pregnancy or post-operative procedures;

  Treatment must be performed by a licensed provider (check with your claims administrator).
- Allergy testing and treatment;
- Chemotherapy and radiation treatments;
- Chiropractic care when medically necessary as determined by the claims administrator to diagnose or treat illness, injury, or disease. Coverage is limited to 20 visits per year (including initial consultation) 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;

- Home health care, which may require precertification; limited to a maximum of 200 visits/calendar year; one visit = four hours. (Please see "Mental Health Benefits" on page 80 for more information.) The attending physician must submit a detailed description of the medical necessity and scope of services provided to the claims administrator. The following are covered if ordered by the physician under the home health care plan and provided in the patient's home:
  - Medical supplies and laboratory services prescribed by a physician;
  - Nutrition counseling provided by or under the supervision of a registered dietitian;
  - Part-time or intermittent nursing care provided or supervised by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);
  - Part-time or intermittent home health services, primarily for the patient's medical care; and
  - Physical, occupational, speech, or respiratory therapy by a licensed qualified therapist.
- 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 the claims administrator;
- Mental health care/substance abuse care;
- Occupational therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis. Please see "Mental Health Benefits" on page 80 for more information.)
- Outpatient surgery and related follow-up care;
- Physical therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis. Please see "Mental Health Benefits" on page 80 for more information.)
- Podiatric care when medically necessary as determined by the claims administrator 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 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis. Please see "Mental Health Benefits" on page 80 for more information.)
- Temporomandibular joint syndrome (TMJ) medical treatment only; including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery up to $1,000 combined in-network and out-of-network maximum per year (appliances are not covered); and
- Virtual doctor.

The items/services listed above may change at any time.

Inpatient Hospital and Related Services

The 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, 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. **Please Note:** To receive benefits for bariatric surgery, you must contact your health care company before obtaining services; you will be informed of any required precertification. If you and/or your covered spouse/domestic partner use a Center of Excellence (COE) for your treatment you may be eligible for reimbursement of travel and lodging expenses. To learn more about the travel and lodging benefit including reimbursement see the bullet in the list below starting with "Travel Benefit" for further details.
- 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 under the Medical Plan 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 level within prescribed enrollment time frames;

Multiple Surgical Procedure Reduction Policy

The 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, these options will pay:

- 100% of your medical option's coinsurance percentage amount for the primary or major surgical procedure; and
- 50% of your medical option's coinsurance percentage amount for the secondary procedure.; and

If more than two procedures are performed, please check with your claims administrator for coverage details. Please see contact information in the *Contacts* section.

- — Care required because of 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 level within prescribed enrollment 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 level 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 after a vaginal delivery or 96 hours after a cesarean section. (However, your attending physician — after consulting with the mother — may decide to discharge the mother or newborn child earlier.)

Please Note

You have 90 days from the date of birth or adoption of a child to add your newly eligible dependents to the Medical Plan. Please see "Eligible Dependents" and "Changing Your Coverage Midyear" in the *Health Care Participation* section for more information.

- Mental health care/substance abuse care;
- 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 or tissue transplants including replacing a non-functioning or damaged organ or tissue with a working organ or tissue from another person. **Please Note**: To receive benefits for transplant surgery, you must contact your health care company before obtaining services; you will be informed of any required precertification. Covered services include physician and hospital costs, donor search, tests 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 this Plan, but only to the extent that the donor expenses are not covered under another health insurance plan. If you and/or your covered spouse/domestic partner uses a Center of Excellence (COE) for your treatment, you may be eligible for reimbursement of travel and lodging expenses if your treatment facility is more than 50 miles away from your home, see the Travel Benefit below for more information. To locate a COE, visit your health care company's website at **My Health** or call your health care company.
- Pre-admission testing when completed within seven days of hospital admission;
- Semi-private room and board;
- Take-home drugs and medications; and
- Travel Benefit: The Plan offers travel benefits for the following conditions/surgery: bariatric surgery and organ transplant up to a maximum of $10,000 per covered person per surgery/condition for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all certified and approved procedures. To qualify for this, benefit the procedure/treatment needs to take place more than 50 miles from your home.
  - — The claims administrator must receive valid receipts for such charges before you will be reimbursed. The items/services listed above may change at any time so check with your health care company to see if your condition or surgery qualifies for this benefit and for additional details on this benefit.

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 Medical Plan will provide certain benefits related to benefits received in connection with a mastectomy. The Medical 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 Medical 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 Medical Plan.

Other Covered Services

The 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, subject to any limitations or requirements of the Medical Plan, such as prior authorization, and based on medical necessity:

- Compression stockings (two pair per calendar year for the following conditions only: diabetes, varicose veins, varicose ulcers, statis dermatitis, post-phlebitic syndrome, and lymphedema);
- Coverage abroad (coverage outside of the U.S. or international coverage), as follows:

Benefit Provision	Coverage under Options 1 and 2
Treatment for a true emergency*; for example, sudden, serious chest pain	80% after in-network deductible
Treatment for an urgent situation that is not a true emergency	80% after in-network deductible
All other treatment; for example, elective surgery scheduled several months in advance	50% after out-of-network deductible

If you receive treatment while traveling outside the United States, you will have to pay for the services up front and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, please see "Filing a Claim for Benefits" on page 92. If you have any questions about benefits while traveling abroad, please call your health care company.

* True emergency as determined based on what a prudent person would consider an emergency, not on the final diagnosis reached by doctors.

- Dental procedures resulting from a congenital 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 a medical setting. **Please Note:** The charges must not be covered by the JPMorgan Chase Dental Plan or any other dental plan that you might be enrolled in.
- Diabetes services, diabetes self-management and training, and diabetic eye examinations/foot care — outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a physician and provided by appropriately licensed or registered health care professionals. Covered services also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
- Diabetic self-management items — Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under durable medical equipment (DME), and Prosthetics. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets, and lancet devices are described under the separate prescription drug plan. Please note: Specific insulin pumps may also be covered under the Prescription Drug Plan. Contact CVS Caremark for additional information on which insulin pumps are covered under the Prescription Drug Plan.
- External cochlear devices and systems;
- Gender Affirmation Surgery (may be referred to by our healthcare companies as Gender Reassignment Surgery or GRS). To be eligible, the participant must meet certain medically established guidelines that are outlined in your healthcare companies clinical polices (which may align with the WPATH Standards of Care v7), for obtaining the surgery which require the participant to, among other things:

  — Be at least 18 years old;

  — Have a gender identity disorder diagnosis;

  — Have been approved for hormone therapy;

  — Have at least one year's real life experience living in desired gender; and

  — Have two letters endorsing surgery, including one from a mental health provider at the master's degree level.

  Please refer to your health care company's clinical policies or call your health care company to discuss coverage of any specific procedure under the Plan.

  In-network surgery preauthorization is the responsibility of the in-network provider. For out-of-network surgery, you are responsible for preauthorization.
- Hearing aids: reimbursement for up to $3,000 every 36 months.

  — Hearing aids do not need to be prescribed by or obtained from an in-network provider or from an in-network Durable Medical Equipment (DME) provider in order to be considered a covered, eligible charge. You will be subject to out-of-network pricing if you obtain your hearing aid from an out-of-network provider/DME equipment provider.

  — Hearing aid evaluations and hearing tests (not included in the hearing aid maximum benefit).
- Intensive behavior therapy, such as applied behavior analysis for autism spectrum disorder.
- Local emergency ambulance service or air ambulance to the nearest hospital qualified to treat the condition if medically necessary and confirmed by a licensed provider.
- Medical equipment and supplies ordered or provided by a physician including:

  — artificial eyes and larynx (including fitting);

  — artificial limbs (excluding replacements);

- Athner monitor;
- blood and blood plasma (unless donated on behalf of the patient);
- cane;
- casts;
- crutches;
- custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot;
- heart pacemaker;
- hospital bed;
- insulin pump;
- iron lung;
- manual pump-operated enema systems;
- orthopedic braces;
- ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers and bags;
- splints;
- surgical dressings;
- trusses;
- ventilator;
- walker;
- wheelchair; and
- other items necessary to the treatment of an illness or injury that are not excluded under the Plans.

Prior authorization or pre-certification may be required for coverage of some medical equipment and supplies. The claims administrator 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;
- Non-emergency transportation is covered if it is provided by a licensed professional ambulance (either ground or air ambulance as determined appropriate) when the transport is:
  - from an out-of-network hospital to the closest in-network hospital with capabilities to care for the condition;
  - to a hospital that provides a higher level of care that was not available at the original hospital (when medically necessary for the patient's care);
  - to a more cost-effective acute care facility (as authorized by the Plan) from an acute facility to the nearest sub-acute facility;
- Nutritional support, including nutritional counseling (limited to 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.

— The limits noted above do not apply for nutritional counseling for behavioral disorders (eating disorders).

* 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; that is, 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 related supplies, including fitting, adjustments, and repairs, and biomechanical devices, if ordered by a licensed provider. Please check with the claims administrator 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 — includes cranial orthotics (helmets) custom molded, when prescribed by physician — as determined by the claims administrator and if ordered by a licensed provider. Frequency and other limitations may apply. At the claims administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear when repair costs exceed new purchase price, or when a change in the medical condition occurs sooner than the end of a three-year time frame. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouthpieces, etc., for necessary durable medical equipment are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.
- Services and supplies that are part of an alternate care proposal. This is a course of treatment developed and authorized by the claims administrator 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 benefits, maximum amounts, copayments, and deductible will apply to these services.
- Skilled nursing facility for up to 365 days per lifetime (combined in-network and out-of-network). The lifetime maximums reflect services received across all JPMorgan Chase Medical Plans.
- Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to sickness or injury.
- Termination of Pregnancy

  — Voluntary (i.e. abortion)

  — Involuntary (i.e. miscarriage)

- Urgent care;
- Voluntary sterilization; and
- Wigs up to a $500 per year limit, for burns, chemotherapy or radiation, accidental injury, after a diagnosis of alopecia, or for other medically necessary reasons.

The items/services listed above may 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 $10,000 ($30,000 if a Center of Excellence (COE) is used) combined lifetime maximum benefit for each covered individual. This limit applies to all benefits received under the Medical Plan regardless of whether the service was received in-network or out-of-network. Please note: amounts paid by the Plan (not your out-of-pocket expenses) apply to the Lifetime Infertility maximum. This limit does not apply to the services used to determine the initial diagnosis of infertility and/or its cause, which are not subject to the $10,000 ($30,000 if using a COE) benefit maximum. All procedures and access will be governed by the health care company's clinical policies for determining appropriateness of care. Please also see the "Infertility Drugs" information under "What's Covered and Not Covered" on page 86 for information on a $10,000* lifetime maximum on prescription drugs related to infertility treatment. Please contact your health care company for specific details.

Please Note:

- To receive benefits for infertility services, you must contact your health care company and receive precertification before obtaining services.
- If you use a COE for your treatment, your lifetime infertility benefit maximum will be increased to $30,000. You must complete all program requirements to earn the increase to the benefit maximum. To locate a COE, contact your health care company.

  * The lifetime maximum for prescription drugs under the infertility benefit includes the charges paid by the Plan. Your prescription drug out-of-pocket expenses (dollars you pay towards the deductible, coinsurance/copayment and costs for non-covered drugs) are not included in the either the Medical or prescription drug plan lifetime maximum.

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. To use infertility benefits covered under the Plan, you must contact your health care company and work with them and your doctor to determine your appropriate course of treatment.

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.

Mental Health Benefits

Mental health care or benefits, in accordance with the Mental Health Parity and Addiction Equity Act, are items or services for mental health or substance use disorder conditions, as determined solely within the discretion of the plan administrator, consistent with generally recognized independent standards of current medical practice. Conditions affecting physical health that are related to a mental health condition or substance use disorder are medical/surgical benefits rather than mental health care benefits under the Medical Plan. However, for those individuals with a mental health diagnosis, associated medical treatments subject to visit limits (such as physical, occupational, and speech therapy and home health care services) will not be subject to an annual visit limitation.

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 the claims administrator. It must be either a hospital or a freestanding 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 the claims administrator. If such a program is required by federal or state 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 or 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.

The items/services listed above may change at any time.

Coverage Limitations

As mentioned earlier, certain covered services are limited to a specific number of visits or days or limitations, subject to applicable deductibles and coinsurance.

These limitations are included in the coverage charts earlier in this section. Please see “Mental Health Benefits” on page 80 for more information.

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 Medical Plan covers a wide variety of medically necessary services, some expenses 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’s/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 (unless prescribed by a physician); corrective shoes (unless prescribed by a physician); 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);
  - If you enter into an agreement with a provider regarding the waiver of an expense, you are required to inform your health care company of the agreement.
- Expenses in excess of reasonable and customary charges for out-of-network services;
- Expenses submitted later than December 31 of the year after the year in which services were provided;
- Experimental, investigational, or unproven services, devices, or supplies (see the definition of “Experimental, Investigational, or Unproven Services” under “Defined Terms” on page 109);
- Extended benefit coverage after termination from JPMorgan Chase (other than coverage elected through COBRA). If you are hospitalized on the date your JPMorgan Chase Medical Plan coverage terminates, Medical Plan coverage will end at midnight that day.
- Hospital admissions and other services that began before the participant’s effective date of coverage under the 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 JPMorgan Chase Prescription Drug 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 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 because of 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.
  - Food supplements, specialized infant formulas (e.g., Alimentum, Elecare, and Neocate), lactose-free foods, vitamins and/or minerals may be used to replace intolerable foods, for lactose intolerance, to supplement a deficient diet, or to provide alternative nutrition in the presence of such conditions as allergies, gastrointestinal disorders, hypoglycemia, and obesity. Food supplements, lactose-free foods, specialized infant formulas, vitamins and/or minerals taken orally are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.
- Personal services for comfort or convenience while in the hospital, such as television, telephone, etc.;
- Physical, psychiatric, or psychological exams, testing, vaccinations, or treatments if required solely for purposes of school, sports or camp, 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 after cataract surgery;
- Refractive eye surgery including, but not limited to, LASIK or radial keratotomy;
- Reproductive education and conception prevention classes;
- Reversals of sterilization;
- Routine dental care (please see the Dental Plan Summary Plan Description on **My Health** for information about services covered under the JPMorgan Chase Dental Plan);
- Routine eye exams (please see the Vision Plan Summary Plan Description on **My Health** for information about services covered under the JPMorgan Chase Vision Plan);
- Services, supplies, or treatment for weight loss, nutritional supplements, or dietary therapy;
- Sickness or loss covered by state workers' compensation law 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 the claims administrator in its sole discretion to be part of a global procedure; and
- Vision Therapy

The items/services listed above may change at any time.

Defined Terms

As you read this SPD for the JPMorgan Chase Core Medical Plan, you'll come across some important terms related to the Plan. To help you better understand the Plan, many of those important terms are defined here.

Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical Plan payroll contributions are taken on a before-tax basis.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Medical Plan. If you elect Medical Plan coverage, your claims administrator is your health care company (Aetna or Cigna, depending on your election) and CVS Caremark for prescription drug coverage.
Coinsurance	Coinsurance is the way you and the Plan share costs for certain covered health care services, generally after you pay any applicable deductible under the Medical and/or Prescription Drug Plan. For medically necessary covered in-network services, the Medical Plan pays a percentage of providers' negotiated fees and you pay the remainder. For medically necessary covered out-of-network services, the Medical Plan pays a percentage of the reasonable and customary (R&C) charges for services and you pay the remainder (you are responsible for paying any additional amount above R&C charges). The coinsurance percentage you pay depends on 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 Medical Plan. There are separate in-network and out-of-network coinsurance maximums. Once the coinsurance maximum is reached, the 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. Under the Medical Plan, amounts that you pay toward your medical deductible, amounts above R&C charges for out-of-network care, and your deductible, copayments, and coinsurance for prescription drugs do not count toward your medical coinsurance maximum. There is a separate coinsurance maximum for the Prescription Drug Plan. Please see "Right of Recovery" in the *Plan Administration* section for information on circumstances when you may be required to repay the benefits you've received under the Plan.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that allows you and/or your covered dependents to continue Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise end. The *Health Care Participation* section provides details on COBRA coverage.

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 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).
- Covered by Medicare.

If you or a dependent are eligible for Medicare because of disability or end-stage renal disease, please see "Coordination with Medicare" in the *Plan Administration* section for more information.

Copayment

A copayment (also known as a copay) is the fixed dollar amount you pay for certain medications under the Prescription Drug Plan. For example, copayments apply for generic drugs.

Covered Services

While the Plan provides coverage for numerous services and supplies, there are limitations on what's covered. For example, experimental treatments, most cosmetic surgery expenses, and inpatient private duty nursing are not covered under the Medical Plan. Medical procedures are generally reimbursable by the JPMorgan Chase Medical Plan only if they meet the definition of "Medically Necessary" (see the definition "Medically Necessary," below).

Custodial Care

Custodial care is medical or non-medical services that do not seek to cure, are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel. An example of custodial care is assistance in the activities of daily living.

Deductible

The deductible is the amount you pay up front each calendar year for covered expenses before the Medical Plan generally begins to pay benefits for many expenses. There are separate in-network and out-of-network deductibles. Amounts in excess of reasonable and customary (R&C) charges and ineligible charges do not count toward the deductible. A separate deductible applies for the Prescription Drug Plan.

Domestic Partner

You may cover a "domestic partner" as an eligible dependent under the Medical Plan if you're not currently covering a spouse.

- 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 see "Domestic Partners" in the *Health Care Participation* section for more information.

Eligible Dependents	Under the Medical Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see the above definition of "Domestic Partner" and see "Eligible Dependents" in the *Health Care Participation* section for more information.
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 Medical Plan and through any related Medical Reimbursement Account and/or Health Care Spending Account.
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, the supervision of intravenous therapy or other skilled nursing care.
Hospice Care Program	A hospice care program is a program that tends to the needs of a terminally ill patient as an alternative to traditional health care, while meeting medically necessary and acceptable standards of quality and sound principles of health care administration. The program must be a written plan of hospice care for a covered person, and it must be approved by the appropriate claims administrator.
Hospital	A hospital is an institution legally licensed as a hospital — other than a facility owned or operated by the United States government — that's engaged primarily in providing bed patients with diagnosis and treatment under the supervision of licensed physicians. The hospital must have 24-hour-a-day registered graduate nursing services and facilities for major surgery. Institutions that don't meet this definition don't qualify as hospitals.
Hospital Notification	Hospital notification refers to the requirement under the Medical Plan that you should notify the claims administrator in advance of a non-emergency hospital admission or if a maternity stay exceeds the guidelines. However, you will not be penalized under the Plan if you do not notify the claims administrator.

In-Network

"In-network" describes a covered service that is performed by a physician, 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.

Medical Reimbursement Account

A Medical Reimbursement Account ("MRA," also known as a Health Reimbursement Account" or "HRA") is a tax-free account established on your behalf at your health care company when you enroll in the Medical Plan. You (and your covered spouse/domestic partner) can earn Wellness Rewards for your MRA by completing the Initial Wellness Activity and Additional Wellness Activities. This account is JPMC-funded only; you cannot contribute to your MRA. You can use the funds in your MRA to pay for covered out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments).

Medically Necessary

Medically necessary health care services and supplies are services or supplies that are determined by the claims administrator in its sole discretion 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.

Multiple Surgical Procedure Reduction Policy

The multiple surgical procedure reduction policy applies under the Medical Plan. 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.

Non-Duplication of Benefits	Non-duplication of benefits is a provision that requires that the Medical Plan does 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 Medical 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 Medical 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.
Out-of-Network	"Out-of-network" describes a covered service that is performed by a physician, 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	An out-of-pocket expense is the amount you pay for eligible expenses when you receive treatment. This includes your deductible, coinsurance, and copayments.
Out-of-Pocket Maximum	The out-of-pocket maximum, under the Prescription Drug Plan, is the maximum amount you would have to pay each year in copayments and coinsurance for prescription drugs. The annual out-of-pocket maximum does not include the deductible. After you reach the annual out-of-pocket maximum, the Prescription Drug Plan would pay 100% of the cost of covered prescription drugs for the remainder of the year. Please see "Right of Recovery" in the *Plan Administration* section for information on circumstances when you may be required to repay the benefits you've received under the Plan.
Primary Care Physician	A primary care physician ("PCP") is the network physician who provides or coordinates all the care you receive. Primary care physicians include doctors who practice family medicine, internal medicine,* obstetrics/gynecology, and pediatrics. Care provided by an in-network primary care physician is covered at 90% of the pre-negotiated fee and is not subject to the deductible. * Internists must be contracted with Aetna or Cigna as Primary Care Physicians. (A list of doctors who are designated as Primary Care Physicians is available on Aetna or Cigna's websites.)
Primary Plan	The primary plan is the plan that provides initial coverage to the participant. If the participant is covered under both a JPMorgan Chase Medical Plan option 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 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 information.
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.) Any changes you make during the year must be consistent with your QSC. Please see "Changing Your Coverage Midyear," in the *Health Care Participation* section for more information. **Please Note:** Regardless of whether you experience a QSC, you cannot change your health care company during the year.

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. 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 Plan, you'll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered covered expenses. Therefore, they don't count toward your deductible, benefit limits, or coinsurance maximums.
Regional Cost Category	The regional cost category is the category that is assigned to a state or region based on the cost of health care for that region in relation to the national average. The Regional Cost Category is used to determine your Medical Plan contributions and is based on your home address.
Self-Insured	A self-insured plan is a plan where the sponsor (in the case of the Medical Plan, JPMorgan Chase) is responsible for the payment of medical claims under the Medical Plan, including the Prescription Drug Plan. This makes the Plan self-insured.
Skilled Nursing Facility	A skilled nursing facility is an institution that primarily provides skilled nursing care and related services for people who require medical or nursing care, and that rehabilitates injured, disabled, or sick people.
Spouse	Your spouse is the 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 **My Health**.
Tobacco-User Surcharge	The tobacco-user surcharge refers to additional Medical Plan contribution costs for employees and covered spouses/domestic partners who use tobacco products. Eligible employees and covered spouses/domestic partners who do not use tobacco products pay less for coverage under the Medical Plan than those who use tobacco products. A "tobacco user" (for a plan year), as defined in the Medical Plan, is any person who has used any type of tobacco products (for example, cigarettes, cigars, pipes, chewing tobacco, snuff, or a pipe) regardless of the frequency or location (this includes daily, occasionally, socially, at-home only, etc.) in the 12 months preceding January 1 of the plan year. Tobacco users may be able to qualify for lower non-tobacco user rates by completing a tobacco cessation program (see "Tobacco Cessation Program" on page 68).
Total Annual Cash Compensation	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. Total Annual Cash Compensation is used for purposes of determining your Medical Plan contribution pay tier, deductible and in-network coinsurance maximum.
Visit	A visit is an encounter with a provider involving direct patient contact. Some benefit provisions limit the number of covered visits. Unless a visit is defined for a particular benefit provision (such as home health care), each procedure code billed counts as a visit toward the limit. The length of a visit may vary by procedure code.

The Simplified Medical Plan

Effective 1/1/21

If you are a benefits eligible employee living in Arizona or Ohio, the JPMorgan Chase Medical Plan coverage for you is available via the Simplified Medical Plan.

- *If you are a U.S. benefits-eligible employee residing anywhere in the U.S. other than Arizona or Ohio, the JPMorgan Chase Medical Plan coverage for you is available via the Core Medical Plan. For details on the Core Medical Plan, see that section of Your JPMC Benefits Guide.*

The Simplified Medical Plan has no in-network deductible or coinsurance. Instead, there are fixed copayments for covered services. This health care "menu" approach allows you to learn about and understand your out-of-pocket costs prior to receiving care. And, if your copayments ("copays") add up to the out-of-pocket maximum in a plan year, the Plan pays 100% of your eligible in-network costs for the remainder of that year.

In addition to providing coverage in the event of illness, the Simplified Medical Plan offers coverage for eligible preventive care and eligible preventive generic prescription drugs for free ($0 cost share), along with an integrated Simplified Wellness Program to help you and your family stay healthy and a Medical Reimbursement Account (MRA) to help you pay for eligible out-of-pocket costs. You can earn funds for your MRA when you (and your covered spouse/domestic partner) participate in certain wellness activities.

About this Summary Plan Description

This section is the summary plan description (SPD) and the plan document for the Simplified Medical Plan. Please retain this section for your records. Other sections and subsections of *Your JPMC Benefits Guide* may also constitute the complete SPD/plan document, including the *Health Care Participation Plan Administration* and sections.

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.

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

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

For U.S. Benefits-Eligible Employees Outside of Arizona and Ohio

If you are a U.S. benefits-eligible employee living anywhere but Arizona or Ohio, your JPMorgan Chase medical coverage is available via the Core Medical Plan, not the Simplified Medical Plan. For details, see the *Core Medical Plan* section.

Two Options

The Simplified Medical Plan offers two options, Simplified Option 1 and Simplified Option 2. Both options offer the same coverage for medically necessary services and supplies, including prescription drugs. In addition to choosing between the two options, you also choose whether your coverage is provided through Aetna or Cigna, both of which have broad networks of doctors and hospitals. The key differences between the two options is the level of payroll contributions, copays and out-of-pocket maximums.

- Option 1 has higher payroll contributions but a lower annual out-of-pocket maximum and generally lower copays.
- Option 2 has lower payroll contributions but a higher annual out-of-pocket maximum and generally higher copays.

Both Aetna and Cigna have networks of selected health care providers, and you are strongly encouraged to go to in-network providers, as this saves both you and JPMorgan Chase money. However, you have the option to use out-of-network providers if you choose. The Prescription Drug Plan is part of the Simplified Medical Plan and is administered by CVS Caremark — regardless of which option or health care company you choose.

Our Health Care Companies

JPMorgan Chase has selected **Aetna and Cigna** to administer our Simplified Medical Plan. Both are large, established companies that offer broad nationwide provider networks.

They also offer strong, well-established clinical programs and provide tools and resources to help you research and understand your health treatment alternatives. You can choose to have one of these health care companies administer your Medical Plan, regardless of whether you choose Option 1 or Option 2.

Provider Directories

You can easily check which health care providers participate in the various JPMorgan Chase Medical Plan options by accessing your health care company's website at **My Health**.

Please Note: You should always check with your health care provider to ensure that he or she plans to continue participating in the network of the Medical Plan option you choose. **If your health care provider decides to leave the network, it does not qualify as an event that allows you to change your health care company during the year.**

The Medical Reimbursement Account

When you enroll in Option 1 or Option 2 through Aetna or Cigna, you will automatically be set up with a Medical Reimbursement Account (MRA). The MRA is a company-funded account that you can use to help pay for covered out-of-pocket medical and prescription drug expenses (out-of-network deductibles and copayments). You can earn Wellness Rewards for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in certain wellness activities.

Questions?

For questions or concerns regarding the Medical Plan, please contact your health care company (Aetna or Cigna) or the Prescription Drug Plan administrator, CVS Caremark:

Aetna
(800) 468-1266
8 a.m. to 8 p.m., all times zones

Cigna
(800) 790-3086
24/7

CVS Caremark
(866) 209-6093
24/7

For additional specialty 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 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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Simplified Medical Plan Coverage Highlights

My Health

My Health is your central internal online resource for our health care plans. From **My Health**, you can easily connect to the Medical Plan carriers' websites to find in-network provider directories, access treatment cost estimators, check claims status, view Explanations of Benefits (EOBs), track your Medical Reimbursement Account balance, access your electronic ID card and much more. **My Health** also has benefits materials, tip sheets and other information on health and wellness.

Your Simplified Medical Plan Options

Option 1 and Option 2 of the Simplified Medical Plan, each offered through Aetna and Cigna, are copayment-based plans that do not have a deductible for in-network services. Both options cover the same medically necessary services and supplies, including prescription drugs and pre-existing conditions.

However, Option 1 has higher payroll contributions but generally lower copays and out-of-pocket maximums, while Option 2 has lower payroll contributions but generally higher copays and annual out-of-pocket maximums.

Option 1 and Option 2 benefits are offered through a network of participating health care providers (for example, doctors, hospitals, labs, and outpatient facilities that belong to Aetna and Cigna's networks).

You can visit any provider each time you need care, even if it's not in the network. But even though there is an out-of-network benefit available, JPMorgan Chase strongly urges you to stay in-network. Selecting out-of-network providers and services cost more for all employees and JPMorgan Chase. Selecting in-network providers and services will reduce your out-of-pocket costs. Additionally, to help make it easier for you to find in-network care, Aetna and Cigna continue to increase the size of their network by adding doctors and hospitals and other ancillary providers (e.g., laboratories).

For In-Network Care

- There is no annual deductible and no coinsurance.
- You pay only the copayment — a fixed out-of-pocket amount — associated with each covered service.
- You are not required to select or assign a Primary Care Physician.
- You do not need referrals to see a specialist.
- **Important:** Eligible in-network preventive care, including physical exams and recommended preventive screenings, is covered at 100% with no copays; and in-network primary care and mental health care office visits (psychologists, therapists, etc.) are covered after a $15 copayment. Primary care physicians include doctors who practice family medicine, internal medicine (and are contracted with Aetna or Cigna as Primary Care Physicians), obstetricians/gynecologists, and pediatricians. Visits to convenience care clinics, such as CVS Minute Clinic®, are also considered primary care visits.

The Out-of-Pocket Maximum

The plan's out-of-pocket maximum — your financial "safety net" — limits the total amount you are required to pay out-of-pocket each year. The out-of-pocket maximum includes both medical and prescription drug amounts (i.e., a combined maximum). Note that there are separate out-of-pocket maximums for in-network and out-of-network charges.

For Out-of-Network Care	▪ You generally must meet an annual deductible before the copays apply for covered services. ▪ Benefits for out-of-network care have a higher copay than for in-network care. ▪ There is a separate, higher out-of-pocket maximum for out-of-network charges. ▪ Benefits for out-of-network care are limited to reasonable and customary (R&C) charges after you meet the out-of-network deductible. These R&C charges are based on average claims data in your area and are determined by your health care company to be appropriate fees for medical services. You are responsible for any amount above the R&C charges. ▪ It's important to understand that if you are using out-of-network providers (doctors, facilities or other service providers), it is your responsibility to check with your health care company to see if there is a prior authorization or medical necessity requirement that you need to meet before receiving any out-of-network treatment, service or procedure. Otherwise, the treatment, service or procedure may not be covered by the Plan and you will be responsible for the full cost.
Prescription Drug Coverage	Prescription drug coverage copays are based on the drug category and where you fill your prescription. Preventive generic drugs are covered at 100%, with no copay. There is no deductible for prescription drug coverage.
Medical Reimbursement Account (MRA)	When you enroll in Simplified Option 1 or Simplified Option 2, you are eligible to receive funding in a tax-free account, the Medical Reimbursement Account (MRA), that you can use to pay for eligible medical and prescription drug out-of-pocket expenses not covered by your plan. Your MRA is funded by JPMorgan Chase when you and your covered spouse/domestic partner complete certain wellness activities. You cannot contribute your own dollars.
Your Coverage Level	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).
Contribution Rates	Contribution rates vary by the types of dependent whom you choose to cover — for example, 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 meet eligibility requirements.) Contributions will also vary based on your Total Annual Cash Compensation, geographical location, the Simplified Medical Plan option you select, your and your covered spouse's/domestic partner's tobacco user status, and your and your covered spouse's/domestic partner's Initial Wellness completion status. The amount you pay does not differ depending on whether you choose Aetna or Cigna as your health care company.
Covered Services	Covered services will generally include: ▪ Hospitalization; ▪ Surgical procedures; ▪ Physician's office visits; ▪ Lab services/X-rays; ▪ Emergency room services; ▪ Maternity care; ▪ Mental health and substance abuse care; and ▪ Prescription drugs. The Medical Plan also covers various preventive care services. Services and procedures must be considered medically necessary to be covered.
Resources	Resources to help you make health care decisions include: ▪ NurseLine; ▪ Expert Medical Advice; ▪ Health Advocate; ▪ Condition Management; ▪ Treatment Decision Support; and ▪ Maternity Support Program.

Simplified Medical Plan Options

The Simplified Medical Plan offers two options, Simplified Option 1 and Simplified Option 2. Both options offer the same coverage for medically necessary services and supplies, including prescription drugs. In addition to choosing between the two options, you also choose whether your coverage is provided through Aetna or Cigna, both of which have broad networks of doctors and hospitals. The key differences between the two options is the level of payroll contributions, copays and out-of-pocket maximums.

Here's how the two Medical Plan options compare:

- Option 1 has higher payroll contributions but a lower annual out-of-pocket maximum and generally lower copays.
- Option 2 has lower payroll contributions but a higher annual out-of-pocket maximum and generally higher copays.

JPMorgan Chase uses a "flat-dollar subsidy" approach, which means that JPMorgan Chase will generally contribute the same dollar amount (or "subsidy") to the cost of your coverage regardless of which Medical Plan option you choose.

Cost of Coverage

You and JPMorgan Chase share the cost of coverage under each of the Simplified Medical Plan options. You pay for coverage through payroll contributions with before-tax dollars.

The amount you pay via payroll contributions depends on several factors:

- The Medical Plan option you choose (described under "The Simplified Medical Plan" on page 115);
- The number and type of eligible dependents you cover (described under "Eligible Dependents" in the *Health Care Participation* section;
- The level of your Total Annual Cash Compensation (see "Total Annual Cash Compensation" on page 123);
- Your and your covered spouse's/domestic partner's Initial Wellness Activity completion status (see "Initial Wellness Activity (New Activity for 2021, Applies to Wellness Activity Completed in 2020)" on page 128); and
- Your and/or your covered spouse's/domestic partner's tobacco user status (see "Tobacco User Status" on page 124).
- Where you live (see "Regional Cost Categories" on page 125).

If you cover your children, 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 meet eligibility requirements).

The amount you pay does not differ depending on whether you choose Aetna or Cigna as your health care company.

You will have a higher cost for coverage if your Total Annual Cash Compensation (TACC) is higher, you elect Option 1, you cover more dependents, you and/or your covered spouse/domestic partner are a tobacco user, you and/or your covered spouse/domestic partner do not complete the Initial Wellness Activity and/or costs in your geographic area are higher than they are elsewhere.

Tax Treatment of Domestic Partner Coverage/Gross-Up Policy

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 medical 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.

Enrolling a Domestic Partner

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

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

Total Annual Cash Compensation

Under the Medical Plan, Total Annual Cash Compensation (TACC) is used to determine your Medical Plan contribution pay tier, the annual deductible and the annual coinsurance maximum.

Your TACC is:

- Your annual rate of base salary plus applicable job differential pay (for example, shift pay) as of each August 1, plus
- Any cash earnings from any incentive plans (for example, annual incentive compensation, 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.

For purposes of determining the Medical Plan contribution pay tier that applies to you, your TACC is recalculated as of each August 1 to take effect the next January 1, and will remain unchanged throughout the year. For most employees hired on or after August 1, TACC will be equal to base salary plus job differentials.

Separate definitions may apply to employees in certain positions who are paid on a draw-and-commission basis. If this situation applies to you, you will be notified by your Line of Business.

Your TACC in effect for the plan year is available on the Benefits Web Center via **My Health.**

Please Note: Your TACC is measured as of August 1 and remains unchanged for purposes of determining Medical Plan contributions and the coinsurance maximum for the next calendar year.

Tier	Total Annual Cash Compensation	Employee Pays
1	< $45,000	*Least* ↓ *Most*
2	$45,000–$59,999	
3	$60,000–$79,999	
4	$80,000–$149,999	
5	$150,000–$249,999	
6	$250,000–$349,999	
7	$350,000 and above	

Simplified Wellness Program

By completing the Initial Wellness Activity, during the annual specified time frame, you can save $500 in your annual medical payroll contributions. If you cover your spouse/domestic partner, you can save an additional $500 if your spouse/domestic partner also completes their Initial Wellness Activity during the annual specified time frame. In addition to savings on medical payroll contributions, timely completion of this activity will also earn employees Wellness Rewards in their Medical Reimbursement Account (MRA). For the 2021 plan year, Initial Wellness Activity is the online Wellness Assessment only. There are special provisions for newly eligible members or employees on a leave of absence. Please see “Initial Wellness Activity (New Activity for 2021, Applies to Wellness Activity Completed in 2020)” on page 128 for more information about the 2021 Initial Wellness Activity and other ways to earn Wellness Rewards for your MRA.

Tobacco User Status

Employees and their covered spouses/domestic partners who do not use tobacco products pay less for medical coverage. Each year, employees must verify their status as a non-tobacco user or tobacco user, as well as the status of their covered spouse/domestic partner. To be considered a non-tobacco user and pay lower, non-tobacco user rates under the Medical Plan for a plan year, you and/or your covered spouse/domestic partner must either:

- Be tobacco-free for at least 12 months as of January 1 of that plan year; or
- Complete an approved tobacco cessation program.

If you continue to use tobacco, you will need to complete the Quit for Life tobacco cessation program offered free of charge by JPMorgan Chase annually to continue to qualify for the lower, non-tobacco user rates. If you and/or your covered spouse/domestic partner meet the definition of a tobacco user but fail to declare your tobacco user status, you may be subject to disciplinary action.

Please Note: In your first calendar year of employment, you will be assigned non-tobacco user rates for you and your covered spouse’s/domestic partner’s coverage. This assignment applies even if you declare yourself and/or your covered spouse/domestic partner as tobacco users, because you may not have had an opportunity to complete a tobacco cessation course to qualify for the lower non-tobacco user rates. In subsequent years, however, you will be eligible for non-tobacco user rates only if you have been tobacco-free for 12 months (as of January 1) or if you complete the Quit for Life tobacco cessation program, as described in the preceding paragraph.

If you were hired on or after September 1, for the current plan year and in the next plan year, you will be assigned non-tobacco user rates for your and your covered spouse’s/domestic partner’s coverage even if you declare yourself and/or your covered spouse/domestic partner as a tobacco user. This assignment applies because you may not have had an opportunity to complete a tobacco cessation program to qualify for the lower non-tobacco user rates.

You’ll receive more information about the opportunity to update your tobacco user status during each Annual Benefits Enrollment.

For more information on the Tobacco Cessation Program, go to **My Health**.

How Tobacco User Is Defined

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

Regional Cost Categories

Costs for medical care differ across the United States. To ensure equity in how the Medical Plan options are priced, JPMorgan Chase applies the concept of geographic cost differences to the Medical Plan. Under the Plan, each state or region is assigned to a "Regional Cost Category" based on the cost of health care for that region in relation to the national average.

The Regional Cost Category for your home state or region will be a factor in determining your medical payroll contributions, along with the other factors described in "Cost of Coverage" on page 122.

The following chart shows the different Regional Cost Categories for Medical Plan coverage (categories are the same for Option 1 and Option 2). The chart below includes all states. The Simplified Plan is offered to U.S. benefits-eligible employees living in Arizona and Ohio.

Regional Cost Category*	Locations
Category 1 (lowest cost category)	California; Colorado; Evansville and Jeffersonville, Indiana; Kansas; Nebraska; New York (excluding Metro New York); Utah; Washington
Category 2	**Arizona**; Arkansas; Delaware; Georgia; Illinois (excluding Chicago); Iowa; Kentucky; Maryland; Missouri; Nevada; North Carolina; Oklahoma; Oregon; Pennsylvania; South Carolina; Austin and San Antonio, Texas; Virginia; Washington, D.C.
Category 3	Alabama; Alaska; Florida; Hawaii; Idaho; Chicago, Illinois; Gary, Indiana; Maine; Massachusetts; Michigan; Minnesota; Mississippi; Montana; New Hampshire; New Mexico; North Dakota; **Ohio**; Rhode Island; South Dakota; Tennessee; Houston, Texas; Vermont; Wyoming
Category 4	Connecticut; Indiana (excluding Evansville, Gary and Jeffersonville); New Jersey; Metro New York; Dallas, Texas
Category 5 (highest cost category)	Louisiana; West Virginia; Wisconsin

*Category numbers range from 1-5 (with 1 being the lowest cost; and 5 being the highest cost)

The Medical Reimbursement Account (MRA) and Wellness

The Medical Plan includes a health reimbursement account, which we call the Medical Reimbursement Account (MRA). This tax-free account will automatically be established on your behalf at your health care company — Aetna or Cigna. PayFlex, an Aetna company, will administer the MRA if you select Aetna. Your MRA is completely company-funded; you are not permitted to contribute.

To Check Your MRA Balance

Go to **My Health** > My MRA Balance.

You can earn funds, called Wellness Rewards, for your MRA when you take action for your health by completing certain wellness activities. You can also earn Wellness Rewards for your MRA when your covered spouse/domestic partner also completes certain wellness activities.

Wellness Rewards are available through the Wellness Program, which gives you and your covered spouse/domestic partner ways to get and stay healthy. The program provides tailored, personal support to help you make educated health care decisions when you need treatment. In addition to earning Wellness Rewards, you can also save money on your medical payroll contributions by completing the Initial Wellness Activity. See "Wellness Activities within the MRA" on page 127 for more information.

You can access all the Wellness Program offerings easily through **My Health** > Wellness Activities & Services or by calling Cigna about Initial Wellness Activity or Virgin Pulse about Additional Wellness Activities.

The MRA

You can use the MRA to help pay for covered out-of-pocket medical and prescription drug expenses, such as copayments incurred by you and your covered dependents and deductibles for out-of-network services. **Please Note:** MRA funds cannot be used to pay for dental or vision expenses. However, you can be reimbursed for these expenses from a Health Care Spending Account (HCSA), if you choose to participate in that plan. Please see the *Spending Accounts* Summary Plan Description on **My Health** for more information.

Unused funds left in your MRA at year-end automatically carry over for use in future years, as long as:

- You remain a JPMorgan Chase employee enrolled in the Medical Plan*; or
- You leave JPMorgan Chase and you are eligible for retiree medical plan coverage or you elect to continue your medical coverage through COBRA (see "What Happens to Your MRA If Your Employment with JPMorgan Chase Ends" on page 132).

* If you are an active employee who previously enrolled in the Medical Plan and had an MRA balance but you currently choose not enroll in the Medical Plan, any unused MRA funds will be placed on hold for you by your health care company and will be available to you if you re-enroll in the Medical Plan in a subsequent year.

You can earn up to $740 ($1,110 if your covered spouse/domestic partner also participates) in Wellness Rewards for your MRA by completing certain wellness activities in a given year. The following sections summarize the opportunities for 2021 to earn Wellness Rewards.

See "MRA Payment Elections" on page 131 and "Using Your MRA and HCSA to Pay for Services" on page 157 for more information.

Your MRA and/or Spending Accounts (HCSA, DCSA) are administered by your health care company (Aetna/PayFlex or Cigna), or Cigna if you are not enrolled in the JPMC Medical Plan. If you change health care companies (from Aetna to Cigna or vice versa) during Annual Benefits Enrollment, your balance will automatically be transferred to your new health care company (generally the April timeframe).

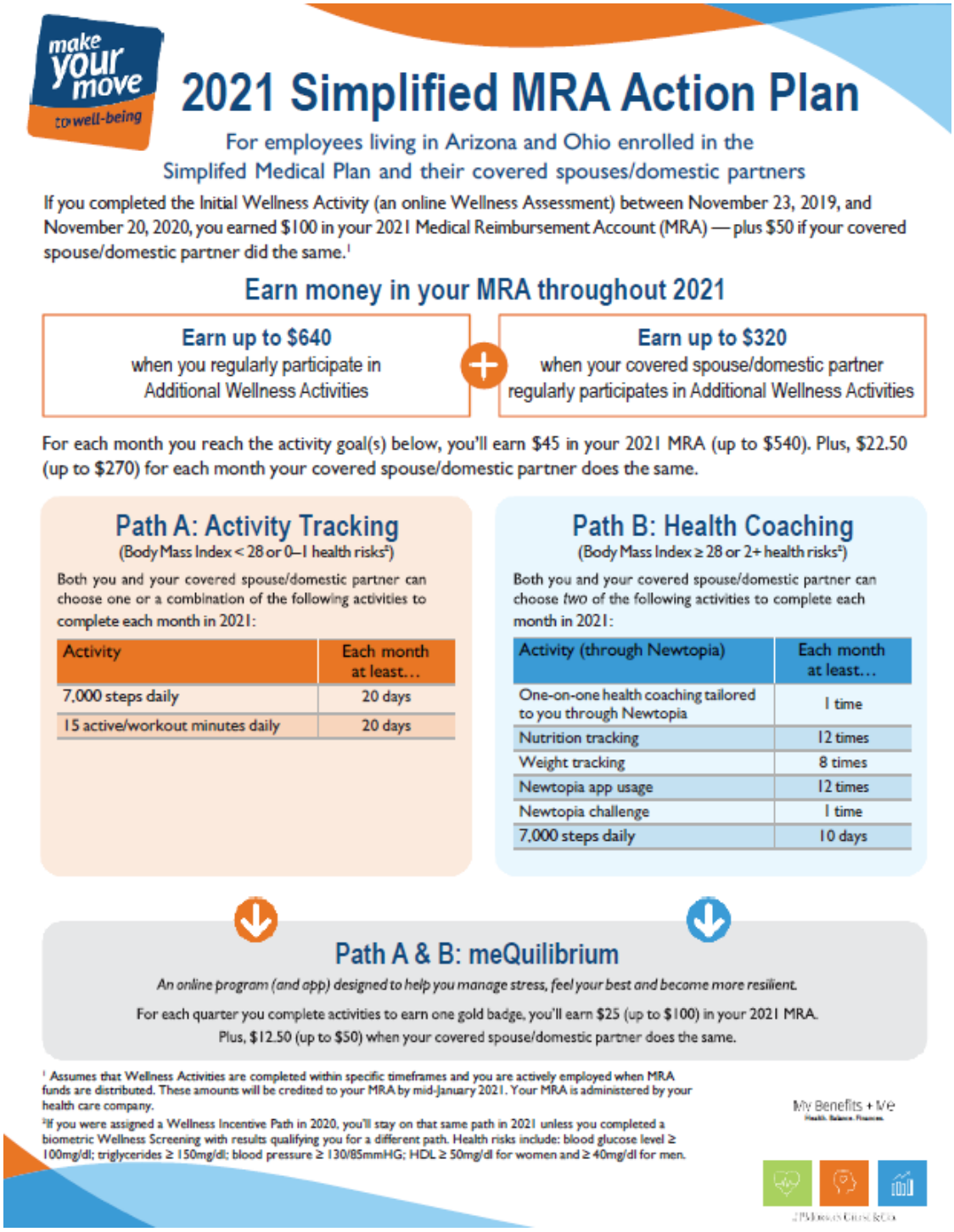
However, if you change health care companies (from Aetna to Cigna or vice versa) because you are a late year hire, late year COBRA enrollee or in certain other limited circumstances on or before January 31, of any given year, your associated MRA, HCSA and/or DCSA accounts will transition to your new health care company.

If you change health care companies after February 1, your MRA, HCSA and/or DCSA accounts will remain with the health care company you were enrolled with as of January 1 of that year automatically. Your new health care company will also create an MRA for you to store wellness incentives earned for completing wellness activities.

You may carry over **only** your MRA balance to your new health care company, however it is incumbent upon you to request this transfer from your health care company.

Wellness Activities within the MRA

This is a summary of the wellness activities that are eligible for Wellness Rewards. Be sure to review the more detailed information about each activity to understand it better, especially when to complete the Initial Wellness Activity to save money on your medical payroll contributions. See the following table for a list of activities and amount of MRA funds you can earn.



A Reasonable Alternative may be requested and authorized when you and/or your covered spouse/domestic partner are not able to achieve the standards for the rewards under your assigned path (A or B). If you believe you may qualify for a reasonable alternative, please contact Virgin Pulse to work with you (and, if you wish, with your doctor) on an alternative.

Initial Wellness Activity (New Activity for 2021, Applies to Wellness Activity Completed in 2020)

Online Wellness Assessment

The online Wellness Assessment is an online survey that asks you questions about your biometric values, current health conditions and lifestyle. The Wellness Assessment can be completed at mycigna .com (even if you are enrolled with Aetna).

- You and your covered spouse/domestic partner (if applicable) must complete the Wellness Assessment between November 23, 2019 and November 20, 2020 at 11:59 pm Eastern time in order to:
  - Earn Wellness Rewards in your MRA for 2021 ($100 for you and $50 if covering a spouse/domestic partner); and
  - Save $500 in medical payroll contributions ($1,000 if covering a spouse/domestic partner) in 2021.

If you became eligible for benefits coverage — and/or your covered spouse/domestic partner is added to medical coverage — after September 1, 2020, you and your covered spouse/domestic partner have from your coverage effective date until the 2021 Initial Wellness Activity deadline (to be communicated in 2021), to complete an online Wellness Assessment to earn 2021 MRA funds. You will automatically pay the reduced medical payroll contributions for 2020 and 2021. If you and/or your covered spouse/domestic partner complete this activity in 2020, you earn Wellness Rewards in your 2020 MRA and your 2021 MRA.

The 2021 medical payroll contributions (payroll deductions for Medical Plan coverage) shown when you enroll on the Benefits Web Center assume you and your covered spouse/domestic partner completed the Wellness Assessment between November 23, 2019 and November 20, 2020. This means the $500 savings (or $1,000 if you cover a spouse/domestic partner) will be reflected in your 2021 medical payroll contributions. If you and/or your covered spouse/domestic partner didn't complete the Wellness Assessment by the deadline, your medical payroll contributions will increase in February 2021. The $500 or $1,000 increase will be applied in equal installments to each pay from the first effective pay in February 2021 through December 2021.

Note: You have until June 30, 2021, to open a case with your health care company if you believe your online Wellness Assessment was completed by the deadline and not reflected in your medical payroll contributions.

For employees currently on an approved Leave of Absence: You and your covered spouse/domestic partner are encouraged to participate in the Initial Wellness activity. However, if you are on an approved Leave of Absence for at least 45 consecutive days between September 1 and November 20, 2020, and do not complete your online Wellness Assessment during that period, you will not lose the $500 in 2021 medical payroll contribution savings ($1,000 if covering a spouse/domestic partner). Other provisions of the Medical Plan and Wellness Program will continue to apply, including the opportunity to earn MRA funds by completing Additional Wellness Activities (maximum of $640 employees and $320 for covered spouses/DPs).

Additional Wellness Activities Managed by Virgin Pulse

Complete Additional Wellness Activities through Virgin Pulse via Path A (Activity Tracking) or Path B (Health Coaching) between January 1 – December 31 and earn up to $640 in your MRA. Your covered spouse/domestic partner can complete Additional Wellness Activities during the same time period, and you will receive up to an additional $320 in your MRA.

- Paths A or B:
  - For each month the employees participate, they earn $45 (up to $540 in 2021) for active engagement in personalized health management
  - For each month spouses/domestic partners participate, they earn $22.50 (up to $270 for 2021)

- meQuilibrium
  - For each quarter employees complete activities to earn one gold badge, they will earn $25 (up to $100 in 2021)
  - For each quarter spouses/domestic partners complete activities to earn one gold badge, they will earn $12.50 (up to $50 for 2021)
- Path A: Activity Tracking (Body Mass Index less than 28 and no more than one health risk)

  Employees and covered spouses/domestic partners can choose to walk 7,000 steps daily for 20 days or complete 15 active/workout minutes daily for 20 days to achieve this goal.
- Path B: Health Coaching (through Newtopia) (Body Mass Index 28 or more or two or more health risks)

  Newtopia, a Health Coach program, is part of the Simplified Wellness Program. Employees and covered spouses/DPs qualify to participate in this program if they have certain health risk factors. Completion of defined activities which are part of the health coaching program qualifies members to earn Wellness incentives.
- meQuilibrium (Path A or B)

  meQuilibrium is an online and mobile program designed to help you manage stress, feel your best, and become more resilient. It targets your individual stress triggers based on your personalized stress profile. In addition, the program provides a specific set of skills to help you practice behavior changes to stay calm and focused, boost self-confidence, sleep better, work well under pressure, better handle life's competing demands and more. Go to ***www.mymeQ.com/jpmc***.

Since the Wellness Screening — used to determine your Wellness Incentive Path as part of the Simplified Wellness Program — was not part of the 2020 Initial Wellness Activities:

- You will continue your current Path (A or B) for 2021 (no action required).
- If you are NOT currently assigned to a Path (A or B), you will automatically be assigned to follow Path A (Activity Tracking), starting Jan. 1, 2021 (no action required).
- The path you were assigned as of Jan. 1, 2021 will stay in effect for the entire year.

Other Available Wellness Activities

While these activities are **not** eligible for Wellness Rewards, there are benefits to participating in these wellness activities.

Preventive Care

The Medical Plan covers eligible in-network preventive care at 100% with no copayments. Out-of-network preventive care is also covered but you will have to meet a deductible and pay a copay.

- Wellness physical;
- Cervical or prostate screening;
- Mammogram; and
- Colonoscopy.

Health Coaching

Aetna and Cigna offer access to health coaches who can answer questions about your Wellness Screening and/or Wellness Assessment, as well as help you set and achieve your health goals, assess treatment options, navigate the Wellness Program, and remind you about prescription refills and preventive tests. You have your choice of receiving telephonic or online support.

You May Be Contacted by Your Health Care Company

If your health care company (Aetna or Cigna) feels you could benefit by working with a health coach based on its review of your Wellness Screening numbers, Wellness Assessment responses, and/or claims data, a health care company representative (not JPMorgan Chase) may contact you directly.

Please Note: Aetna and Cigna have access to your medical, prescription drug, and lab claims. So even if you do not get a Wellness Screening or complete a Wellness Assessment, you may still be contacted by your health care company to inform you of health programs available to you.

You don't have to wait to receive a call to participate; you can contact your health care company directly at the number on the back of your medical card.

Listed below are the most common health topics addressed by the health coaches at Aetna and Cigna. However, you can contact them on any health topic.

- Emphysema and chronic bronchitis;
- Depression and anxiety;
- Diabetes/pre-diabetes;
- Healthy eating;
- High blood pressure;
- High cholesterol;
- Physical activity;
- Stress management; and
- Weight management.

Maternity Support Program

The Maternity Support Program provides expectant mothers with help throughout their pregnancy. If you or a covered spouse/domestic partner are pregnant, you can enroll in the program anytime throughout your pregnancy to receive support from a health coach. This is a confidential program and JPMorgan Chase will not be notified of your individual enrollment. This program is available only if you are enrolled in the Medical Plan.

Contact your health care company to learn more.

Condition Management

The Condition Management program provides you with personal support from a registered nurse to help you find practical ways to manage chronic conditions. Condition Management offers support for asthma, coronary artery disease, COPD, diabetes, and heart failure. This program is available only if you are enrolled in the Medical Plan.

Contact your health care company to learn more.

Expert Medical Advice

An expert second medical opinion through Grand Rounds allows you to receive medical guidance from a national leading expert on a documented diagnosis — without leaving your home. Leading experts are available to review documentation on treatment plans, complex medical conditions, scheduled surgeries or major procedures and medications you are taking. This program is available only if you are enrolled in the JPMC U.S. Medical Plan.

Additionally, Grand Rounds can also help you find a highly rated, in-network doctor or specialist, assist you with scheduling office appointments and advise you on how to prepare for the office visit. And if you're in the hospital, a Care Coordinator can help answer your questions and connect with your care team.

Visit www.grandrounds.com/jpmc or call (888) 868-4693.

Treatment Decision Support

The Treatment Decision Support program offers access to registered nurses, or in the case of Grand Rounds, staff clinicians who can help you deal with conditions that have multiple treatment options, such as breast cancer and prostate cancer. The Treatment Decision Support program provides detailed information to help you choose the best treatment option(s), along with names of high-quality, cost-effective physicians near you and questions to ask your doctor. This program is available only if you are enrolled in the Medical Plan.

- **Cigna:** Treatment Decision Support offers support for benign uterine conditions, breast cancer, coronary artery disease, hip osteoarthritis/replacement, knee osteoarthritis/replacement, low back pain, and prostate cancer.
- **Aetna:** Treatment Decision Support offers support for a variety of medical and surgical conditions including but not limited to angina, benign prostate disease, breast cancer, dysfunctional uterine bleeding, endometriosis, fibroids, hip replacement, knee replacement, low back pain, and prostate cancer.
- **Grand Rounds:** Treatment Decision Support offers support for coronary artery disease/heart disease, hyperlipidemia, metabolic disease, hypertension, obesity, low back pain, shoulder pain, knee pain, hip pain, other chronic joint pain, migraines, anxiety, depression, benign uterine conditions, prostate cancer, and breast cancer.

Contact your health care company or Grand Rounds to learn more.

Wellness Program If You Do Not Enroll in JPMC Medical Coverage

Employees who do not enroll in the Simplified Medical Plan will still have the opportunity to complete their online Wellness Assessment during the annual required time frame to earn $100 payable in January's payroll if actively employed at that time. This program is administered by Cigna.

Employees not enrolled in the Simplified Medical Plan are not eligible for Additional Wellness Rewards. Wellness Rewards are also not available to spouse/domestic partners of employees who do not enroll in the JPMorgan Chase Simplified Medical Plan.

Special rules for company couples: If you are covering a spouse/domestic partner who is also a JPMorgan Chase employee (i.e., company couple), they will be incented as a covered spouse/domestic partner and the wellness rewards they earn for completing wellness activities will be deposited into your MRA. They will not be incented as a waiver (i.e., an employee who chooses not to enroll in the JPMorgan Chase Simplified Medical Plan).

MRA Payment Elections

During Annual Benefits Enrollment or when you first enroll in Option 1 or Option 2, you must choose how claims will be paid from your MRA when you have a covered expense. There are two ways claims can be paid:

- Through automatic claim payment or
- With a debit card (default option for new Medical Plan enrollees).

Your choice will also apply to your Health Care Spending Account (HCSA), if you elect to participate in that plan. If you do not make an election when you first enroll in the Medical Plan, you will be enrolled in the debit card payment method. Your election will remain in effect for future years, unless you make a change during a subsequent Annual Benefits Enrollment. (Annual Benefits Enrollment is the only time during the year that you can change your MRA payment election*.) **Please Note:** During 2020, all Aetna enrollees were defaulted to the debit card option and those enrollees will remain in the debit card option unless they elect automatic claim payment during Annual Benefits Enrollment.

Your MRA payment election determines how in-network claims are processed by your health care company. If an out-of-network provider agrees to submit a claim to your health care company on your behalf, your election would also apply to the processing of that claim. The claims payment process takes into account whether there is money in your MRA (and/or HCSA, if applicable) available to pay for all or part of your share of the covered medical or prescription drug expense. Please see "Using Your MRA and HCSA to Pay for Services" on page 157, which contains detailed instructions about payments at in-network and out-of-network providers.

Remember, your MRA can be used to pay for eligible medical and prescription drug out-of-pocket expenses, and your MRA account must be exhausted before you can use your HCSA for medical and prescription drug out-of-pocket expenses. Further, your MRA cannot be used for vision or dental expenses — only your HCSA can be used for those expenses. (For information about the HCSA, please see the Spending Accounts Summary Plan Description, at **My Health**. Also see the "Automatic Claim Payment vs. Debit Card" tip sheet on **My Health**.)

* You are eligible for a mid-year payment method change (from automatic claim payment to debit card) if you or your dependent is eligible for a prescription drug co-payment or discount program.

What Happens to Your MRA If Your Employment with JPMorgan Chase Ends

If your employment with JPMorgan Chase ends and you do not enroll in COBRA or retiree medical coverage you:

- Cannot earn additional Wellness Rewards beyond your termination of employment;
- Can use your remaining MRA balance for covered eligible out-of-pocket medical and prescription drug expenses incurred before the end of the month in which your employment ends. Claims for these costs must be submitted no later than one year following the end of the plan year in which you were enrolled. For example, if you terminated employment on September 23, 2021, you would have until December 31, 2022, to submit an MRA claim for covered expenses incurred during 2021. You will forfeit any remaining MRA funds.
- Will also forfeit any rewards for completing an online Wellness Assessment during the annual required time frame if you don't elect COBRA and remain on COBRA through the January award cycle or enroll in Retiree Medical coverage.

If your employment with JPMorgan Chase ends and you enroll in COBRA or retiree medical coverage:

- Your account balance will be available if you elect COBRA medical coverage (see "Continuing Coverage Under COBRA" in the *Health Care Participation* section). While you remain enrolled in COBRA medical coverage, you can use the remaining balance in your MRA to pay for your covered out-of-pocket costs related to covered medical and prescription drug expenses. You can also continue to earn Wellness Rewards for your MRA as if you were an active employee up to the full annual amount of $740 (or $1,110 if you are covering a spouse/domestic partner).
- You qualify as "retired" from JPMorgan Chase (that is, at the time your employment ends with JPMorgan Chase, you are age 55 or older with at least 15 years of service, or age 50 or older with at least 20 years of service in the case of severance). If you retire from JPMorgan Chase, you can continue to access your MRA regardless of what medical coverage you have in retirement, whether it is through COBRA, the JPMorgan Chase Retiree Medical Plan, or another plan. However, you can no longer earn additional Wellness Rewards to increase your MRA balance.
- If you are enrolled in COBRA, the MRA can be used to pay for eligible out-of-pocket medical and prescription drug expenses. You may use automatic claim payment or the debit card to pay for expenses from your MRA.

- If you are enrolled in the JPMorgan Chase Retiree Medical Plan, the MRA can be used to pay for eligible out-of-pocket medical and prescription drug expenses, and you will have to submit your claims for reimbursement.
- If you are covered by another plan, the expenses eligible for reimbursement from the MRA will be determined by the expenses covered by that plan. You will need to file an MRA and/or HCSA Claim Form for reimbursement of your covered out-of-pocket medical and prescription drug expenses (see "Filing a Claim for Benefits" on page 159).
- If you are enrolled in JPMorgan Chase Retiree Medical Plan, administrative fees for your MRA will apply, and will be automatically deducted from your MRA each month.
- Your MRA will be managed by the last health care company in which you were enrolled while you were an active employee.

For more information, please see the **As You Leave Guide** on **My Health**.

Please see the *Health Care Participation* section for more information on COBRA.

Covered MRA Expenses

You can use the funds in your MRA to pay for covered out-of-pocket medical and prescription drug expenses (out-of-network deductibles, and copayments) under the Medical Plan. Please see "What Is Covered" on page 163 for a list of covered expenses.

Expenses that are not covered under the Medical Plan are not eligible to be reimbursed by the MRA. Please see "What Is Not Covered" on page 173 for a list of excluded expenses. **Please Note**: While the MRA cannot be used to pay for expenses that are not considered covered expenses under the Medical Plan, such as charges above reasonable and customary levels for out-of-network care, or for dental or vision expenses, you can be reimbursed for these expenses from a Health Care Spending Account, if you choose to participate in that Plan. Please see the *Spending Accounts* section for more information.

Other Wellness Programs

In addition to the Wellness Activities and Programs that are associated with the Medical Plan, JPMorgan Chase offers other wellness related benefits to give you and your family more ways to stay healthy. These programs are provided to benefits-eligible employees, regardless of whether you enroll in the Medical Plan, and coverage under these programs does not begin or end with participation in the Medical Plan.

Employee Assistance Program (EAP) and Work-Life Program

The Employee Assistance and Work-Life Program (EAP) is available to provide professional, confidential counseling, consultation and referral services to help you and your eligible dependents find solutions to the many challenges faced in managing work and personal lives. The EAP is available to active U.S. benefits-eligible employees (that is, U.S. employees who are regularly scheduled to work 20 hours or more a week). That means you and your dependents can participate in the EAP even if you're not enrolled in a JPMorgan Chase Medical Plan. As part of the EAP, you have access to referrals for free professional counseling for topics related to stress, anxiety, depression, marriage, family, relationship issues and more.

Employee Assistance Program Counselors are professionally trained, licensed, or certified mental health professionals.

Employees can receive up to five counseling sessions a year per issue. All services provided by the EAP are free, confidential, and available 24 hours a day, seven days a week. If referral to some other professional is made and fees are involved, the counselor will help you determine whether your Medical Plan benefits will offset some of the costs.

Use of the Employee Assistance Program is voluntary and completely confidential as required by law and JPMorgan Chase policy.

When Employee Assistance Program coverage ends for you and/or your eligible dependents, you may be able to continue coverage for a certain period of time under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please see the *Health Care Participation* section for more information on COBRA.

For additional information about the EAP and Work-Life Program, go to me@jpmc > Health, Life & Parenting > Employee Assistance and Work Life Program > U.S. or call 1-877-576-2007 or access the Employee Assistance Program on **MyHealth >** Wellness Activities & Services.

Tobacco Cessation Program

JPMorgan Chase offers tobacco cessation through Optum's Quit For Life® Program. By enrolling in this program, you and/or your covered spouse/domestic partner can obtain experienced help in committing to a tobacco-free lifestyle.

The program provides, at no cost:

- Telephone coaching and online support;
- A Quit Guide; and
- Quitting aids (for example, patches and gum).

Upon completion of the program, you may be eligible for lower "non-tobacco user" rates for certain benefits, including the Medical Plan (see "Tobacco User Status" on page 124 for more information).

Call 866-QUIT-4-LIFE ((866) 784-8454) or access the program at **My Health**.

Onsite Health & Wellness Centers

At certain large locations, JPMorgan Chase provides fully staffed Health & Wellness Centers. These Centers provide:

- Basic medical services;
- Wellness Screenings (see "Wellness Activities within the MRA" on page 127 for more information) and other health evaluations; and
- Help understanding health information and guidance on resources available to you.

You pay nothing for these services. These Centers are for benefits-eligible employees (not just those enrolled in the JPMorgan Chase Medical Plan) and are not available for use by spouses/domestic partners or children.

For a list of the locations of the JPMorgan Chase Health & Wellness Centers, visit **My Health**.

Please see the Health & Wellness Centers Summary Plan Description for more information.

How Your Medical Plan Works

The Simplified Medical Plan has no in-network deductible. Instead, there are fixed copayments for covered services. This health care "menu" approach allows you to learn about and understand your out-of-pocket costs prior to receiving care. And, if your copayments ("copays") add up to the out-of-pocket maximum in a plan year, the Plan pays 100% of your eligible in-network costs for the remainder of that year.

Option 1 and Option 2 cover the same services and prescription drugs. What differs between the two options for in-network services are:

- the payroll contributions required for each option and
- the copayments (or "copays") you pay for the service, as explained in the following sections
- the annual out-of-pocket maximums and
- the out-of-network deductibles.

Whether you choose Option 1 or Option 2, Aetna or Cigna, your JPMC Medical Plan includes prescription drug coverage administered by CVS Caremark. For a description of coverage for prescription drugs, please see "The Prescription Drug Plan" on page 149.

Highlights

- Plan benefits are offered through a network of participating health care providers (for example, doctors, hospitals, labs, and outpatient facilities).
  - Even though there is an out-of-network benefit available, JPMorgan Chase strongly urges you to stay in-network. Selecting out-of-network providers and services cost more for all employees and JPMorgan Chase. Selecting in-network providers and services will reduce your out-of-pocket costs. Additionally, to help make it easier for you to find in-network care, Aetna and Cigna continue to increase the size of their network by adding doctors and hospitals.
- **For in-network care:**
  - There is no annual deductible
  - You are not required to select or assign a Primary Care Physician.
  - You do not need referrals to see a specialist.
  - You pay only the copayment — a fixed out-of-pocket amount — associated with each covered service.
    - **Important:** In-network preventive care, including physical exams and recommended preventive screenings, is covered at 100% with no copays; and in-network primary care and mental health care office visits are covered after a $15 copayment.
      - Primary care providers include family practitioners, internists, pediatricians, OB/GYNs, nurse practitioners and Convenience Care Clinics. Internists must be contracted with Aetna or Cigna as a Primary Care Physician (PCP).
      - Mental health care providers include psychologists, therapists and social workers.
      - Go to Aetna's or Cigna's websites through **My Health** > My Medical Plan Website to search for PCPs/primary care physicians and mental health care providers.
- The plan's out-of-pocket maximum — your financial "safety net" — limits the total amount you are required to pay out-of-pocket each year. The out-of-pocket maximum includes both eligible medical and prescription drug amounts (i.e., a combined maximum). Note that there are separate out-of-pocket maximums for in-network and out-of-network charges.
- **Out-of-network information:**
  - You must meet an annual deductible before the copays apply for covered services.
  - Benefits for out-of-network care have a higher copays.
  - There is a separate, higher out-of-pocket maximum for eligible out-of-network charges.
  - Benefits for out-of-network care are limited to reasonable and customary (R&C) charges after you meet the out-of-network deductible. These R&C charges are based on average claims data in your area and are determined by your health care company to be appropriate fees for medical services. You are responsible for any amount above the R&C charges.
  - It's important to understand that if you are using out-of-network providers (doctors, facilities or other service providers), it is your responsibility to check with your health care company to see if there is a prior authorization or medical necessity requirement that you need to meet before receiving any out-of-network treatment, service or procedure. Otherwise, the treatment, service or procedure may not be covered by the Plan and you will be responsible for the full cost.
  - More information can be found on the Tip Sheet, What You Need to Know and Do for Out-of-Network Care, available on **My Health** > Benefits Enrollment > 2021 Benefits Resources.

- Prescription drug coverage copays are based on the drug category and where you fill your prescription. Preventive generic drugs are covered at 100%, with no copay.
- Simplified Option 1 and Simplified Option 2 can be used in conjunction with a Medical Reimbursement Account (MRA) you can use to help pay for covered out-of-pocket medical and prescription drug copays. The MRA is funded by JPMorgan Chase when you take action and complete designated Wellness Activities. Employees cannot contribute funds to an MRA.

If You Move During the Year

In general, the medical plan you participate in as of January 1 of a given year will be the medical plan you remain in for the entire calendar year. If you are a new hire or have a qualified status change and first enroll in the medical plan after January 1 (e.g., you were hired in April), you will remain in the plan you first join for the entire calendar year.

If you live in Arizona or Ohio and enroll in the Simplified Medical Plan, but later move out of Arizona or Ohio to one of the other U.S. states you will remain in the Simplified Medical Plan for the rest of the calendar year (i.e., you will not switch between Simplified and Core Medical Plans). You will become eligible for the Core Medical Plan effective January 1 of the next calendar year.

The Annual Deductible

Under Options 1 and 2, there is **no** in-network annual deductible, however, if you go out-of-network, certain expenses are subject to an annual deductible. The annual deductible is the amount you must pay "up front" each calendar year before the Plan begins to pay benefits for most covered expenses.

Amounts in excess of reasonable and customary (R&C) charges do not count toward the out-of-network deductible.

The annual deductible you are subject to depends on your coverage level. The following table shows the annual deductibles for the different coverage levels under each option.

Deductibles (Medical Only)				
Coverage Level	**Option 1**		**Option 2**	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Employee (Also serves as "per person" amount)*	None	$2,000	None	$4,000
Employee + spouse/domestic partner or Employee + child(ren)	None	$3,000	None	$6,000
Family (employee + spouse/domestic partner + child(ren))	None	$4,000	None	$8,000

* For out-of-network deductibles, the "per person" rule allows the employee or any covered dependent(s) [e.g., spouse/domestic partner or child] to reach an individual deductible, after which the deductible is satisfied for the year for that person. Covered individuals who have not met the deductible may combine to meet the remainder of the deductible for that particular coverage level. If no one person has met the individual deductible, the expenses of all covered individuals can combine to meet the deductible for that coverage level.

If you elect coverage for yourself and go out-of-network for care, you must pay up front for all eligible out-of-network expenses until you meet the per-person deductible. After you meet the annual per-person deductible, you will then pay the applicable out-of-network copay.

If you cover dependents, all eligible out-of-network expenses paid by you and/or your covered dependents combine to meet the out-of-network deductible amount for the coverage level.

However, no individual must satisfy more than the per-person deductible amount. This means that once an individual's expenses meet the per-person deductible, your maximum cost will be the in-network copay amount, even if the family has not yet met the full deductible for the coverage level.

The Annual Out-of-Pocket Maximum

Under Options 1 and 2, the annual out-of-pocket maximum is the maximum amount you must pay in copays and out-of-network deductibles in a plan year toward eligible expenses, **including** prescription drug expenses.

There are separate out-of-pocket maximums for in-network and out-of-network charges.

The out-of-pocket maximum varies based on coverage level and TACC, which provides greater financial protection for lower-paid employees, as shown in the following table.

The out-of-pocket maximum functions as your "financial safety net." It prevents you from having to pay very high health care expenses in the event of a serious medical situation. Once the out-of-pocket maximum is reached, you pay no copays for covered in-network care and out-of-network care for the rest of the year.

Amounts that you pay toward costs above the reasonable and customary charges for out-of-network care do not count toward your out-of-pocket maximum.

Annual Out-of-Pocket Maximums
(Medical AND prescription drug; out-of-network maximums are inclusive of deductible)

Coverage Levels	In-Network		Out-of-Network	
	Option 1	*Option 2*	*Option 1*	*Option 2*
Total Annual Cash Compensation*: less than $60,000				
Employee (Also serves as the "per person" maximum)	$2,500	$5,500	$10,000	$12,000
Employee + Spouse/Domestic Partner (DP) *or* Child(ren)	$4,000	$8,500	$16,000	$19,000
Employee + Spouse/DP + Child(ren)	$5,500	$11,500	$22,000	$26,000
Total Annual Cash Compensation*: $60,000 - $149,999				
Employee (Also serves as the "per person" maximum)	$4,000	$7,500	$10,000	$12,000
Employee + Spouse/DP *or* Child(ren)	$6,500	$11,500	$16,000	$19,000
Employee + Spouse/DP + Child(ren)	$9,000	$16,000	$22,000	$26,000
Total Annual Cash Compensation*: $150,000+				
Employee (Also serves as the "per person" maximum)	$5,500	$7,500	$10,000	$12,000
Employee + Spouse/DP *or* Child(ren)	$8,500	$11,500	$16,000	$19,000
Employee + Spouse/DP + Child(ren)	$12,000	$16,000	$22,000	$26,000

* Total Annual Cash Compensation (see "Total Annual Cash Compensation" on page 123).

Per Person Rule for Out-of-Pocket MaximumsFor the out-of-pocket maximums, the "per person" rule allows the employee or any covered dependent(s) (e.g., spouse/domestic partner or child) to reach an individual out-of-pocket maximum, after which the out-of-pocket maximum is satisfied for the year for that person. Covered individuals who have not met the out-of-pocket maximum may combine to meet the remainder of the out-of-pocket maximum for that particular coverage level. If no one person has met the individual out-of- pocket maximum, the expenses of all covered individuals can combine to meet the out-of-pocket maximum for that coverage level.

Note: There are separate safety nets for in-network and out-of-network services. The out-of-network, out-of-pocket maximum calculation does not include amounts above reasonable and customary (R&C) charges if you use out-of-network providers. An R&C limit is based on data in your area and determined to be an appropriate fee for a specific medical service.

Example: John is enrolled in Option 1, has TACC less than $60,000 and is covering his spouse and 2 children. John's spouse, Mary, has a complicated surgery and is in an in-network hospital for 4 days. The out-of-pocket expenses related to Mary will be $2,500 — the individual out-of-pocket maximum — not $4,000 (hospital inpatient copay of $1,000 per day for 4 days). Now that Mary has paid $2,500 and met the individual out-of-pocket maximum, all other eligible in-network expenses for Mary for the rest of the year will be covered at 100% by the plan. John and his children will continue to pay copays for in-network services they use during the year until:

- any one of them reaches $2,500 out-of-pocket and that individual will then have met their maximum (similar to Mary), or
- all three of them combined spend $3,000 ($5,500 family out-of-pocket maximum less $2,500 spent by Mary).

Maximum Lifetime Benefits

There is no dollar limit on the amount Options 1 and 2 would pay for covered benefits while you and your covered dependents are enrolled in the Medical Plan.

However, there is a $10,000 lifetime infertility services maximum provided by the Medical Plan ($30,000 if you and/or your covered spouse/domestic partner receive your care in a Center of Excellence, as explained under "Centers of Excellence (COEs)" on page 146). These amounts do not include the infertility benefit provided by the Prescription Drug Plan.

There is also a lifetime limit of 365 days for in- or out-of-network care in a skilled nursing facility. The infertility services and skilled nursing facility lifetime maximum benefits apply to both in-network and out-of-network care.

An Important Note on the Option 1 and Option 2 Benefit Maximums

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

- Medical Plan Option 1.
- Medical Plan Option 2.

You do not gain a new benefit maximum if you switch your coverage between options or health care companies.

Choosing Between In- and Out-of-Network Care

Under Options 1 and 2 of the Medical Plan, you can choose to see any provider, but the Plan is intended to encourage the use of in-network care. You'll pay less when you receive your care through your health care company's network of physicians and facilities because network providers have agreed to charge negotiated discounted fees for their services. In addition, your only pay up to the copay amount for in-network care, so your share of charges, if any, is less for in-network care. Lastly, there is no deductible for in-network care.

Forgot Your ID Card?

Not to worry. You can access an electronic version of your medical coverage ID card online at your health care company's website or on their apps.

When you receive in-network care:

- You usually don't have to file any claim forms.
- Your out-of-pocket expenses will be lower compared to your expenses for the same type of care on an out-of-network basis. In-network doctors have agreed with Aetna and Cigna to charge pre-negotiated copays that are on average lower than the fees charged by doctors outside the network. You cannot be billed for any amounts above those copays.

When you receive out-of-network care:

- You may need to file a claim form to receive out-of-network benefits. Please see "Filing a Claim for Benefits" on page 159 for more information.
- Your out-of-pocket costs for medically necessary covered services generally will be higher than if you received in-network care.

Covered services performed by providers not participating in the network 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 your health care company to be appropriate fees for medical services. Out-of-network charges are typically higher than the pre-negotiated fees that are covered for in-network care. **Please Note:** You will be responsible for paying any charges above the R&C amount. Charges in excess of reasonable and customary levels are not considered a covered expense under the Plan, and they therefore do not count toward the deductible or out-of-pocket maximum.

The Shared Savings Program is a program in which Aetna and Cigna may obtain a discount to a non-Network provider's billed charges. This discount is obtained by the non-Network provider agreeing to a reduced charge either directly with Aetna or Cigna or with a third party on behalf of Aetna or Cigna. When this happens, you may share in the savings because your out-of-pocket costs are determined using the reduced charge. In addition, the non-Network provider should not bill you for any amount above the agreed upon reduced charge. If this happens, however, you should call the number on your ID Card for either Aetna or Cigna. In some instances, Aetna or Cigna may not obtain a discount. In this case the non-Network provider may bill you not only for the deductible and coinsurance applicable to the allowed amount determined by Aetna or Cigna under the terms of the Plan, but for all charges above that allowed amount. Non-Network providers that agree to reduced charges are not credentialed by Aetna or Cigna and are not Network Providers.

Copayments ("Copays") You Pay for Covered Services

In the Simplified Medical Plan, you pay a fixed copay per service you receive as detailed in the chart below, rather than deductibles and coinsurance. However, if you choose to go out-of-network, there is a deductible that you must meet prior to the Plan sharing in the costs of your healthcare; once you reach the deductible, the copays in the chart below will apply.

No PCP or Referrals

Remember: You are not required to select or assign a Primary Care Physician (PCP) and you do not need referrals to see a specialist in the Simplified Medical Plan.

The Copays Shown Are Your Maximum Cost

Important! These copay amounts are maximum amounts — if the service or drug costs less than the copay, then you pay the lesser amount.

See "Covered Service Categories" on page 141 for a detailed description of the types of services that fall into each category below.

	In-Network				Out-of-Network
	Total Annual Cash Compensation (TACC)[1]: <$60,000		Total Annual Cash Compensation (TACC)[1]: $60,000+		All TACC[1] levels
Medical Service	*Option 1*	*Option 2*	*Option 1*	*Option 2*	*Options 1 & 2*
Preventive care	Free	Free	Free	Free	$60
Primary care office visit (PCP, Pediatrician, OB/GYN)	$15	$15	$15	$15	$60
Medical Virtual doctor visit	$15	$15	$15	$15	Not applicable

Medical Service	In-Network Total Annual Cash Compensation (TACC)[1]: <$60,000 *Option 1*	 *Option 2*	Total Annual Cash Compensation (TACC)[1]: $60,000+ *Option 1*	 *Option 2*	Out-of-Network All TACC[1] levels *Options 1 & 2*
Behavioral/Mental Health Virtual Visits[2] services delivered through Teladoc (Aetna) and MDLive (Cigna)					
Psychologist/Therapist	$15	$15	$15	$15	Not applicable
Psychiatrist	$75	$110	$75	$110	Not applicable
Outpatient therapy for mental health[2], chemical, alcohol dependence	$15	$15	$15	$15	$60
Lab	$20	$35	$20	$35	$60
Physical therapy, speech therapy, occupational therapy, and cognitive rehabilitation therapy service[3]	$25	$35	$25	$35	$80
Chiropractic visit	$50	$50	$50	$50	$100
Standard radiology	$50	$75	$75	$75	$200
Urgent care visit	$50	$75	$100	$100	$200
Specialist office visit[2]	$75	$110	$100	$110	$350
Outpatient procedure/surgery	$300	$600	$500	$800	$1,500
Durable medical equipment (DME)	$100	$100	$100	$100	$300
Advanced imaging (CT/MRI) — per service	$250	$350	$250	$350	$1,000
Ambulance	$250	$250	$250	$250	$250
Emergency room (ER) visit[4]	$500	$750	$800	$900	Same as In-Network
Hospitalization (inpatient admission)	$1,000/day	$1,250/day	$1,000/day	$1,250/day	$3,000/day

1 Total Annual Cash Compensation (see "Total Annual Cash Compensation" on page 123).

2 Psychologists are classified in outpatient therapy and psychiatrists are classified as specialists.

3 See "Covered Service Categories" on page 141 for limits.

4 Non-emergency care will cost $100 more for Option 1 and $150 more for Option 2.

Covered Service Categories

The following chart is intended to describe the types of services that are covered within each Medical Services category defined in the preceding copay chart. This list is not exhaustive. For more detailed questions on how certain services will align or adjudicate, please contact your health care company — Aetna or Cigna.

Medical Service	Description of Services
Preventive care	The preventive care services are covered at 100% in-network by the Simplified Medical Plan and include routine care such as: • Routine physical exams • Well-child/adult care office visits • Immunizations • Mammograms and PAP tests • Prostate exams and colonoscopy exams Detailed preventive care flyers from Aetna and Cigna, which will include the types of preventive care and any associated frequency, are available on **aetna.com and mycigna.com**. Preventive care services are determined by your health care company 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.
Primary care office visit (PCP, Pediatrician, OB/GYN)	Primary care office visits are non-preventive care visits with the following types of clinicians: Primary Care physician (PCP), OB/GYNs, GYNs, Pediatricians, Family Practitioners, General Practitioners, Internal Medicine (contracted as PCPs with Aetna/Cigna), Certified Nurse Midwife, Nurse Practitioner, and Physician Assistants (within a PCP's office). Convenience care clinics (e.g., CVS Minute Clinic) are treated as a primary care office visit. "Incidental" labs, such as a swab for strep throat, urine analysis for a urinary tract infection (UTI), etc., are included in the PCP copay (not a separate copay when performed as part of the office visit). Other lab work (e.g., blood draw), and all standard radiology (e.g., X-rays) and advanced imaging (e.g., CAT scans) performed during a PCP visit will be assessed a separate copay.
Medical and Behavioral/Mental Health Virtual doctor visit (also known as telemedicine)	Connect to a doctor in minutes — anytime, anywhere — using a smartphone, phone, tablet or computer. Doctors can make diagnoses, provide advice and call in prescriptions to your local pharmacy. Medical and Behavioral/Mental Health Virtual doctor visits are delivered through Aetna (via Teladoc) and Cigna (via MDLive). Go to **My Health** > Medical Specialty Services for details on how to access virtual doctor visits.
Outpatient therapy for mental health, chemical, alcohol dependence	Outpatient mental health/substance use therapy includes office visits with: Psychologists, Clinical Social Workers, Drug and Alcohol Counselors, Licensed Professional Counselors, Marriage/Family Therapists, Behavioral Health Nurse Practitioners, and Psychiatric Nurses. Please Note: An office visit with a psychiatrist is considered a Specialist Office Visit. Lab work, standard radiology (e.g., X-rays) and advanced imaging (e.g., CAT scans) performed during a mental health, chemical, alcohol dependence outpatient therapy visit will be assessed a separate copay.

Medical Service	Description of Services
Lab	Lab work includes tests such as complete blood count (CBC), basal metabolism, lipid panel, liver panel, hemoglobin A1C, etc. Generally, you will be assessed a single copay per blood draw even if multiple tests are performed on that single blood draw. Labs also includes the following: hearing test, heart monitor, pre-admission testing and genetic testing (when approved as medically necessary).
Physical therapy (PT), speech therapy (ST), occupational therapy (OT) cognitive rehabilitation therapy services	Physical, speech, occupational, and cognitive rehabilitation therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year per therapy type, when the underlying condition/diagnosis is medical in nature. For instance, the plan provides 60 PT visits in total (in- and out-of-network visits combined), 60 ST visits in total (in- and out-of-network visits combined), etc. For those individuals with a mental health diagnosis[1], associated medical treatments for physical, occupational, speech therapy and cognitive rehabilitation therapy will not be subject to an annual visit limitation.
Chiropractic visit	Chiropractic care when medically necessary as determined by Aetna/Cigna to diagnose or treat illness, injury, or disease. Coverage is limited to 20 visits per year (including initial consultation) and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance and/or managing pain.
Standard radiology	Standard radiology includes radioisotopes, scans, sonograms, pre-admission X-ray, ultrasound, and X-rays and includes the costs associated with the image itself as well as cost associated with the provider's reading of the image. Standard radiology will follow Aetna and Cigna's individual definition of standard radiology; therefore please contact your health care company for a complete list. Standard radiology performed in a PCP, Specialist and/or Outpatient settings will be assessed this separate copay amount. Standard radiology performed as part of an inpatient hospital stay or emergency room (ER) visit will not be assessed this separate copay, instead it will be included in the inpatient or ER copay.
Urgent care visit	Visits to an urgent care facility. Please contact the health care companies for information on in-network urgent care centers.
Specialist office visit[2]	Office visit with a specialist, such as: ABA/BCBA therapist, acupuncturist, allergist[3], cardiologist, dermatologist, endocrinologist, oncologist, otorhinolaryngologist/otolaryngologist (ENT specialist), psychiatrist, rheumatologist, reproductive endocrinologist, etc. (This is not intended to be an exhaustive list of all specialists.) Dialysis or an infusion performed during a specialist office visit[4] will be assessed the Specialist Office visit copay; this copay is inclusive of the costs of the associated infused drugs. Minor surgery performed at your specialist's office will be assessed the Specialist Office visit copay. Examples of minor surgery that could be performed at a specialist's office includes: mole removal, ingrown toenail correction, breast biopsy, and vasectomy. Minor in-office procedures performed during your specialist office visit such injections into a joint (knee, shoulder, elbow) will be included in the Specialist Office visit copay. Examples include pain relieving steroid injection, knee gel (e.g., Synvisc) or withdrawing excess fluid from a joint. Lab work, standard radiology (e.g., X-rays) and advanced imaging (e.g., CAT scans) performed at a specialist office visit will be assessed a separate copay.

Medical Service	Description of Services
Outpatient procedure/surgery	This category includes procedures or surgeries performed in an outpatient facility, without an overnight stay, such as at an ambulatory surgical center. The types of procedures performed at an outpatient facility include endoscopies (includes colonoscopies), cardiac catheterization, upper gastrointestinal, diagnostic colonoscopy, ovary removal, hernia repair, tonsil removal, cataract, kidney stone removal, etc. (This is not meant to be an exhaustive list of services performed outpatient.) The Outpatient Procedure/Surgery copay includes fees related to professional services (e.g., doctor or surgeon costs) and the facility charges (e.g., cost of the center itself). Lab work, standard radiology (e.g., X-rays) and advanced imaging (e.g., CAT scans) performed at an outpatient facility will be assessed a separate copay. Dialysis or an infusion performed during at an outpatient facility visit[5] will be assessed the Outpatient Procedure/Surgery copay; this copay is inclusive of the costs of the associated infused drugs.
Durable medical equipment (DME)	Durable medical equipment (DME) and supplies ordered or provided by a Physician. DME equipment/supplies or other items covered at the DME copay include: crutches; wheelchair; walker; cane; insulin pump; surgical dressings; casts; splints; trusses; orthopedic braces; hearing aids[6]; custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot; hospital bed; ventilator; iron lung; artificial limbs (excluding replacements); artificial eyes and larynx (including fitting); heart pacemaker; ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers and bags; manual pump-operated enema systems and other items necessary to the treatment of an illness or injury that are not excluded under the plans. For more details on covered DMEs, please contact Aetna or Cigna. Prior authorization or pre-certification may be required for coverage of some medical equipment and supplies. Aetna and Cigna may authorize purchase of an item if more cost-effective than rental.
Advanced imaging (CT/MRI) — per service	Advanced imaging includes CAT Scan, MRI, and PET scans. This copay includes the costs associated with the image itself as well as cost associated with the radiologist's reading of the image. Advanced imaging performed in a PCP, Specialist and/or Outpatient settings will be assessed this separate copay amount. Advanced imaging performed as part of an inpatient hospital stay or emergency room (ER) visit will not be assessed this separate copay, instead it will be included in the inpatient or ER copay.
Ambulance	Local emergency ambulance service or air ambulance to the nearest hospital if medically necessary and confirmed by a licensed provider. Non-emergency transportation is covered if it is provided by a licensed professional ambulance (either ground or air ambulance as determined appropriate) when the transport is from an out-of-network hospital to an in-network hospital; to a hospital that provides a higher level of care that was not available at the original hospital; to a more cost-effective acute care facility; or from an acute facility to a sub-acute setting. **Please note** that Cigna administers the ambulance benefit on a per day basis, not per ride.

Medical Service	Description of Services
Emergency room (ER) visit	All services performed during your emergency room (ER) visit will be covered by the single ER copay. This includes fees related to professional services (e.g., seeing a doctor), facility charges (e.g., cost of the ER itself), lab work, standard radiology, advanced imaging, any medications given in the ER[7], etc. Emergency room visits will be covered as in-network and subject to the $500/$800 copay (Option 1) or $750/$900 copay (Option 2) if considered a true emergency. If your health care company determines that you did not have a true emergency, your copay will be $600/$900 copay (Option 1) or $900/$1,050 copay (Option 2). In accordance with applicable regulations, a true emergency is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors. If you go to the emergency room and are subsequently admitted to the hospital, the ER copay will be waived and instead you will be subject to the inpatient hospital admission copay.
Inpatient hospital admission	All services performed during your inpatient hospital stay will be covered by the single hospital per day copay. Generally, a patient is considered inpatient if formally admitted to the hospital. This includes fees related to: • Professional services (costs related to the surgeon, assistant surgeon, anesthesiologist, radiologist, etc.), • Facility charges (e.g. cost of the hospital room itself), • Lab work, standard radiology, advanced imaging, and • Any medications provided while in the hospital If you're provided with a durable medical equipment upon discharge (e.g., crutches or wheelchair), that will be subject to the Durable Medical Equipment copay.

1 Mental health care or benefits, in accordance with the Mental Health Parity and Addiction Equity Act, are items or services for mental health or substance use disorder conditions, as determined solely within the discretion of the plan administrator, consistent with generally recognized independent standards of current medical practice. Conditions affecting physical health that are related to a mental health condition or substance use disorder are medical/surgical benefits rather than mental health care benefits under the Medical Plan. However, for those individuals with a mental health diagnosis, associated medical treatments subject to visit limits (such as physical, occupational and speech therapy) will not be subject to an annual visit limitation.

2 Certain mental health / substance use services adjudicate at the Specialist Office Visit copay as well, including: intensive out-patient (IOP) and inpatient partial hospitalization, both of which are assessed daily copays; transcranial magnetic stimulation (TMS); and electroconvulsive therapy. Also, home health care visits and private duty nursing visits (when medically necessary and approved by your health care company) are assigned the specialist copay; 200 visit limit per year continues to apply.

3 An office visit with your allergist is assigned the Specialist Office Visit copay. Any allergy shots or serums delivered during that office visit will be covered by the Specialist Office Visit copay (there will not be a separate copay assigned for this)

4 The specialist office copay will apply for dialysis/infusions that occur in the specialist's office, when the provider is billing that visit as having occurred in the specialist's office. Some specialists may be associated with an outpatient facility and bill these services as an outpatient facility visit. If that is the case, you will be subject to the Outpatient Procedure/Surgery Copay. If you are uncertain as to how your provider bills, you can look at a prior Explanation of Benefits (EOB) and then discuss this with your health care company (Aetna or Cigna).

5 The Outpatient Procedure/Surgery copay will apply for dialysis/infusions that occurs in the outpatient facility, including if your specialist bills the infusion/dialysis visit you had with him/her under an outpatient facility code rather than a specialist office visit code. If you are uncertain as to how your provider bills, you can look at a prior Explanation of Benefits (EOB) and then discuss this with your health care company (Aetna or Cigna).

6 Hearing aids are limited to two devices every 36 months.

7 Prescriptions given to you in the Emergency Room or hospital that you fill at a pharmacy are subject to the applicable prescription drug copays.

Additional Plan Provisions

Prior Authorization

Prior authorization is required for many services and procedures, such as hospital stays and some surgical procedures.

In general, in-network providers are responsible for obtaining prior authorization before providing these services to you. Before receiving these services, you may want to contact your health care company to verify that the hospital, physician and other providers are in-network providers and that they have obtained the required prior authorization. In-network facilities and providers cannot bill you for services if they fail to obtain prior authorization as required.

If you are using an out-of-network provider, you are responsible for obtaining prior authorization before you receive these services. **Note:** You must obtain prior authorization when an out-of-network provider intends to admit you to an in-network facility or refers you to other in-network providers.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs.

Hospital Notification

You should contact your health care company at least 48 hours before all scheduled hospital admissions. You should also contact your health care company if a maternity stay will exceed 48 hours for the mother and/or newborn child following a vaginal delivery, or 96 hours for the mother and/or newborn child following a cesarean section delivery.

To provide notification, please contact your health care company at the number on the back of your ID card. You will not be penalized under the Plan if you do not notify the claims administrator.

Mental Health Benefits

Mental health care or benefits, in accordance with the Mental Health Parity and Addiction Equity Act, are items or services for mental health or substance use disorder conditions, as determined solely within the discretion of the plan administrator, consistent with generally recognized independent standards of current medical practice. Conditions affecting physical health that are related to a mental health condition or substance use disorder are medical/surgical benefits rather than mental health care benefits under the Medical Plan. However, for those individuals with a mental health diagnosis, associated medical treatments subject to visit limits (such as physical, occupational and speech therapy) will not be subject to an annual visit limitation.

If You Need Emergency Care

If you have a medical emergency that's sudden, urgent and serious or life-threatening, you should go to the nearest physician, hospital emergency room, or other urgent care facility. Your emergency care will be covered at a lower copay if your health care company approves the care as being required for a true emergency:

If your health care company determines that you did not have a true emergency, your copay will be higher. Please see "Copayments ("Copays") You Pay for Covered Services" starting on page 139 for details on the emergency room copay amounts, including services bundled as part of these copay amounts.

If you go to the emergency room and are subsequently admitted to the hospital, the emergency room copay will be waived and instead you will be subject to the inpatient hospital admission copay.

Note: The determination of whether the visit was a true emergency will be based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors. True emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Centers of Excellence (COEs)

Organ transplants, bariatric surgery and infertility treatment are complex procedures and services that require highly specialized or quality care. As a result, the Medical Plan has in-network hospitals that have been designated as Centers of Excellence because of the high-quality care they consistently provide for these procedures and services.

You must contact your health care company in advance of an organ transplant, bariatric surgery or receiving infertility treatment to receive instruction on any required precertification. This applies whether or not you choose a Center of Excellence.

The Medical Plan contains incentives designed to encourage use of COEs for infertility services. Your infertility medical benefit maximum will be increased from $10,000 to $30,000 if you and/or a covered spouse/domestic partner choose a COE for treatment. (**Please Note**: There is a separate $10,000 prescription drug benefit for infertility services.)

To locate a Center of Excellence, visit your health care company's website at **My Health** or call your health care company.

NurseLine

You can call Aetna and Cigna and speak to a registered nurse at any time. You can get help with health advice 24 hours a day, seven days a week — even on weekends and holidays. There are no limitations on how many times you might use the NurseLine. Examples include:

- Recognize urgent and emergency symptoms;
- Understand medication interactions;
- Locate in-network doctors and hospitals; and
- Research treatment costs.

Contact your health care company to learn more:

- **Cigna:** Call (800) 790-3086 and select the prompt, "24-Hour Health Information Line."
- **Aetna:** Call (800) 468-1266 and select the prompt for "24 hour NurseLine."

Virtual doctor visits through Teladoc (an Aetna partner) and MDLive (a Cigna partner) allow you to connect to a doctor in minutes — anytime, anywhere — using a smartphone, tablet, or computer. Doctors can make diagnoses, provide advice and call in prescriptions to your local pharmacy. Register before you need care: Go to **My Health**.

The copay for virtual doctor visits are $15 for medical doctors and psychologists/therapists. The copay for virtual doctor visits for psychiatrists (considered specialists) is $75 – $110 (varies by contribution pay tier and Plan option).

Maternity Benefits

The Simplified Medical Plan will pay for most in-network maternity services through a global fee arrangement. Under such an arrangement, the copays that a member will be assessed are:

- $15 copay for an initial office visit with OB/GYN (i.e., to confirm pregnancy)
- Lab or standard radiology copays associated ultrasounds, amniocentesis, fetal stress tests and other related tests
- Inpatient hospital copay for delivery (per day in the hospital) Additional copays will apply for high risk or complex pregnancies.

If the obstetrician is out-of-network and/or does not have a global fee arrangement in place, the member will be charged for each visit and service based upon the copay for that service.

Infertility Benefits

The Simplified Medical Plan provides infertility benefits with lifetime limits, similar to the Core Medical Plan. The Medical Plan covers a combined in-network and out-of-network maximum of $10,000/lifetime for each covered employee and/or spouse/domestic partner. However, your infertility medical benefit maximum will be increased from $10,000 to $30,000 if you and/or a covered spouse/domestic partner choose a Centers of Excellence (COE) for treatment. (If there isn't a COE within a certain number of miles of your home address, Aetna and Cigna will work with you to find appropriate in-network alternatives, and the higher benefit limit will apply.) There is a separate $10,000/lifetime prescription drug benefit.

Please Note

These are lifetime limits and will carry over from the Core Medical Plan to the Simplified Plan, and carry over across health care companies.

Amounts paid by the plan (not your out-of-pocket expenses) apply to the Lifetime Infertility maximum.

Under the Simplified Plan, copays will be assessed based on the type and setting of the service you receive. For instance, a visit with a reproductive endocrinologist will be assigned a specialist copay; while in-vitro fertilization might be assessed an outpatient procedure/surgery copay.

Organ Transplants and Bariatric Surgery

Organ transplants and are complex procedures and services that require quality care. As a result, the Simplified Medical Plan has in-network hospitals that have been designated as Centers of Excellence because of the high-quality care they consistently provide for these procedures and services.

You must contact your health care company in advance of an organ transplant or bariatric surgery to receive instruction on any required precertification. This applies whether or not you choose a Center of Excellence.

You should also contact your health care company to understand the various copays that will apply.

Copayment Paid for Covered Benefits

The following table shows the copayment required for covered expenses. Please also see "What Is Covered" on page 163 for a more detailed list of covered expenses under the Medical Plan.

Covered Benefits: Eligible Preventive Care

	Plan's Copayment for In-Network Care	Plan's Copayment for Out-of-Network Care*
Eligible Preventive Care**		
Please Note: Preventive care services will be free only if they are performed by an in-network provider and are 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 your health care company, as preventive medical care rather than as a diagnostic service. Additional lab or other services performed during a preventive care visit that are not considered preventive in nature may not be free and/or covered.		
Fecal Occult Blood Test	• Free • One test per year	• $60 coverage after deductible • One test per year
Immunizations (routine adult and child) (includes immunizations related to travel)	• Free	• $60 coverage after deductible
Preventive Sigmoidoscopy/Colonoscopy	• Free • One baseline screening and one follow-up screening every five years	• $60 coverage after deductible • One baseline screening and one follow-up screening every five years
Routine Gynecological Exams and Pap Smears	• Free • One exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines	• $60 coverage after deductible • One exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines
Routine Mammography, Prostate Specific Antigen (PSA) Test, and Digital Rectal Exam	• Free • Age 40 and over: one exam per year based on age and gender	• $60 coverage after deductible • Age 40 and over: one exam per year based on age and gender
Routine Physical Exams	• Free • One exam annually	• $60 coverage after deductible** • One exam annually
Routine Screenings Provided During Pregnancy (For example, gestational diabetes and bacteriuria screenings, as well as items such as certain breast pumps)	• Free	• $60 coverage after deductible

* Covered 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.

** Your health care company determines which preventive care services performed by an in-network provider are free based on guidelines and clinical recommendations for the general population developed 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. For a list of preventive services go to your health care company's website accessible via **My Health** > My Medical Plan Website.

Covered Benefits: Other Services

Durable Medical Equipment and Prosthetics (includes certain** glucose monitors, insulin pumps and related pump supplies)	$100	$300 after deductible
Lab	$20 - $35	$60 after deductible
Prescription Drugs	Please see “The Prescription Drug Plan” on page 149.	
Standard Radiology	$50 - $75	$200 after deductible

* Covered 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.

** Some glucose monitors and insulin pumps are available under the prescription drug plan. For information on which insulin pumps are covered under the Medical and/or prescription drug plan, please contact the appropriate provider (Aetna/Cigna and/or CVS Caremark).

The Prescription Drug Plan

The Prescription Drug Plan is part of the Simplified Medical Plan and is administered by CVS Caremark — regardless of the health care company you choose. The covered drug lists are the same under Option 1 and Option 2 of the Simplified Medical Plan.

You will receive a separate prescription drug identification (ID) card from CVS Caremark in addition to your Medical Plan ID card.

For Help with Prescription Drug Coverage

You can reach a Caremark Customer Service Representative 24 hours a day, seven days a week at (866) 209-6093. In addition, once you are enrolled, you can visit CVS Caremark’s website accessible via **My Health** or directly at www .caremark.com. The site allows you to:

- View the covered and excluded drug lists;
- View your personal prescription drug history;
- Estimate drug costs and identify prescription drug cost saving opportunities;
- Order/refill/check the status of mail order prescriptions;
- Look for network retail pharmacies;
- Research drug information;
- Set up personal email reminders for refills; and
- Print temporary CVS Caremark ID cards.

How Prescription Drug Coverage Works

Highlights of prescription drug coverage are listed below; detailed information follows.

- There is no deductible for prescription drug coverage.
- Free preventive generic drugs. Eligible preventive generic medications are covered at 100% with no copayments at network pharmacies. **Please Note**: Generic prescription contraceptives are also fully covered (as are brand-name, contraceptive drugs for which a generic is not available).
- Your copay for prescription drugs count toward the same out-of-pocket maximum that applies to other health care expenses in the Simplified Medical Plan;
- MRA funds can be used to pay for covered out-of-pocket prescription drug costs;
- If you have elected automatic claim payment, at the time of purchase, your MRA funds will automatically be used to offset your out-of-pocket cost after the Plan pays its share of the cost of your medication. If you elected or were automatically assigned the debit card, you may pay your out-of-pocket costs by using the card or your own funds. If you pay out-of-pocket, you can submit a claim form for reimbursement from the MRA. Once your MRA funds are depleted, you can use your HCSA for eligible prescription drug expenses if you elected to participate in the HCSA and have available funds.
  - If you elected autopay during enrollment and subsequently receive a prescription drug coupon or prescription drug copay assistance card, you have the option to switch to debit card mid-year.
- Discounted prices that are available at network pharmacies (you'll generally pay more at an out-of-network pharmacy); if you use an out-of-network pharmacy that does not accept your prescription drug ID card, you will generally pay more and will need to file a claim for eligible reimbursement.
- Option of having maintenance prescriptions filled through a convenient mail-order program or at a pharmacy; Maintenance Choice® offers advantageous pricing when you receive 90-day supplies of maintenance medication by mail or pick up your prescription at CVS retail pharmacies, where the same discounts are available;
- Traditional (non-specialty) and specialty lists of preferred/covered and excluded drugs; the most recent lists can always be found on the CVS Caremark website; and
- Mandatory Generic Drug Program; if you fill a prescription for a brand-name medication when a generic equivalent is available, you will pay the difference in cost between the brand-name drug and generic drug, plus the generic copay.

Free Preventive Generic Drugs

Preventive drugs are medications that can help prevent the onset of a condition if you are at risk or help you manage your health if you have a condition.

The CVS Caremark Generic Preventive Drug List is a list of generic drugs covered at 100% with no copays, as determined by CVS Caremark. To see a list of drugs in this category, visit CVS Caremark's website, which is accessible via **My Health.**

If You Take a Non-Covered Drug

If you choose to take a non-covered drug, you will pay the full cost of the drug. This could be a costly option. Be sure to consider carefully how the costs of taking a non-covered drug could add up.

Categories of Prescription Drugs

Your prescription drug coverage depends on the type of drug your doctor prescribes and where you fill your prescription. Prescription drugs are split into two main categories — traditional drugs and specialty drugs.

- **Traditional drugs**, also known as non-specialty drugs, are usually the ones which most people are familiar with and represent the majority of prescription drugs used. This includes medicines used to treat common conditions like high blood pressure, diabetes and asthma, and most short- term medicines used to treat acute conditions like coughs, flu and infections. Traditional drugs generally don't have special handling or shipping requirements, are available at most pharmacies, and are lower cost.
- **Specialty drugs** are generally used to treat complex medical conditions such as rheumatoid arthritis, multiple sclerosis and psoriasis. These drugs include biological drugs, often require special handling, such as refrigeration, and are generally not available at the majority of pharmacies. Additionally, specialty drugs are usually higher cost.

Types of Prescription Drugs within the Traditional and Specialty Categories

There are three types of drugs within the Traditional and Specialty categories:

- **Generic Drugs:** Generics have equivalent ingredients to brand name drugs, but can cost significantly less. And eligible generic preventive drugs are covered at 100% — which means you pay nothing for these prescription drugs at network pharmacies.
- **Preferred Brand Name Drugs:** Preferred brand name drugs have been patented by the companies that developed them and placed on a preferred drug list by CVS Caremark. They're generally more expensive than generic drugs but less expensive than non-preferred brand drugs.
- **Non-Preferred Brand Name Drugs:** Non-preferred brand name drugs are brand name medications that are not on CVS Caremark's preferred drug list and are usually more expensive than generics and preferred brand name drugs. Often they have either generic alternatives and/or one or more preferred brand name drug options that may be substituted for the non-preferred brand name drug.

Please note: When a generic prescription drug is not available, there are often many different brand-name alternatives. CVS Caremark has reviewed these alternatives and determined which are clinically appropriate and cost-effective. These are called preferred brand-name prescription drugs, and are covered at a higher level than non-preferred brand-name drugs. To see a list of preferred drugs, visit CVS Caremark's website, which is accessible via **My Health**.

Prescription Drug Copays

There is no deductible for prescription drug coverage.

Note: The copay amounts shown in the following table are the maximum amounts. If your prescription costs less, you will pay less.

Prescription Drug Copays	Simplified Option 1		Simplified Option 2	
	Traditional	Specialty	Traditional	Specialty
Preventive Generic Drugs*	Free		Free	
Retail Pharmacy (up to a 30-day supply)				
Non-preventive Generic*	$10	$100	$15	$125
Preferred Brand name*	$75	$150	$125	$200
Non-preferred brand name*	$150	$200	$250	$250

Prescription Drug Copays	Simplified Option 1		Simplified Option 2	
	Traditional	Specialty	Traditional	Specialty
Mail Order Pharmacy or CVS Retail Pharmacy/ Maintenance Choice® (up to a 90-day supply; opt-out available)**	2 times Retail copay amount shown above		2 times Retail copay amount shown above	
Out-of-Pocket Maximum (combined with Medical Out-of-Pocket Maximum)	See "The Annual Out-of-Pocket Maximum" on page 137		See "The Annual Out-of-Pocket Maximum" on page 137	
CVS Caremark Excluded Drugs* (Traditional and Specialty)	Not covered; you will pay the full cost for these drugs.			
Non-Sedating Antihistamines (also known as NSAs)	Not covered; you will pay the full cost for these drugs.			

* CVS Caremark determines which drugs are considered "generic," "brand," "preventive generic," "preferred," "non-preferred," "maintenance," and "specialty," etc. We use CVS Caremark's lists of covered and excluded drugs. An independent committee made up of pharmacists, physicians and medical ethicists reviews and approves the drug lists (also known as formularies). These lists are subject to change quarterly by CVS Caremark. If you take a non-covered drug, you will pay the full cost of the drug. To see a list of drugs in these categories, visit CVS Caremark's website at **My Health**.

** The Maintenance Choice® program covers 90-day supplies of maintenance medication. Maintenance Choice® allows you to: 1) send your 90-day prescription to CVS Caremark and have your medicine delivered by mail to your home; or 2) fill your 90-day prescription at any CVS retail pharmacy. If you "opt out" out of Maintenance Choice®, your prescription costs will generally be higher. Please see "Details About Maintenance Choice®" on page 152.

Details About Maintenance Choice®

The Maintenance Choice® program provides discounted pricing for 90-day supplies of long-term maintenance drugs. Some examples of long-term maintenance drugs are those taken for:

- Asthma;
- Diabetes;
- High blood pressure; and
- High cholesterol.

To see a list of maintenance drugs and to compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS retail network pharmacy, visit CVS Caremark's website.

With Maintenance Choice®, a 90-day supply of maintenance medicine can be delivered by mail to your home, or you can fill your 90-day prescription at any CVS retail pharmacy, where the same discounts are available.

You may also "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy (see "Opting Out of Maintenance Choice®" on page 153).

Before filling a long-term prescription through Maintenance Choice®, you can obtain two 30-day supplies at a network pharmacy by paying retail pharmacy rates. This "trial period" gives you and your doctor the ability to confirm that the medication and dosage is right for you. After that, you will need to use Maintenance Choice® to obtain the most advantageous pricing (or you may opt out of the program, but you may pay more).

A CVS Caremark Mail Order Form is available on the CVS Caremark site. Mail your prescriptions with your completed order form to the address noted on the form.

Opting Out of Maintenance Choice®

You will generally pay the lowest price for maintenance medications if you use Maintenance Choice® to obtain a 90-day supply by mail or at a CVS retail pharmacy. However, you may "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy, but you may pay more, as shown in the following table.

Comparing Per-prescription Maximums Under Maintenance Choice® to Opting Out of Maintenance Choice®

	Option 1 Maximum per-prescription charge		Option 2 Maximum per-prescription charge	
	Maintenance Choice® (obtain through mail or at a CVS retail pharmacy)	***Opt Out (obtain prescription at a non-CVS retail in-network pharmacy*)***	***Maintenance Choice® (obtain through mail or at a CVS retail pharmacy)***	***Opt Out (obtain prescription at a non-CVS retail in-network pharmacy*)***
Non-preventive Traditional Generic 90-day supply	$20	$30	$30	$45
Traditional Preferred brand-name 90-day supply	$150	$225	$250	$375
Traditional Non-preferred brand-name 90-day supply	$300	$450	$500	$750

* Or picking up three 30-day supply prescriptions at a CVS retail pharmacy.

To compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS retail in-network pharmacy, visit CVS Caremark's website.

To continue to fill your maintenance medication prescription at a non-CVS retail in-network pharmacy after your two 30 days' supplies at a network pharmacy, you must opt out of Maintenance Choice® by calling CVS Caremark. If you order maintenance medications through a non-CVS retail in-network pharmacy without calling CVS Caremark first, your claim will be rejected and you will pay the full cost of the medication. **Please Note:** Your "opt out" status will apply to all maintenance medications that you fill through the Plan.

Filing a Paper Prescription Drug Claim

If you purchase your prescription drugs through a non-network pharmacy or do not show your CVS Caremark ID card at a network pharmacy, you will have to pay for the prescription drug and then file a CVS Caremark Claim Form to be reimbursed for the Plan's share of the eligible expense. If you have funds in your MRA and/or HCSA, you can be reimbursed for your share of the expense by filing an MRA and/or HCSA Claim Form (see "If You Paid Out-of-Pocket for a Prescription Drug" on page 160. Reminder, you can only be reimbursed from your HCSA once your MRA is depleted.

Forgot Your ID Card?

Not to worry. You can access an electronic version of your prescription drug ID card online at the CVS Caremark website or by downloading the CVS Caremark app.

What's Covered and Not Covered

The following chart shows common prescription drugs and their coverage status. **Please Note:** This list does not show every drug covered under the Plan. For the most current information and a full list of covered medications, visit CVS Caremark's website, accessible through **My Health** or directly at caremark.com.

Prescription Drugs Covered by the Prescription Drug Plan

Drug	Coverage Status
Allergy Serums (oral immunotherapy drugs)	Covered but requires prior authorization
Aspirin	Covered — generic aspirin (81mg only) is fully covered as prevention medication 1) after 12 weeks of gestation in women who are at high risk for preeclampsia (Age limit: 12 or older, quantity limit: 100 units per fill); 2) for primary prevention of cardiovascular disease and colorectal cancer (Age limit: 50 to 59 years, quantity limit: 100 units per fill) OTC products require prescription
Breast Cancer Drugs	Covered — generic anastrozole, exemestane, raloxifene, and tamoxifen are fully covered as part of a treatment therapy for women at risk for breast cancer and/or diagnosed with breast cancer for age 35 or older
Contraceptives	Covered — generic prescription contraceptives are fully covered, as are brand-name prescription contraceptives for which a generic is not available, such as Lo Loestrin® 24 Fe.* * **Please Note:** If a generic prescription becomes available for a brand-name contraceptive, the generic form of the contraceptive will be fully covered, while the brand-name version of the contraceptive would be covered according to the provisions for other brand-name medications (see chart under "What's Covered and Not Covered" on page 154).
Diabetic Supplies (includes certain glucose monitors, insulin pumps and related pump supplies)*	Covered — except alcohol wipes
Diet Medications (anorexiants and anti-obesity)	Covered but requires prior authorization
Fluoride Supplements	Covered — generic fluoride supplements are fully covered for children age 5 or younger
Infertility Drugs (exclusive of treatment)	Covered up to a $10,000 lifetime maximum (combined Retail Pharmacy Benefit and Maintenance Choice® program) per person
Legend Vitamins	Covered
Male Impotency Drugs	Covered at 8 units per 30 days (24 units per 90 days through Maintenance Choice®).
Prescription Tobacco Cessation Products	Covered

Drug	Coverage Status
Proton Pump Inhibitors (PPIs) (such as Prilosec, Tagamet, and Nexium)	Covered subject to preauthorization, as described under "Coverage for Proton Pump Inhibitors" on page 155
Respiratory Therapy Supplies	Covered — except nebulizers.
Solaraze (Diclofenac sodium gel 3%)	Covered but requires prior authorization.
Solodyn	Covered but requires prior authorization.

* Some glucose monitors and insulin pumps are available under the Medical Plan. For information on which insulin pumps are covered under the Medical and/or Prescription Drug Plan, please contact the appropriate provider (Aetna/Cigna and/or CVS Caremark).

Prescription Drugs Not Covered by the Prescription Drug Plan

Drug	Coverage Status
Allergy Serums (injectable)	Not covered
Blood Plasma/ Blood Transfusion Agents	Not covered
Botox and Myoblock	Not covered — for cosmetic purposes; requires prior authorization for other uses.
Bulk Powders & Topical Analgesic (compounds)	Not covered*
Cosmetic Products (such as depigmenting agents, hair growth stimulants, hair removal agents)	Not covered
Mifeprex	Not covered
Non-Sedating Antihistamines (NSAs) (such as Clarinex and Allegra)*	Not covered
Nutritional Supplements (injectable or oral)	Not covered
Over-the-Counter Drugs	Not covered (but still may be less expensive than related prescription drugs)
Renova	Not covered
Rx Devices Other Than Respiratory (such as elastic bandages and supports, GI-guostomy and irrigation supplies, other Rx devices)	Not covered
Select Medical Devices and Artificial Saliva products	Not Covered
Vaccines/Toxoids	Not covered (except seasonal flu and COVID-19 vaccines, which are covered)

* Your physician and/or pharmacist may contact CVS Caremark to seek exception approval for specific medical reasons.

** Although non-sedating antihistamine (NSA) drugs are not covered under the Prescription Drug Plan, you can still obtain these and other non-covered prescription drugs (versus the over-the-counter alternative) at discounted prices through Maintenance Choice®. You pay 100% of the discounted price for non-covered drugs obtained through Maintenance Choice®.

Coverage for Proton Pump Inhibitors

If you are prescribed a brand-name proton pump inhibitor (PPI) prescription medication, you must have previously tried a generic proton pump inhibitor to receive coverage for the brand-name PPI. You should talk to your doctor to see if a generic alternative is appropriate for you. If your physician has a medical reason for you to take a brand-name PPI prescription medication rather than a generic alternative, your physician will need to contact CVS Caremark for preauthorization and a determination will be made. If the brand-name prescription is not authorized and you opt not to obtain the generic alternative available, you will be responsible for the entire cost of the prescription under the terms of the JPMorgan Chase Prescription Drug Plan.

Additional Plan Provisions

Mandatory Generic Drug Program

The plan contains a **mandatory generic drug program,** in which generic drugs are substituted for certain brand-name* prescription drugs. If you fill your prescription with a brand-name drug when a generic equivalent is available, you pay the entire cost difference plus the generic drug copay. **Please Note:** These cost differences will not be limited by prescription copayments or annual out-of-pocket maximum limits. Your physician can contact CVS Caremark to seek a medical exception review for possible approval for specific clinical reasons.

*For this purpose, brand drugs refer to those brand drugs with a direct generic equivalent produced by at least two manufactures.

Step Therapy Program

Step Therapy is a program that lets members get the treatment they need affordably. It also helps the Plan maintain affordable prescription drug coverage. In step therapy, medicines are grouped in categories based on treatment and cost.

- First-line medicines are the first step. First-line medicines are typically generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.
- Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who don't respond to first-line medicines. Second-line drugs are the most expensive options.

Prior Authorization

Certain medications may only be covered by the Plan under certain conditions with a prior authorization (PA) from CVS Caremark prior to purchasing the medicine. To find out if a drug requires a PA, log in to www.caremark.com and click on "Check Drug Cost & Coverage" on the "Plan & Benefits" tab, or call CVS Caremark.

Quantity Restrictions on Covered Medications

There may be quantity limits on certain medicines. Quantity limits are based on the Food and Drug Administration's (FDA) recommended dosing guidelines for each medication and are reviewed regularly by CVS Caremark to ensure clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions.

Certain prescriptions may also be limited to less than the standard days supply, which is a thirty (30) day supply. For specific medicine limitations, please log in to www.caremark.com or call CVS Caremark at (866) 209-6093. Quantity limits may change periodically based on updates from the FDA's recommended dosing guidelines.

To determine whether your medication is subject to CVS Caremark's utilization management program such as Step Therapy, Prior Authorization or Quantity limit, etc., please contact CVS Caremark.

Pharmacy Advisor

The plan also offers **Pharmacy Advisor**, a voluntary counseling program offered through CVS Caremark to help employees (and covered spouses/domestic partners) with certain conditions — such as diabetes or heart disease — adhere to their prescription regimen, manage their medications and make sure their medications don't conflict with each other. When you pick up your prescription at a CVS retail pharmacy, the pharmacist will automatically offer to provide onsite counseling.

Coverage for Specialty Drugs

Certain conditions such as asthma, growth hormone deficiency, hepatitis C, immune disorders, infertility, multiple sclerosis, and rheumatoid arthritis may be treated with specialty drugs. These drugs may be oral or self-injectable, include biological drugs, often require special handling, such as refrigeration, and are generally not available at the majority of pharmacies. CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides specialty drugs directly to covered individuals along with supplies, equipment, and care coordination.

Certain specialty drugs require further clinical review and prior authorization before coverage will be approved. The "CVS Caremark Specialty Drug List" can be found on CVS Caremark's website. The CVS Caremark Specialty Guideline Management Program evaluates the appropriateness of drug therapy with specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. This clinical program helps ensure patient safety, efficacy, and optimal therapeutic benefit.

If you submit a prescription for a specialty drug that requires preauthorization, CVS Caremark will undertake a review. The provider who prescribed the medication will be required to call (866) 814-5506 as part of the review process. After the review is complete, you and your physician will receive a letter confirming whether coverage has been approved or denied (usually within 48 hours after CVS Caremark receives the information it needs).

In certain cases, a first-line specialty drug may be required. This is a step therapy program that encourages the use of a preferred drug before using a non-preferred drug. Preferred drugs under this program are well-supported treatment options and represent the most cost-effective drug for a given condition. Before a non-preferred specialty drug is covered, an established evidence-based protocol must be met.

If coverage is approved, you'll pay your normal copay amount for your prescription. If coverage is not approved, you have the right to appeal (please see the *Plan Administration* section).

You may contact CVS Caremark Specialty Customer Care at (800) 237-2767 from 6:30 a.m. to 8 p.m. Central time, Monday – Friday, and Saturday from 6 a.m. to 3 p.m. Central time, to arrange for expedited, confidential delivery of your specialty drug to the location of your choice. You will also have access to a pharmacist-led or nurse-led Care Team that can provide customized care, counseling on how to best manage your condition(s), patient education, and evaluation to assess your progress and to discuss your concerns.

Using Your MRA and HCSA to Pay for Services

When you need to use the Plan for covered services and expenses — whether at a doctor's office or other health care facility or at the pharmacy to purchase a covered prescription drug — you should present your Medical Plan ID card or your separate CVS Caremark prescription drug ID card. With your ID card, the provider can start the claims payment process with your health care company.

If You See an In-Network Provider

When you see an in-network provider, you will generally not be asked to pay at the point of service. Providers will typically submit a claim to your health care company, Aetna or Cigna, using the information from your ID card. Your claim for medical care will be processed as follows.

Using the Automatic Claim Payment Method

When you use the automatic claim payment method, your health care company will automatically use your MRA funds first, then HCSA funds, to pay for your portion of eligible medical and prescription drug expenses.

You generally will not be asked to pay anything during a visit to an in-network provider. Your health care company will pay the provider first from the Plan, then for your share of the cost using your MRA funds. Once your MRA funds are depleted, your HCSA funds (if applicable) will be used to pay the remaining balance. This will happen automatically through your health care company (either Aetna or Cigna). Any bill you receive from your provider will be after your MRA funds and any available HCSA funds are applied. You should pay the bill after comparing it to the statement you receive from your health care company.

For covered prescription drug expenses, the Plan will pay for its portion of the cost at the time of purchase, and your MRA funds will automatically be applied to your portion of the cost. Once your MRA funds are depleted, your HCSA funds (if applicable) will be applied, as described above. The pharmacy will tell you what amount, if any, you will need to pay.

Using the Debit Card Payment Method

With the debit card payment method, you have the option of using your debit card or paying out-of-pocket for covered expenses. Keep in mind that you will need to keep your receipts and be prepared to substantiate any debit card claims, as required by the IRS. The same debit card accesses funds from both your MRA and HCSA, if applicable.

When you have a covered medical expense, your in-network provider will generally not require payment at the time of service.

After your medical claim is processed by your health care company or at the time of a prescription drug purchase, you can either pay with your debit card or pay out-of-pocket. (You will have to pay out-of-pocket if your provider does not accept the debit card as a form of payment.) When you use your debit card, your MRA funds will be used first. Once your MRA funds are depleted, your HCSA (if applicable) will then be applied. If you pay using personal funds and later decide you wish to be reimbursed from your MRA or HCSA, you must submit a paper claim form (via mail or fax) or an online claim form for reimbursement from your MRA or HCSA. The form can be found on your health care company's website (Aetna or Cigna) or on **My Health** > Medical, Rx, MRA & Spending Accounts > Claims and Other Forms.

If Your In-Network Provider Asks You to Pay at the Point of Service

While in-network providers have been asked by Aetna and Cigna to submit claims for JPMorgan Chase employees directly to the health care companies and not to ask for payment at the time of service, occasionally an in-network provider may nevertheless ask you to pay at the time of service.

If this happens, you should show your provider your ID card and explain that your health care company needs to review the claim first to see what you owe. If you are still required to pay at the time of service, you should do so and get a receipt from your provider. For instructions on how to file for reimbursement, see the "Filing a Claim for Benefits" on page 159.

If You See an Out-of-Network Provider

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 they agree to do so, your claim will be processed as explained in "If You See an In-Network Provider" on page 157 (your health care company will see if funds are available — first from your MRA and then from your HCSA, if applicable).

If an out-of-network provider will not file a claim for you, you will need to pay for the service at the time of your visit and submit a Medical Claim Form to your health care company to be reimbursed for the Plan's share of the expense. You can file a claim online at mycigna.com or medical claim forms can be found on **My Health** or on your health care provider's website. You can also be reimbursed from your MRA/HCSA, if applicable, for your out-of-pocket share of the expense. Please see "Filing a Claim for Benefits" on page 159 for instructions.

The MRA/HCSA and Your Prescription Drug Expenses

You must pay for your share of prescription drug expenses at the time of purchase. The payment process differs according to whether you elected automatic claim payment or whether you elected or were assigned the debit card method of payment for your MRA/HCSA. Your health care company manages both your MRA and HCSA accounts.

If You Elected Automatic Claim Payment	If You Elected or Were Assigned the Debit Card
Your network pharmacy will submit the claim through your prescription plan with CVS Caremark. After CVS Caremark pays its share of the cost, your health care company will pay your share of the expense first from your MRA and then from your HCSA, if applicable. Your MRA balance will be used first to cover your share of the cost; you won't need to pay anything. If your MRA has been exhausted, your health care company will use your HCSA balance, if any, to pay the pharmacy; you won't need to pay anything if the HCSA covers your remaining amount due. If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost, your health care company will inform your pharmacy. You will need to pay the amount you owe out-of-pocket at the time of your pharmacy visit.	Your network pharmacy will submit the claim through your prescription plan with CVS Caremark. After CVS Caremark pays its share of the cost, you can decide whether to use your debit card to pay your share of the cost or pay out-of-pocket at the pharmacy. If you use your debit card, the card would first use funds from your MRA and then from your HCSA, if applicable, to pay the pharmacy. You should keep your receipt in case you are asked to substantiate your expense. If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost, you will need to pay the remaining balance out-of-pocket. If you choose not to use your debit card and instead pay out-of-pocket, you may request reimbursement for your share of the expense from your MRA/HCSA, if applicable, later. You will need to provide a receipt if you file for reimbursement from your MRA/HCSA (see "If You Paid Out-of-Pocket for a Prescription Drug" under "Filing a Claim for Benefits" on page 159).

Filing a Claim for Benefits

When you receive in-network care, your network doctor or other provider will file the claim for you; you will generally not be asked to pay at the time of service. However, there may be instances in which you paid out-of-pocket for an expense. In these cases, you would need to file a claim form to receive reimbursement from the Medical Plan and from your MRA and/or HCSA, if applicable. After the Plan pays its share of the expense, reimbursement to you is made first from your MRA, followed by your HCSA, if applicable.

How to file a claim and determine which claim form to use depends on the services you received and whether you paid out-of-pocket, as detailed in the following sections. Always keep your receipt for any out-of-pocket expense for which you intend to file for reimbursement. Instructions for accessing claim forms, if necessary, and mailing addresses are in "How to Submit a Claim" on page 161.

If You Saw an In-Network Provider and Paid Out-of-Pocket

While in-network providers have been asked by Aetna and Cigna to submit claims for JPMorgan Chase employees directly to their health care companies and not to ask for payment at the time of service, occasionally an in-network provider may nevertheless ask you to pay at the time of service.

- If you elected automatic claim payment, you will typically be reimbursed automatically by your health care provider. However, if reimbursement is not made automatically, you will need to call your provider when you receive your Explanation of Benefits (EOB). The EOB will show that your health care company made payment to your provider. You should explain to the provider's billing office that they have been paid twice: once by you at the time of service, and again when the Plan paid them from your MRA/HCSA. (On the Cigna EOB, the "What My Accounts Paid" section shows the amount paid; on the Aetna EOB, this information is in the "You may owe" section.) If you need additional assistance, you can call your health care company at the number on the back of your ID card or the JPMorgan Chase Health Advocate for help in getting reimbursed for amounts paid out-of-pocket (see "If You Have Questions About a Claim" on page 162).
- If you elected the debit card, use the MRA and/or HCSA Claim Form to request reimbursement from your accounts (see "How to Submit a Claim" on page 161).

If You Saw an Out-of-Network Provider and Paid Out-of-Pocket

Out-of-network providers may require payment at the point of service. In these circumstances, you should submit a Medical Claim Form to your health care company (see "How to Submit a Claim" on page 161) to be reimbursed for the Plan's share of the expense. Be sure **not** to sign the box on the Medical Claim Form or check the box when submitting the claim online on aetna.com or mycigna.com that authorizes your health care company to make payment directly to your provider, as the payment should be made to you.

Your health care company will process your claim to determine your and the Plan's responsibility.

- If you elected automatic claim payment, in addition to processing the claim to determine the amount the Plan should have paid, your health care company will determine what amount can be paid directly to you by available MRA funds first, and then from your HCSA, if applicable.
- If you elected or were defaulted to the debit card, you will receive an EOB showing the amount paid by the Plan. You can then submit an MRA and/or HCSA Claim Form to request reimbursement if you paid with your personal funds (see "How to Submit a Claim" on page 161).

If You Paid Out-of-Pocket for a Prescription Drug

If you paid out-of-pocket for a prescription drug at a network pharmacy because you have a debit card but chose not to use it, use the MRA/HCSA Claim Form to be reimbursed for your share of the expense (see "How to Submit a Claim" on page 161).

If you paid out-of-pocket for a prescription drug because you purchased your drugs through a non-network pharmacy or did not show your ID card at a network pharmacy, use the CVS Caremark Claim Form to be reimbursed for the amount owed by the Prescription Drug Plan (see "How to Submit a Claim" on page 161). If you have funds in your MRA/HCSA, you can be reimbursed for your out-of-pocket costs by filing a MRA and/or HCSA Claim Form (see "How to Submit a Claim" on page 161).

If You Paid Out-of-Pocket Because Your MRA/HCSA Was Depleted (But You Have Since Earned MRA Funding)

If you paid out-of-pocket for an expense because you had no funds left in your MRA/HCSA, but you have since earned MRA funds, use the MRA and/or HCSA Claim Form to be reimbursed (see "How to Submit a Claim" on page 161).

How to Submit a Claim

The Medical Claim Form and the MRA and/or HCSA Claim Form are available on **My Health**. The forms are also available on the health care company's websites.

Please Note: You can elect to have your MRA reimbursement directly deposited into an account of your choice by accessing your health care company at **My Health**.

You need to file your Medical and MRA reimbursement claims by December 31 of the year after the one in which you received the service or purchased the prescription. For example, if you incur an expense on July 1, 2021, you must file your claim for reimbursement by December 31, 2022. If you fail to meet this deadline, your claim will be denied.

Be sure to attach itemized receipts to your claim form, and keep copies for your records.

You can submit an MRA/HCSA reimbursement request online or via the App (Cigna or PayFlex).

Mail your claim form to the address printed on the forms:

Medical Claim Forms

Aetna:

Aetna
PO Box 14079
Lexington, KY 40512- 4079

(800) 468-1266

Cigna:

Cigna
P.O. Box 182223
Chattanooga, TN 37422-7223

Customer Service: (800) 790-3086

Remember: If you have already paid your medical provider, be sure not to sign the box on the Medical Claim Form or check the box when submitting the claim online on aetna.com or mycigna.com that authorizes your health care company to make payment directly to your provider, as the payment should go to you.

Generally, Medical Claim Forms are processed in 10–12 business days and mailed with an Explanation of Benefits (EOB). Payment (if any) is sent about two weeks after the claim is processed.

MRA and/or HCSA Claim Forms

Aetna (PayFlex is an Aetna company):

PayFlex Systems USA, Inc.
P.O. Box 14879
Lexington, KY 40512-4879

Fax: 1-888-238-3539

Phone: 1-800- 468-1266

Cigna:

Cigna
P.O. Box 182223
Chattanooga, TN 37422-7223

Customer Service: (800) 790-3086

CVS Caremark Claim Forms

The CVS Caremark Claim Form is available at **My Health**. The form is also available on the CVS Caremark website. Please mail your completed claim form to:

CVS Caremark Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196

Member Services: (866) 209-6093

Generally, prescription claims are processed weekly and mailed with payment (if any) in about two to three weeks.

You can also submit your prescription claim through the CVS Caremark website or mobile app. To do so, please visit the CVS Caremark website and click on “Submit Prescription Claim” on the Plan & Benefits tab. On the mobile app, click “Submit Claims” on the main screen. Your prescription information and receipt are required for claim submission with CVS Caremark.

If You Change Health Care Companies During Annual Benefits Enrollment

If you change health care companies during Annual Benefits Enrollment, you will also be changing the company that administers your MRA and HCSA. The transition of your MRA and HCSA accounts will happen automatically — you do not need to take any action.*

It is important to note that there will be a delay in transferring your unused MRA funds (if any) from the prior year to your MRA at your new health care company (generally occurs in the April time frame). This delay is designed to allow your prior health care company continued access to funds in your MRA to pay prior year medical and prescription drug claims that are processed in the first four months of the new year. However, if this policy creates a financial hardship, you may contact your new health care company to accelerate the transition of your MRA/HCSA account, which will allow you to access your prior year unused MRA funds more quickly.

* Any balance of up to $550 remaining in your Health Care Spending Account (HCSA) at the end of the 2020 calendar year will be automatically carried over to the next year. Any amount over $550 in your HCSA, after processing claims for the 2020 year, will be forfeited. If you were previously enrolled in the HCSA and decide not to participate in 2020, any unused amounts under $25 will be forfeited. Even if you do not participate in 2020, amounts of $25 or more will remain available for future eligible health care expenses. If you do not enroll in the JPMorgan Chase Medical Plan your balance will be managed by Cigna.

If You Have Questions About a Claim

You can check the status of your claim by accessing your health care company’s website, or you can call your health care company at the number on the back of your ID card.

If you are experiencing difficulty with a claim, the JPMorgan Chase Health Advocate program, available at **My Health**, can also help you resolve benefit claim issues.

Appealing a Claim

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

Help Pursuing Claims

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

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

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

What Is Covered

Each of the Medical Plan options cover a wide variety of services, as long as the services are medically necessary (please see the definition of "Medically Necessary" under "Defined Terms" on page 176) and their costs do not exceed reasonable and customary (R&C) charges. (Please see "Defined Terms" on page 176 for the definitions of "Necessary Services" and "Reasonable and Customary Charges.") Covered services and frequency limits may vary slightly across the healthcare companies — Aetna and Cigna. The lists on the pages that follow include examples of covered services, but the lists are not exhaustive and coverage remains subject to any Plan requirements or limitations and clinical policies. For specific information on the Medical plan's covered services and frequency limits, please contact the appropriate claims administrator (Aetna or Cigna) directly, using the telephone numbers provided under "Where to Submit Claims." The list of covered services may change at any time.

Important Note

While the services listed in this section are covered by the Medical Plan, they must be "medically necessary." Please see the definition of "Medically Necessary" under "Defined Terms" on page 176.

Quality Providers

The health care companies (Aetna and Cigna) designate a select number of their participating providers to be "quality" providers. This is a special designation for physicians and other medical providers who have been proven to provide high-quality and cost-effective care. If you choose to use these providers, you may have better outcomes, lower medical costs, or both. Visit your health care company's website for more information.

Preventive Care Services

The preventive care services covered at 100% in-network are determined by your health care company 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. For a list of preventive services that are covered at 100%, go to your health care company's website. Age and frequency limits apply. Please contact your health care company for further information.

These services generally include:

- Routine care including:
  - PAP tests (one per year, includes related laboratory fees);
  - Prostate exams (based on provider's recommendation)
  - Flexible sigmoidoscopy (one baseline screening, and one follow-up screening every five years);
  - Screening colonoscopy (one baseline screening and one follow-up screening every five years);
  - Fecal occult blood test (one test per year);

- Routine physical exams (one per year office visit with appropriate laboratory and radiology services);
- Mammography screenings (one mammogram per year);
- Routine screenings during pregnancy (for example for gestational diabetes and bacteriuria);
- Breast pumps (please contact your health care company for details about which breast pumps are fully covered);
- Travel immunizations; 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

This list is subject to change at any time without notice.

Please Note: An in-network medical service will only be covered at 100% if it is 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 the claims administrator, as preventive medical care rather than as a diagnostic service.

Outpatient Services

Outpatient services under the Medical Plan include, but are not limited to, the following services, subject to any limitations or requirements of the Plan and based on medical necessity. Please refer to your health care company's clinical guidelines or call your health care company to discuss coverage of any specific services listed below:

- Acupuncture, is covered when it's used:
  - as a form of pain control, or
  - for treatment of nausea because of chemotherapy, pregnancy or post-operative procedures;

  Treatment must be performed by a licensed provider (check with your claims administrator).
- Allergy testing and treatment;
- Chemotherapy and radiation treatments;
- Chiropractic care when medically necessary as determined by the claims administrator 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;

- Home health care, which may require precertification; limited to a maximum of 200 visits/calendar year; one visit = four hours. (Please see "Mental Health Benefits" on page 172 for more information.) The attending physician must submit a detailed description of the medical necessity and scope of services provided to the claims administrator. The following are covered if ordered by the physician under the home health care plan and provided in the patient's home:
  - Medical supplies and laboratory services prescribed by a physician;
  - Nutrition counseling provided by or under the supervision of a registered dietitian;
  - Part-time or intermittent nursing care provided or supervised by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);
  - Part-time or intermittent home health services, primarily for the patient's medical care; and
  - Physical, occupational, speech, or respiratory therapy by a licensed qualified therapist.
- 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 the claims administrator;
- Mental health care/substance abuse care;
- Cognitive rehabilitation therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis). Please see "Mental Health Benefits" on page 172 for more information.
- Occupational therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis). Please see "Mental Health Benefits" on page 172 for more information.
- Outpatient surgery and related follow-up care;
- Physical therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis). Please see "Mental Health Benefits" on page 172 for more information.
- Podiatric care when medically necessary as determined by the claims administrator 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 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis). Please see "Mental Health Benefits" on page 172 for more information.
- Temporomandibular joint syndrome (TMJ) medical treatment only; including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery up to $1,000 combined in-network and out-of-network maximum per year (appliances are not covered); and
- Virtual doctor.

The items/services listed above may change at any time.

Inpatient Hospital and Related Services

The 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, 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. **Please Note:** To receive benefits for bariatric surgery, you must contact your health care company before obtaining services; you will be informed of any required precertification. If you and/or your covered spouse/domestic partner use a Center of Excellence (COE) for your treatment you may be eligible for reimbursement of travel and lodging expenses. To learn more about the travel and lodging benefit including reimbursement see the bullet in the list below starting with "Travel Benefit" for further details.
- 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 under the Medical Plan 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 level within prescribed enrollment time frames;

Multiple Surgical Procedure Reduction Policy

The 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, these options will pay:

- 100% of your medical option's coinsurance percentage amount for the primary or major surgical procedure; and
- 50% of your medical option's coinsurance percentage amount for the secondary procedure.; and

If more than two procedures are performed, please check with your claims administrator for coverage details. Please see contact information in the *Contacts* section.

- — Care required because of 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 level within prescribed enrollment 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 level 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 after a vaginal delivery or 96 hours after a cesarean section. (However, your attending physician — after consulting with the mother — may decide to discharge the mother or newborn child earlier.)

Please Note

You have 90 days from the date of birth or adoption of a child to add your newly eligible dependents to the Medical Plan. Please see "Eligible Dependents" and "Changing Your Coverage Midyear" in the *Health Care Participation* section for more information.

- Mental health care/substance abuse care;
- 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 or tissue transplants including replacing a non-functioning or damaged organ or tissue with a working organ or tissue from another person. **Please Note**: To receive benefits for transplant surgery, you must contact your health care company before obtaining services; you will be informed of any required precertification. Covered services include physician and hospital costs, donor search, tests 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 this plan, but only to the extent that the donor expenses are not covered under another health insurance plan. If you and/or your covered spouse/domestic partner uses a Center of Excellence (COE) for your treatment, you may be eligible for reimbursement of travel and lodging expenses if your treatment facility is more than 50 miles away from your home, see the Travel Benefit below for more information. To locate a COE, visit your health care company's website at **My Health** or call your health care company.
- Pre-admission testing when completed within seven days of hospital admission;
- Semi-private room and board;
- Take-home drugs and medications; and
- Travel Benefit: The plan offers travel benefits for the following conditions/surgery: bariatric surgery and organ transplant up to a maximum of $10,000 per covered person per surgery/condition for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all certified and approved procedures. To qualify for this benefit the procedure/treatment needs to take place more than 50 miles from your home.
  - — The claims administrator must receive valid receipts for such charges before you will be reimbursed. The items/services listed above may change at any time so check with your health care company to see if your condition or surgery qualifies for this benefit and for additional details on this benefit.

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 Medical Plan will provide certain benefits related to benefits received in connection with a mastectomy. The Medical 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 Medical 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 Medical Plan.

Other Covered Services

The 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, subject to any limitations or requirements of the Medical Plan, such as prior authorization, and based on medical necessity:

- Compression stockings (two pair per calendar year for the following conditions only: diabetes, varicose veins, varicose ulcers, statis dermatitis, post-phlebitic syndrome, and lymphedema);
- Coverage abroad (coverage outside of the U.S. or international coverage), as follows:

Benefits Provision	Option 1 and 2
Treatment for an emergency*, for example, sudden serious chest pain	Emergency Room Copay
Treatment for an urgent situation	Urgent Care INN Copay
All other treatment; for example, elective surgery scheduled several months in advance	Out-of-network copays apply after deductible based on type of service

* True emergency as determined based on what a prudent person would consider an emergency, not on the final diagnosis reached by doctors.

If you receive treatment while traveling outside the United States, you will have to pay for the services up front and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, please see "Filing a Claim for Benefits" on page 159. If you have any questions about benefits while traveling abroad, please call your health care company.

- Dental procedures resulting from a congenital 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 a medical setting. **Please Note:** The charges must not be covered by the JPMorgan Chase Dental Plan or any other dental plan that you might be enrolled in.

- Diabetes services, diabetes self-management and training, and diabetic eye examinations/foot care — outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a physician and provided by appropriately licensed or registered health care professionals. Covered services also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
- Diabetic self-management items — Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under durable medical equipment (DME), and Prosthetics. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets, and lancet devices are described under the separate prescription drug plan. Please note: Specific insulin pumps may also be covered under the Prescription Drug benefit. Contact CVS Caremark for additional information on which insulin pumps are covered under the Prescription Drug Plan.
- External cochlear devices and systems;
- Gender Affirmation Surgery (may be referred to by our healthcare companies as Gender Reassignment Surgery or GRS). To be eligible, the participant must meet certain medically established guidelines that are outlined in your healthcare companies clinical polices (which may align with the WPATH Standards of Care v7), for obtaining the surgery which require the participant to, among other things:
  - Be at least 18 years old;
  - Have a gender identity disorder diagnosis;
  - Have been approved for hormone therapy;
  - Have at least one year's real life experience living in desired gender; and
  - Have two letters endorsing surgery, including one from a mental health provider at the master's degree level.

  Please refer to your health care company's clinical policies or call your health care company to discuss coverage of any specific procedure under the Plan.

  In-network surgery preauthorization is the responsibility of the in-network provider. For out-of-network surgery, you are responsible for preauthorization.
- Hearing aids: 2 hearing aides every 36 months.
  - Hearing aids do not need to be prescribed by or obtained from an in-network provider or from an in-network Durable Medical Equipment (DME) provider in order to be considered a covered, eligible charge. You will be subject to out-of-network pricing if you obtain your hearing aide from an out-of-network provider/DME equipment provider. Hearing aid evaluations and hearing tests (not included in the hearing aid maximum benefit).
- Intensive behavior therapy, such as applied behavior analysis for autism spectrum disorder.
- Local emergency ambulance service or air ambulance to the nearest hospital qualified to treat the condition if medically necessary and confirmed by a licensed provider.
- Medical equipment and supplies ordered or provided by a physician including:
  - artificial eyes and larynx (including fitting);
  - artificial limbs (excluding replacements);
  - Athner monitor;
  - blood and blood plasma (unless donated on behalf of the patient);
  - cane;
  - casts;
  - crutches;
  - custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot;
  - heart pacemaker;

- hospital bed;
- insulin pump;
- iron lung;
- manual pump-operated enema systems;
- orthopedic braces;
- ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers and bags;
- splints;
- surgical dressings;
- trusses;
- ventilator;
- walker;
- wheelchair; and
- other items necessary to the treatment of an illness or injury that are not excluded under the plans.

Prior authorization or pre-certification may be required for coverage of some medical equipment and supplies. The claims administrator 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;
- Non-emergency transportation is covered if it is provided by a licensed professional ambulance (either ground or air ambulance as determined appropriate) when the transport is:
  - from an out-of-network hospital to the closest in-network hospital with capabilities to care for the condition;
  - to a hospital that provides a higher level of care that was not available at the original hospital (when medically necessary for the patient's care);
  - to a more cost-effective acute care facility (as authorized by the plan) from an acute facility to the nearest sub-acute facility;
- Nutritional support, including nutritional counseling (limited to 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.
  - The limits noted above do not apply for nutritional counseling for behavioral disorders (eating disorders).

  * 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; that is, 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 related supplies, including fitting, adjustments, and repairs, and biomechanical devices, if ordered by a licensed provider. Please check with the claims administrator 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 — includes cranial orthotics (helmets) custom molded, when prescribed by physician — as determined by the claims administrator and if ordered by a licensed provider. Frequency and other limitations may apply. At the claims administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear when repair costs exceed new purchase price, or when a change in the medical condition occurs sooner than the end of a three-year time frame. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouthpieces, etc., for necessary durable medical equipment are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year time line for replacement.
- Services and supplies that are part of an alternate care proposal. This is a course of treatment developed and authorized by the claims administrator 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 benefits, maximum amounts, and copayments will apply to these services.
- Skilled nursing facility for up to 365 days per lifetime (combined in-network and out-of-network). The lifetime maximums reflect services received across all JPMorgan Chase Medical Plans.
- Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to sickness or injury.
- Termination of pregnancy:
  - — Voluntary (i.e., abortion)
  - — Involuntary (i.e., miscarriage)
- Urgent care;
- Voluntary sterilization; and
- Wigs up to a $500 per year limit, for burns, chemotherapy or radiation, accidental injury, after a diagnosis of alopecia, or for other medically necessary reasons.

The items/services listed above may 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 $10,000 ($30,000 if a Center of Excellence (COE) is used) combined lifetime maximum benefit for each covered individual (you and/or your spouse/domestic partner). This limit applies to all benefits received under the Medical Plan regardless of whether the service was received in-network or out-of-network. Please note amounts paid by the plan (not your out-of-pocket expenses) apply to the Lifetime Infertility maximum. This limit does not apply to the services used to determine the initial diagnosis of infertility and/or its cause, which are not subject to the $10,000 ($30,000 if using a COE) benefit maximum. All procedures and access will be governed by the health care company's clinical policies for determining appropriateness of care. Please also see the "Infertility Drugs" information under "What's Covered and Not Covered" on page 154 for information on a $10,000* lifetime maximum on prescription drugs related to infertility treatment. Please contact your health care company for specific details.

Please Note:

- To receive benefits for infertility services, you must contact your health care company and receive precertification before obtaining services.
- If you and/or your covered spouse/domestic partner use a COE for your treatment, your lifetime infertility benefit maximum will be increased to $30,000. You must complete all program requirements to earn the increase to the benefit maximum. To locate a COE, contact your health care company

* The lifetime maximum for prescription drugs under the infertility benefit includes the charges paid by the plan. Your prescription drug out-of-pocket expenses (dollars you pay towards the copayment and costs for non-covered drugs) are not included in the either the Medical or prescription drug plan lifetime maximum.

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. To use infertility benefits covered under the Plan, you must contact your health care company and work with them and your doctor to determine your appropriate course of treatment.

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.

Mental Health Benefits

Mental health care or benefits, in accordance with the Mental Health Parity and Addiction Equity Act, are items or services for mental health or substance use disorder conditions, as determined solely within the discretion of the plan administrator, consistent with generally recognized independent standards of current medical practice. Conditions affecting physical health that are related to a mental health condition or substance use disorder are medical/surgical benefits rather than mental health care benefits under the Medical Plan. However, for those individuals with a mental health diagnosis, associated medical treatments subject to visit limits (such as physical, occupational, and speech therapy and home health care services) will not be subject to an annual visit limitation.

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 the claims administrator. It must be either a hospital or a freestanding 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 the claims administrator. If such a program is required by federal or state 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 or 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.

The items/services listed above may change at any time.

Coverage Limitations

As mentioned earlier, certain covered services are limited to a specific number of visits or days or limitations, subject to applicable copayments.

These limitations are included in the coverage charts earlier in this section. Please see “Mental Health Benefits” on page 172 for more information.

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 Medical Plan covers a wide variety of medically necessary services, some expenses 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’s/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 (unless prescribed by a physician); corrective shoes (unless prescribed by a physician); 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);
  - If you enter into an agreement with a provider regarding the waiver of an expense, you are required to inform your health care company of the agreement.
- Expenses in excess of reasonable and customary charges for out-of-network services;
- Expenses submitted later than December 31 of the year after the year in which services were provided;
- Experimental, investigational, or unproven services, devices, or supplies (see the definition of "Experimental, Investigational, or Unproven Services" under "Defined Terms" on page 176);on
- Extended benefit coverage after termination from JPMorgan Chase (other than coverage elected through COBRA). If you are hospitalized on the date your JPMorgan Chase Medical Plan coverage terminates, Medical Plan coverage will end at midnight that day.
- Hospital admissions and other services that began before the participant's effective date of coverage under the 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 JPMorgan Chase Prescription Drug 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 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 because of 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.
    - Food supplements, specialized infant formulas (e.g., Alimentum, Elecare, and Neocate,), lactose-free foods, vitamins and/or minerals may be used to replace intolerable foods, for lactose intolerance, to supplement a deficient diet, or to provide alternative nutrition in the presence of such conditions as allergies, gastrointestinal disorders, hypoglycemia, and obesity. Food supplements, lactose-free foods, specialized infant formulas, vitamins and/or minerals taken orally are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.

- Personal services for comfort or convenience while in the hospital, such as television, telephone, etc.;
- Physical, psychiatric, or psychological exams, testing, vaccinations, or treatments if required solely for purposes of school, sports or camp, 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 after cataract surgery;
- Refractive eye surgery including, but not limited to, LASIK or radial keratotomy;
- Reproductive education and conception prevention classes;
- Reversals of sterilization;
- Routine dental care (please see the Dental Plan Summary Plan Description on **My Health** for information about services covered under the JPMorgan Chase Dental Plan);
- Routine eye exams (please see the Vision Plan Summary Plan Description on **My Health** for information about services covered under the JPMorgan Chase Vision Plan);
- Services, supplies, or treatment for weight loss, nutritional supplements, or dietary therapy;
- Sickness or loss covered by state workers' compensation law 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 the claims administrator in its sole discretion to be part of a global procedure; and
- Vision therapy.

The items/services listed above may change at any time.

Defined Terms

As you read this SPD for the JPMorgan Chase Simplified Medical Plan, you'll come across some important terms related to the Plan. To help you better understand the Plan, many of those important terms are defined here.

Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical Plan payroll contributions are taken on a before-tax basis.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Medical Plan. If you elect Medical Plan coverage, your claims administrator is your health care company (Aetna or Cigna, depending on your election).
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that allows you and/or your covered dependents to continue Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise end. The *Health Care Participation* section provides details on COBRA coverage.
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 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). ▪ Covered by Medicare. If you or a dependent are eligible for Medicare because of disability or end-stage renal disease, please see "Coordination with Medicare" in the *Plan Administration* section for more information.
Copayment	A copayment (also known as a copay) is the fixed dollar amount you pay for certain services or medications under the Medical and/or Prescription Drug Plan.
Covered Services	While the Plan provides coverage for numerous services and supplies, there are limitations on what's covered. For example, experimental treatments, most cosmetic surgery expenses, and inpatient private duty nursing are not covered under the Medical Plan. Medical procedures are generally reimbursable by the JPMorgan Chase Medical Plan only if they meet the definition of "Medically Necessary" (see the definition "Medically Necessary," below).
Custodial Care	Custodial care is medical or non-medical services that do not seek to cure, are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel. An example of custodial care is assistance in the activities of daily living.

Deductible

If you choose to use an out-of-network provider, the deductible is the amount you pay up front each calendar year for covered expenses before the Medical 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.

Domestic Partner

You may cover a "domestic partner" as an eligible dependent under the Medical Plan if you're not currently covering a spouse.

- 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 see "Domestic Partners" in the *Health Care Participation* section for more information.

Eligible Dependents

Under the Medical Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see the above definition of "Domestic Partner" and see "Eligible Dependents" in the *Health Care Participation* section for more information.

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 Medical Plan and through any related Medical Reimbursement Account and/or Health Care Spending Account.
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, the supervision of intravenous therapy or other skilled nursing care.
Hospice Care Program	A hospice care program is a program that tends to the needs of a terminally ill patient as an alternative to traditional health care, while meeting medically necessary and acceptable standards of quality and sound principles of health care administration. The program must be a written plan of hospice care for a covered person, and it must be approved by the appropriate claims administrator.
Hospital	A hospital is an institution legally licensed as a hospital — other than a facility owned or operated by the United States government — that's engaged primarily in providing bed patients with diagnosis and treatment under the supervision of licensed physicians. The hospital must have 24-hour-a-day registered graduate nursing services and facilities for major surgery. Institutions that don't meet this definition don't qualify as hospitals.
Hospital Notification	Hospital notification refers to the requirement under the Medical Plan that you should notify the claims administrator in advance of a non-emergency hospital admission or if a maternity stay exceeds the guidelines. However, you will not be penalized under the Plan if you do not notify the claims administrator.
In-Network	"In-network" describes a covered service that is performed by a physician, 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.
Medical Reimbursement Account	A Medical Reimbursement Account ("MRA," also known as a Health Reimbursement Account" or "HRA") is a tax-free account established on your behalf at your health care company when you enroll in the Medical Plan. You (and your covered spouse/domestic partner) can earn Wellness Rewards for your MRA by completing the Initial Wellness Activity and Additional Wellness Activities. This account is JPMC-funded only; you cannot contribute to your MRA. You can use the funds in your MRA to pay for covered out-of-pocket medical and prescription drug expenses (out-of-network deductibles and copayments).
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: o For treating a life-threatening sickness or condition; o In a clinically controlled research setting; and o 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.
Multiple Surgical Procedure Reduction Policy	The multiple surgical procedure reduction policy applies under the Medical Plan. 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.
Non-Duplication of Benefits	Non-duplication of benefits is a provision that requires that the Medical Plan does 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 Medical 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 Medical 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.
Out-of-Network	"Out-of-network" describes a covered service that is performed by a physician, 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	An out-of-pocket expense is the amount you pay for eligible expenses when you receive treatment. This includes your out-of-network deductible, and copayments.
Out-of-Pocket Maximum	The out-of-pocket maximum is a "safety net" that protects you from having to pay high expenses in the event of a serious medical situation. The out-of-pocket maximum is the most you would need to pay in a calendar year (in addition to the deductible for out-of-network services) for medically necessary covered services under the Medical Plan. There are separate in-network and out-of-network out-of-pocket maximums. Once the out-of-pocket maximum is reached, the 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. Under the Medical Plan, amounts above R&C charges for out-of-network care do not count toward your medical out-of-network, out-of-pocket maximum. Please see "Right of Recovery" in the *Plan Administration* section for information on circumstances when you may be required to repay the benefits you've received under the Plan.
Primary Care Physician	A primary care physician ("PCP") is the network physician who provides or coordinates all the care you receive. Primary care physicians include doctors who practice family medicine, internal medicine*, obstetrics/gynecology, and pediatrics. Care provided by an in-network primary care physician is covered at 100% with a $15 copayment. *Internists must be contracted with Aetna or Cigna as Primary Care Physicians. (A list of doctors who are designated as Primary Care Physicians is available on Aetna or Cigna's websites.)

Primary Plan	The primary plan is the plan that provides initial coverage to the participant. If the participant is covered under both a JPMorgan Chase Medical Plan option 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 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 information.
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.) Any changes you make during the year must be consistent with your QSC. Please see "Changing Your Coverage Midyear," in the *Health Care Participation* section for more information. **Please Note:** Regardless of whether you experience a QSC, you cannot change your health care company during the year.
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. 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. 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 Plan, you'll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered covered expenses. Therefore, they don't count toward your deductible, benefit limits, or coinsurance maximums.
Regional Cost Category	The regional cost category is the category that is assigned to a state or region based on the cost of health care for that region in relation to the national average. The Regional Cost Category is used to determine your Medical Plan contributions and is based on your home address.
Self-Insured	A self-insured plan is a plan where the sponsor (in the case of the Medical Plan, JPMorgan Chase) is responsible for the payment of medical claims under the Medical Plan, including the Prescription Drug Plan. This makes the Plan self-insured.
Skilled Nursing Facility	A skilled nursing facility is an institution that primarily provides skilled nursing care and related services for people who require medical or nursing care, and that rehabilitates injured, disabled, or sick people.
Spouse	Your spouse is the 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 **My Health**.

Tobacco-User Surcharge	The tobacco-user surcharge refers to additional Medical Plan contribution costs for employees and covered spouses/domestic partners who use tobacco products. Eligible employees and covered spouses/domestic partners who do not use tobacco products pay less for coverage under the Medical Plan than those who use tobacco products. A "tobacco user" (for a plan year), as defined in the Medical Plan, is any person who has used any type of tobacco products (for example, cigarettes, cigars, pipes, chewing tobacco, snuff, or a pipe) regardless of the frequency or location (this includes daily, occasionally, socially, at-home only, etc.) in the 12 months preceding January 1 of the plan year. Tobacco users may be able to qualify for lower non-tobacco user rates by completing a tobacco cessation program (see "Tobacco Cessation Program" on page 134).
Total Annual Cash Compensation	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. Total Annual Cash Compensation is used for purposes of determining your Medical Plan contribution pay tier, deductible and in-network coinsurance maximum.
Visit	A visit is an encounter with a provider involving direct patient contact. Some benefit provisions limit the number of covered visits. Unless a visit is defined for a particular benefit provision (such as home health care), each procedure code billed counts as a visit toward the limit. The length of a visit may vary by procedure code.

The Dental Plan

Effective 1/1/21

The Dental Plan is designed to provide you and your family with access to high quality, cost-effective dental care. The Plan offers you and your enrolled dependents coverage for a wide range of preventive care, basic and major restorative care, and orthodontia dental services, depending on the option you choose.

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

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

Important Note: The DMO and DHMO are fully insured dental options for which the benefit payments are the responsibility of the insurance carrier (Aetna for the DMO and Cigna for the DHMO). In the event that there is a discrepancy between the information provided in this Guide and the Plan contracts issued by the carrier (Aetna and Cigna), the Plan contracts will govern.

About this Summary Plan Description

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

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

Questions?

For questions or concerns regarding this Dental Plan, contact the claims administrator for the dental option you chose:

- MetLife Preferred Dentist Program (PDP) Option: MetLife Dental at (888) 673-9582
- Aetna, Inc. Dental Maintenance Organization (DMO) Option: Aetna at (800) 843-3661
- Cigna Dental Health Maintenance Organization (DHMO) Option: Cigna Dental Health at (800) 790-3086

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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Dental Plan Highlights

My Health

My Health is your central online resource for the JPMorgan Chase Benefits plans. From **My Health**, you can easily connect to the dental option websites to find in-network provider directories, check claims status, and much more.

Your Choices

The Dental Plan offers most eligible participants two to three options to choose from, depending on your ZIP code. One option, the PDP Option, is available in all locations. The other option, an HMO-like option, will offer most participants either the DMO and/or the DHMO, depending on your home ZIP code.

Preferred Dentist Program (PDP) Option

The PDP Option, administered by MetLife, lets you choose between receiving in-network or out-of-network care each time you need dental work. You will generally pay less for your care when you use a MetLife in-network dental provider for two reasons:

- In-network care is generally covered at a higher percentage with lower annual deductibles than out-of-network care; and
- In-network dentists have agreed to charge lower, negotiated fees for their services when treating JPMorgan Chase Dental Plan participants.

Dental Maintenance Organization (DMO) or the Dental Health Maintenance Organization (DHMO) Option (depending on your home ZIP code)

The DMO Option, administered by Aetna Inc., and the DHMO Option, administered by Cigna, offer you a broad range of dental services on a pre-paid basis. You will be able to choose one or the other of these options, depending on your home ZIP code. In some ZIP codes, both the DMO and the DHMO will be offered. If you enroll, you agree to receive care solely from dentists associated with the network for your option, and in return, you will have no deductibles to meet and no claim forms to file. The DMO and DHMO administrators actively work to keep dental care costs low by requiring DMO and DHMO dentists to meet strict quality standards, screening for cost-effective practice patterns, and negotiating fees charged for services.

Your Coverage Levels

If you elect coverage, 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).

Disabled Dependents Over Age 26

If you are not enrolled in one of the Medical plans but want to continue coverage for your dependent child over age 26 for the Dental and/or Vision plan, please contact your Medical plan carrier (Aetna or Cigna) to see if they qualify for continued coverage under these plans.

Covered Services

Depending on the option you choose, covered services can include some or all of the following:

- Preventive care services, such as oral exams, fluoride treatment, prophylaxis, X-rays (excluding intra-oral X-rays), sealants and emergency palliative treatment.
- Basic restorative care services, such as fillings, extractions, oral surgery, anesthesia and antibiotic injections.
- Major restorative care services, such as services to replace lost teeth, and inlays, onlays, and crowns, and their repair or recementing.
- Orthodontia services.

Cost of Coverage

You and JPMorgan Chase share the cost of coverage under each of the Dental Plan options. You pay for coverage through payroll contributions with before-tax dollars, in equal installments.

The amount you pay via payroll contributions depends on two factors:

- The Dental Plan option you choose; and
- The "coverage level" you choose (described under "Coverage Levels" in the *Health Care Participation* section).

The cost of coverage for each option offered under each of the coverage levels will be available on the Benefits Web Center.

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

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

Tax Treatment of Domestic Partner Coverage/Gross-Up Policy

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.

Enrolling a Domestic Partner

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

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.

The Preferred Dentist Program (PDP) Option

The Preferred Dentist Program (PDP) Option is administered by MetLife. The PDP Option lets you choose between receiving in-network or out-of-network care each time you need dental work. You will generally pay less for your care when you use a MetLife in-network dental provider for two reasons:

- In-network care is generally covered at a higher percentage with lower annual deductibles than out-of-network care; and
- In-network dentists have agreed to charge lower, negotiated fees for their services.

With the PDP Option…

- You can receive in-network or out-of-network care at any time and still receive benefits.
- In-network preventive care is covered at 100% with no deductible.
- There's no deductible for out-of-network preventive care.
- There's no deductible for orthodontic care.
- Combined in-network and out-of-network annual limits apply to preventive and restorative care.
- Combined in-network and out-of-network lifetime limits apply to orthodontia benefits.
- Claim forms are not needed for in-network providers.

How the PDP Option Works

The PDP Option has networks of participating dentists and other dental providers who have agreed to a negotiated fee arrangement for covered dental services when treating JPMorgan Chase participants. However, you can also choose to receive care from any other dental provider and still receive benefits.

If you're interested in enrolling in the PDP Option, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You may view an online provider directory by accessing MetLife's website (https://mybenefits.metlife.com) or the Benefits Web Center via **My Health**. You can also call MetLife at (888) 673-9582 if you need help finding a provider.

Pre-Determination of PDP Benefits

Under the Preferred Dentist Program (PDP) Option, you should submit an itemized list of any proposed course of treatment (including recent pre-treatment X-rays) that you expect will cost more than $300, before work has begun. A dental consultant at MetLife will review the proposed treatment before work begins and MetLife 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 your JPMorgan Chase Dental Plan option will pay.

How the PDP Option Pays Benefits

Please Note: The way benefits are paid depends on whether you receive your care in-network or out-of-network. The following chart shows how the PDP Option pays benefits.

Benefit Provision	In-Network	Out-of-Network
Annual Deductible		
• Preventive	• None	• None
• Restorative	• $50 individual; $150 family	• $100 individual; $300 family
• Orthodontia	• None	• None
Preventive (no deductible)	100% coverage*	90% coverage*
• Oral exams	• Maximum two per calendar year	• Maximum two per calendar year
• Prophylaxis (cleaning)	• Maximum two per calendar year	• Maximum two per calendar year
• Fluoride	• Maximum one per calendar year, and only covered for participants who are under age 19	• Maximum one per calendar year, and only covered for participants who are under age 19
• Full mouth X-ray	• Maximum one per every 60 months	• Maximum one per every 60 months
• Bitewing X-ray	• Maximum one per calendar year**	• Maximum one per calendar year**
• Sealants	• Maximum two treatments per tooth (permanent molars only) per lifetime; under age 19	• Maximum two treatments per tooth (permanent molars only) per lifetime; and only covered for participants who are under age 19

Benefit Provision	In-Network	Out-of-Network
Basic restorative (fillings, extractions, periodontal, oral surgery, anesthesia, including non-intravenous conscious sedation when medically necessary)	80% coverage, after deductible*	70% coverage, after deductible*
Major restorative (dentures, inlays, onlays, crowns, bridges, root canal)	60% coverage, after deductible*	50% coverage, after deductible*
Orthodontia * **	50% coverage*	50% coverage*
Maximum Benefits		
• Combined annual for preventive and restorative	• Maximum $2,000****	• Maximum $1,500****
• Lifetime for orthodontia	• Maximum $2,500****	• Maximum $2,000****

* All in-network percentages above apply to dentists' negotiated fees. All out-of-network percentages apply to reasonable and customary (R&C) charges.

** Two times per calendar year for covered participants under age 19.

*** For covered children under age 19. Please see "Orthodontic Covered Services" on page 189 for additional information.

**** Reflects a combined amount for both in-network and out-of-network; includes any benefits already applied to any lifetime maximum for orthodontia under the Dental Plan.

Please Note: Wherever benefits are limited to a certain number of visits, combined in-network and out-of-network visits will count toward the benefit limit. For more details on coverage limitations, see "What Is *Not* Covered" on page 195.

Annual Deductible

Under the PDP Option, 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.

Please Note: There are separate deductibles (in-network and out-of-network) for restorative care.

An Example: Amounts Applied Toward In-Network Restorative Care Deductibles	
On behalf of you	$50
On behalf of your spouse/domestic partner	$50
On behalf of child #1	$30
On behalf of child #2	$20
Total	$150
In this example, four people have met the family annual deductible for in-network restorative care. So, any other covered person's in-network restorative care would be reimbursed by the Plan, even if it were on behalf of a person who has not yet met the $50 individual annual deductible. No other covered family members need to meet their in-network restorative care deductible for the rest of the year. **Please Note:** No more than $50 of expenses per individual will be applied towards the family deductible.	

Coinsurance

After you meet the applicable deductible, the 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" beginning on page 200 for the definition of "Reasonable and Customary"). The exact percentage depends on the type of care and whether the care was received on an in-network or out-of-network basis. Please see "How the PDP Option Pays Benefits" on page 186 for the applicable coinsurance rate. You'll pay the remaining amount as coinsurance, plus any amounts above R&C charges.

Alternate Benefit Provision

Under the Preferred Dentist Program (PDP) Option, 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 MetLife, the claims administrator. Under the Plan's alternate benefit provision, if MetLife determines in its sole discretion 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, MetLife 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, MetLife 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, MetLife 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, MetLife 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. MetLife will provide you with an estimate of the dental insurance benefits available for the service.

Maximum Benefits

There are limits on the benefits you can receive from the PDP Option. The maximum benefit for in-network preventive and restorative care is $2,000 per person per year and the maximum benefit for out-of-network preventive and restorative care is $1,500 per person per year. The lifetime maximum benefit for orthodontia is $2,500 per person in-network and $2,000 per person out-of-network. **Please Note:** These maximums reflect a *combined* amount for both in-network and out-of-network care, so out-of-network care will count against your in-network benefit maximum and vice versa.

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 before the child's becoming covered under the JPMorgan Chase 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 MetLife that the orthodontic treatment is continuing.

If the periodic follow-up visits began before the child's becoming covered under the JPMorgan Chase 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 JPMorgan Chase Dental Plan; and
- The total amount of the benefit payable for the periodic visits will be reduced proportionately.

The Dental Maintenance Organization (DMO)

The DMO Option offers you a broad range of dental services on a pre-paid basis. The DMO Option is available in many locations and is administered by Aetna, Inc. You agree to receive care solely from dentists associated with the DMO Option network, and in return, you will have no deductibles to meet and no claim forms to file. Aetna actively works to keep dental care costs low by requiring DMO dentists to meet strict quality standards, screening for cost-effective practice patterns, and negotiating fees charged for services.

How the DMO Option Works

If you decide to enroll in the DMO Option for the first time or add new dependents for coverage under this option, you must select a primary care dentist in order to receive care. **Please Note:** You can choose a different DMO dentist for yourself and each covered dependent. Changes to your primary care dentist must be made by the 15th of the month in order to be effective the first of the following month.

If you're interested in enrolling in the DMO, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You can view an online provider directory by visiting the Benefits Web Center on **My Health**. Once enrolled, you can view an online provider directory by accessing www.aetna.com. You can also call Aetna at (800) 843-3661 if you need help finding a provider. You should check with the dentist before scheduling an appointment or receiving services to confirm that he or she is participating in the network.

With the DMO Option…

- Preventive care is covered at 100%.
- Adult and child orthodontia is covered.
- There are no annual deductibles.
- There are no claim forms to file for in-network care. In limited circumstances, out-of-network care is permitted; you are responsible for filing a claim form to receive reimbursement for DMO out-of-network services.
- There are no lifetime limits on benefits (except orthodontia and sealants).
- You only receive benefits if you use a DMO dentist; however, you can change your DMO dentist during the year. **Please Note:** Requests to change your DMO dentist must be received by the 15th of the month in order to take effect the first of the next month.
- You and your dependents can each have different DMO dentists.
- You and your dependents will receive a DMO ID card following your enrollment.

How the DMO Option Pays Benefits

If you enroll in the DMO Option, you agree to receive care solely from dentists participating in the managed care network. Limited out-of-network coverage may be available based on state mandates or in the case of certain, out-of-area emergencies, as noted below. If you receive any out-of-network care, you must file a claim to receive benefits. Check your Aetna DMO coverage certificate or contact customer service at the number on your ID card for details.

Benefit Provision	Coverage
Annual Deductible	
• Preventive	• None
• Restorative	• None
• Orthodontia	• None
Preventive	100% coverage
• Oral exams	• Maximum two per calendar year
• Fluoride	• Maximum two per calendar year, and only covered for participants who are under age 19
• Prophylaxis (cleaning)	• Maximum two per calendar year
• Full mouth X-ray	• Maximum one every 36 months
• Bitewing X-ray	• Maximum two per calendar year
• Sealants	• Maximum two treatments per tooth (permanent molars only) per lifetime and only covered for participants who are under age 19

Benefit Provision	Coverage
Basic restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)	90% coverage
Major restorative (dentures, inlays, onlays, crowns, bridges)	60% coverage
Orthodontia	50% coverage
Maximum Benefits	
• Combined annual for preventive and restorative	• No maximum
• Lifetime for orthodontia	• One course of treatment per individual per lifetime
Out of Area Emergency Palliative Dental Care Out-of-Area Emergency Dental Care consists of necessary covered dental services given to covered persons by a Non-Participating (out-of-network) dental provider for the palliative (pain relieving; stabilizing) treatment of an emergency condition (if there is severe pain, swelling or bleeding). The emergency care is rendered outside of the 50 mile radius of the covered person's home address. Coverage for Out-of-Area Emergency Dental Care is subject to specific limitations described in the DMO Option. The JPMC DMO Option covers 100% of billed charges for out of area emergency care; benefits are limited to a $100 maximum and subject to R&C.	100% coverage for reasonable and customary charges, up to a maximum benefit of $100 per incident. If you receive any out-of-network care, you must file a claim to receive benefits.

The Dental Health Maintenance Organization (DHMO) Option

The DHMO Option offers you a broad range of dental services on a pre-paid basis. The DHMO Option is available in many locations and is administered by Cigna. You agree to receive care solely from dentists associated with the DHMO Option network, and in return, you will have no deductibles to meet and no claim forms to file. Cigna actively works to keep dental care costs low by requiring DHMO dentists to meet strict quality standards, to be screened for cost-effective practice patterns, and to charge negotiated fees for services.

How the DHMO Option Works

If you decide to enroll in a DHMO option for the first time or add new dependents for coverage under this option, you must select a primary care dentist in order to receive care. You only receive benefits if you use a Cigna DHMO dentist; however, you can change your dentist during the year. **Please Note:** Requests to change your DHMO dentist will take effect on the first of the month following the date the request was made. If you need assistance, prior to the first of the following month, you can call Cigna at (800) 790-3086.

If you're interested in enrolling in the DHMO, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You may view an online provider directory by visiting the Benefits Web Center on **My Health**. Once enrolled, you can view an online provider directory by accessing http://mycigna.com. You can also call Cigna at (800) 790-3086 if you need help finding a provider.

With the DHMO Option…

- Preventive care is covered at 100%.
- Adult orthodontia is covered.
- There are no annual deductibles.
- There are no claim forms to file.
- There are no lifetime limits on benefits (except orthodontia).
- You only receive benefits if you use a Cigna DHMO dentist; however, you can change your dentist during the year. **Please Note:** Requests to change your DHMO dentist will take effect on the first of the month following the date the request was made.
- You and your dependents can each have different DHMO dentists.
- You and your dependents will receive a DHMO ID card following your enrollment.

How the DHMO Option Pays Benefits

Like the DMO Option, the Cigna DHMO Option is a managed care dental option that offers access to a national network of dentists. If you enroll in this option, you agree to receive care solely from dentists participating in the network. Limited out-of-network coverage may be available based on state mandates or in the case of certain, out-of-area emergencies, as noted below. If you receive any out-of-network care, you must file a claim to receive benefits. Check your Cigna DHMO coverage certificate or contact customer service at the number on your ID card for details.

Benefit Provision	Coverage
Annual deductible	
• Preventive	• None
• Restorative	• None
• Orthodontia	• None
Preventive	100% coverage
• Oral exams	Oral evaluations are limited to a combined total of four of the following evaluations during a 12 consecutive month period: • Periodic oral evaluations; • Comprehensive oral evaluations; • Comprehensive periodontal evaluations; and • Oral evaluations for patients under three years of age
• Fluoride	• Maximum two per calendar year • Topical fluoride applications in excess of the two per calendar year are covered for a $15 copayment.
• Prophylaxis (cleaning)	• Maximum two per calendar year • Cleanings in excess of the two per calendar year are covered for a $40 copayment for an adult and a $30 copayment for children.
• Full mouth X-ray	• Maximum one every three years
• Bitewing X-ray	• 100% coverage
• Sealants	• 100% coverage

Benefit Provision	Coverage
Basic restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)	90% coverage (with the exception of certain oral surgery services covered at 50% or 60%)
Major restorative (dentures, inlays, onlays, crowns, bridges)	60% coverage (a few procedures, such as recementations, adjustments, tissue conditioning, and repairs are covered at 90%)
Surgical placement of Implant body	90% coverage, limited to one per year
Orthodontia	50% coverage
Maximum Benefits	
• Combined annual for preventive and restorative	• No maximum
• Lifetime for orthodontia	• 24 months of interceptive and/or comprehensive treatment (cases beyond 24 months or atypical cases require additional payment by the patient)
Emergency Care Away From Home If you have an emergency while you are out of your service area or unable to contact your in-network general dentist, you may receive emergency covered services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your in-network general dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your patient charge schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of $100 per incident (where allowable by state law). To receive reimbursement, send appropriate mycigna.com reports and X-rays to Cigna Dental.	100% coverage for reasonable and customary charges, up to a maximum benefit of $100 per incident. If you receive any out-of-network care, you must file a claim to receive benefits.

What Is Covered

Each of the Dental Plan options covers a wide variety of services, as long as the services are necessary and their costs either do not exceed negotiated fees for in-network services, or are not reasonable and customary (R&C) charges for out-of-network services if allowed for under an option . (Please see "Defined Terms" beginning on page 200 for the definitions of "Necessary Services" and "Reasonable and Customary Charges.") Covered services and frequency limits under each JPMorgan Chase Dental Plan option may differ. 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 the PDP, DMO and DHMO's covered services and frequency limits, please contact the appropriate claims administrator (MetLife, Aetna, or Cigna) directly, using the telephone numbers provided under "Where to Submit Claims" on page 199. The list of covered services may change at any time.

Preventive Care Services

Covered preventive care services include the following services (please see "How the PDP Option Pays Benefits" on page 186, "How the DMO Option Pays Benefits" on page 190 and "How the DHMO Option Pays Benefits" on page 192 for age and frequency limitations):

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

Basic Restorative Care Services

Covered basic restorative care services include:

- Consultations (two per calendar year under the PDP and DMO; no frequency limit under the DHMO);
- Extractions;
- Fillings;
- Injections of antibiotic drugs; (**Please Note:** The DMO and PDP cover injections of antibiotic drugs as a Major Restorative Care Service);
- Most periodontal or other gum disease treatment;
- Periodontal maintenance (four visits per calendar year under PDP combined with regular cleanings; under DMO and DHMO, two visit per calendar year covered only after active periodontal therapy);
- Oral surgery (except as covered by the *Medical Plan* section);
- Administration of general anesthesia in conjunction with oral surgery when medically necessary (may be subject to certain limits as defined by the carrier);
- Periodontal scaling/root planing (one per quadrant per 24 months under PDP and DMO; limited to 4 quadrants per consecutive 12 months under DHMO);
- Periodontal surgery (one per quadrant per 36 months under PDP and DMO; one per site, or per tooth, under DHMO);
- Repair or recementing of crowns, inlays, or onlays; dentures; or bridgework;
- Relines/rebases
  - MetLife PDP and Aetna DMO: one per denture per 36 months, after six months from installation
  - Cigna DHMO: one per denture per 36 months, within first six months after insertion; replacement limit of one every five years; and
- Root canal treatments. (**Please Note:** The Dental DMO/DHMO Option covers root canal as a Basic Care Service. The PDP Option covers root canal as a Major Restorative Care Service.)

Major Restorative Care Services

Covered major restorative care services include:

- Crowns/inlays/onlays (one per tooth per five calendar years);
- Root canal treatments (**Please Note:** The PDP Option covers root canal as a Major Restorative Care Service. The Dental DMO/DHMO Option covers root canal as a Basic Care Service.);
- Injections of antibiotic drugs (**Please Note:** The DMO Option covers injections of antibiotic drugs as a Major Restorative Care Service. The PDP and DHMO Options cover injections of antibiotic drugs as a Basic Care Service.);
- Only appliances related to temporomandibular joint dysfunction (TMJ) (PDP and DMO: subject to a lifetime maximum of $500; the DHMO covers one appliance per 24 months, not subject to a lifetime maximum).
- 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 as described and determined by the claims administrator;
- Treatment for accidental injury (eligible dental expenses are covered under the Dental Plan; eligible medical expenses are covered under the 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.

Orthodontia

Please review the information on orthodontia in the PDP, DMO and DHMO sections:

- For the PDP, orthodontia is for covered children under age 19. Please see “How the PDP Option Pays Benefits” on page 186 and “Orthodontic Covered Services” on page 189.
- For the DMO, orthodontia is covered at a percentage for both children and adults. Please see “How the DMO Option Pays Benefits” on page 190.
- For the DHMO, orthodontia is covered at a percentage for both children and adults. Please see “How the DHMO Option Pays Benefits” on page 192.

What Is Not *Covered*

While the JPMorgan Chase Dental Plan options cover a wide range of dental services, some expenses are not covered. These include but are not limited to those listed below.

For specific information on the PDP, DMO and DHMO’s coverage exclusions and limits, please contact the appropriate claims administrator (MetLife, Aetna, or Cigna) directly (using the telephone numbers provided under “Where to Submit Claims” on page 199). The list of covered services and the list of excluded services may change at any time.

Not Exhaustive and Subject to Change

This list of excluded services is not exhaustive, may vary by Plan option, and may change at any time.

- 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 193, or
  - 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.
- Loss — or portion of a loss — resulting from war or act of war, declared or undeclared.
- 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 previous 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 Medicaid; or
  - Your JPMorgan Chase Medical Plan option.
- 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 that are not necessary services as determined by the claims administrator.
- 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 same or similar geographic area for dental care of a comparable nature. The geographic area and that range are determined by the claims administrator.
- 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 the claims administrator to be experimental, or still under clinical investigation by health professionals.
- Charges for oral hygiene programs (in home care), completion of claim forms by the provider on your behalf, and broken appointments.
- Services provided by a relative or a domestic partner, 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).
- Mail order orthodontics.

In addition, the DMO Option does not cover services provided to a person age five or older if that person becomes covered other than:

- As described for any period of enrollment agreed to by JPMorgan Chase and Aetna, Inc. This limitation does not apply to charges incurred:
  - After the end of the 12-month period starting on the date the person became covered;
  - As a result of accidental injuries sustained while the person was covered; or
  - Preventive service, unless listed above.
  - During the first 31 days the person is eligible for this coverage.

Dentures/Bridgework Limitations

Replacements of — or additions to — existing dentures or bridgework will be covered under the JPMorgan Chase 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.

Missing Tooth Exclusion for the PDP and the DMO
The missing tooth exclusion means that a charge is an ineligible charge if it is 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 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 bridge, or fixed bridge installed during the previous five years.

Claiming Benefits

The following explains when and how to file claims for dental expenses under the PDP Option. If you're enrolled in the DMO or DHMO Option, you usually don't need to file a claim. For more information on your rights with respect to claims, please see the *Plan Administration* section.

Your Dental Identification (ID) Cards

After you enroll you will receive a personalized identification (ID) card. Please carry your ID card(s) with you at all times since it contains information that will help verify your coverage when you present the card during dentists' visits.

How to File Claims

Rules regarding claims depend on which Dental Plan option you're enrolled in and where you receive your care, as follows:

PDP Option	• **In-Network Benefits**: Generally, you do not have to file a claim form. • **Out-of-Network Benefits**: Generally, you must file a claim form. (Some dentists may submit claims electronically on your behalf; you should check with your dentist.) Once the claims administrator has reviewed and approved your completed claim form, you'll be reimbursed for the appropriate portion of the cost. Claim forms for out-of-network benefits are available on **My Health.**
Dental Maintenance Organization (DMO) Option and Dental Health Maintenance Organization (DHMO) Option	You do not have to file a claim form for in-network care. Claim forms for out-of-network emergency services, as defined by the Plan, are available on **My Health.**

To have your claim considered for benefits, you need to file your claim by December 31 of the year following the year in which the services were provided. If you fail to meet this deadline, your claim will be denied. Be sure to attach itemized bills or receipts to your claim form, and keep copies for your records. Separate claim forms must be submitted for each family member for whom a claim is made. After you submit a claim, you will receive a written explanation of how the benefit was paid.

If your dentist submits a paper claim, make sure he or she uses the proper claim form, and that your identification number or Social Security number and signature are included with the information provided. Payment of benefits can be made to you or your dentist. If payment is to be made to your dentist, you should specify this on your claim form by signing the form and dating the appropriate box. If you don't indicate who the payment should be made to, it will be made to you.

Where to Submit Claims

Where you send your completed claims depends on which Dental Plan option you're enrolled in and which organization administers your claims.

The claims administrators' contact information is listed in the following table:

Claims Administrators' Contact Information

Claims Administrator	Address and Telephone Number
MetLife Preferred Dentist Program (PDP) Option	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 (888) 673-9582 8 a.m. to 11 p.m. Eastern Time, Monday – Friday
Aetna, Inc. Dental Maintenance Organization (DMO) Option	Aetna, Inc. P.O. Box 14094 Lexington, KY 40512 (800) 843-3661 8 a.m. to 6 p.m. Eastern Time, Monday – Friday
Cigna Dental Health Maintenance Organization (DHMO) Option	Cigna Dental Health P.O. Box 188045 Chattanooga, TN 37422-8045 (800) 790-3086 24 hours/day; seven days/week

Appealing a Claim

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

Help Pursuing Claims

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

For the Dental Plan, 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 Dental Plan, you'll come across some important terms related to the Plan. To help you better understand the Plan, many of those important terms are defined here.

Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical, Dental, Vision and Spending Accounts Plans' payroll contributions are generally taken on a before-tax basis.
Claims Administrator	The claims administrator(s) are the company(ies) that provide certain claims administration services for the Plan and its options.
Coinsurance	Coinsurance is the way you share costs for certain coverage options after you pay any applicable deductible. Certain Dental Plan options 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.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue 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.
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). 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. In addition, these rules do not apply to the Dental Maintenance Organization (DMO)/Dental Health Maintenance Organization (DHMO), which have their own coordination of benefits provisions. If you are covered by a DMO/DHMO, please check with your Dental Plan carrier to learn how it handles coordination of benefits.
Covered Expenses	The in-network negotiated fees or reasonable and customary (R&C) charges for out-of-network services if allowed for under an option for necessary covered services or supplies that qualify for full or partial reimbursement under the Dental Plan.
Covered Services	Covered services are services and procedures generally reimbursable by the Plan when they are "necessary." (See the definition of "Necessary Services" in this section.) While the Plan provides coverage for numerous services and supplies, there are limitations on what's covered. So, while a service or supply may be necessary, it may not be covered under the JPMorgan Chase Dental Plan. Please see "What Is Covered" on page 193 for more details.
Deductible	The deductible is the amount you pay in a calendar year for covered expenses before the Preferred Dentist Program (PDP) Option begins to pay benefits. Amounts in excess of reasonable and customary (R&C) charges do not count toward the deductible.

Eligible Dependents	Under the Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see "Your Eligible Dependents" in the *Health Care Participation* section for more information.
Explanation of Benefits (EOB)	An explanation of benefits (EOB) is a statement that the claims administrator prepares, which documents your claim and provides a description of benefits paid and not paid under the Dental Plan.
Fully-Insured	Dental Plan options for which the benefit payments are the responsibility of the insurance carrier (DMO and DHMO).
In-Network/ Out-of-Network	"In-network" and "out-of-network" are terms referring to whether a covered service is performed by a dentist who is part of the network associated with the Dental Plan (in-network) or by a dentist who is not part of the network (out-of-network). 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 Preferred Dentist Program (PDP) Option will pay for covered preventive and restorative services for each participant in a year.
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 JPMorgan Chase Dental Plan. The claims administrator 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 Dental Plan does 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 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 Dental 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.
Pre-Authorization/ 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 approximately $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 your JPMorgan Chase Dental Plan option will pay.
Reasonable and Customary (R&C) 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 Dental Plan. 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. 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 Plan, 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 maximums.
Self-Insured	A self-insured option is an option where the sponsor (in the case of the PDP option, JPMorgan Chase) is responsible for the payment of dental claims under the Dental Plan. This makes the option self-insured. JPMorgan Chase is responsible for the payment of dental claims under the PDP Option.

The Vision Plan

Effective 1/1/21

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

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

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

Questions?

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

EyeMed Vision Care
(833) 279-4363

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

About This Summary Plan Description

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

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

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

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Vision Coverage Highlights

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

Cost of Coverage

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

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

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

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

Your Cost Is the Full Cost

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

How Vision Coverage Works

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

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

What Is Covered

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

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

When You Last Received Care

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

Selecting an EyeMed Provider

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

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

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

What the Plan Provides

Exams

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

Care and Service	In-Network Cost	Non-Network Reimbursement
WellVision Exam® A complete initial vision analysis, which includes a comprehensive visual exam, including the prescription for corrective eyewear and dilation, if necessary	$0 copayment	Reimbursed up to $45
Retinal Imaging Screening An enhancement to the WellVision Exam®.	Up to $39 copayment	No coverage
Standard Contact Lens Fit & Follow-Up Exam* Fitting and evaluation	Copayment of up to $40	No coverage
Premium Contact Lens Fit & Follow-Up*	Copayment of up to $55	No coverage

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

Standard Plastic Lenses

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

Care and Service	In-Network Cost	Non-Network Reimbursement
Standard Plastic Single Vision Lenses Lenses having one part that corrects for either near vision or distant vision	$10 copayment	Reimbursed up to $35
Standard Plastic Lined Bifocal Lenses Lined lenses having one part that corrects for near vision, one for distant vision	$10 copayment	Reimbursed up to $50
Standard Plastic Lined Trifocal Lenses Lined lenses having one part that corrects for near vision, one for intermediate vision, and one for distant vision	$10 copayment	Reimbursed up to $65
Standard Plastic Lenticular Lenses Lenses used to assist post-cataract surgery	$10 copayment	Reimbursed up to $100

Care and Service	In-Network Cost	Non-Network Reimbursement
Lens Options		
• Standard Progressive Lenses	$65	Reimbursed up to $50
• Premium Progressive Lenses	$95-$185	Reimbursed up to $50
• Standard Polycarbonate Lenses	$0 copayment	Adults: Reimbursed up to $21 Kids under 19: Reimbursed up to $11
• Tints (Solid or Gradient)	$0 copayment	Reimbursed up to $11
• Standard Plastic Scratch Coating	$0 copayment	Reimbursed up to $11
• UV Coating	$15 copayment	No coverage
• Standard Anti-Reflective Coating	$45 copayment	Reimbursed up to $5
• Premium Anti-Reflective Coating	$57-$85 copayment	Reimbursed up to $5

Frames

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

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

Contact Lenses

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

For information on lens fittings and follow-up, please see the Contact Lens Fit & Follow-Up benefits, under "Exams" on page 206.

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

Medically Necessary Contact Lenses

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

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding — 10D or +10D in meridian powers
- **Keratoconus** where the member's vision is not correctable to $^{20}/_{30}$ in either or both eyes using standard spectacle lenses
- **Vision Improvement**: when the member's best correctable distance vision using a standard visual acuity chart can be improved by at least two lines by the use of contact lenses compared to spectacle lenses

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

Laser Vision Correction

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

Low Vision Benefits

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

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

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

Diabetic Eye Care Benefit

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

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

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

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

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

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

Additional Discounts

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

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

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

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

What Is Not *Covered*

While the JPMorgan Chase Vision Plan covers a variety of vision expenses, not all expenses are covered. Benefits paid are subject to certain limitations and maximums set by the claims administrator.

You are responsible for paying the cost of any optional items or services not covered by the Vision Plan.

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

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

General Limitations and Exclusions

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

Specific Limitations and Exclusions

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

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

Contact Lens Limitation on Prescription Lenses

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

Claiming Benefits

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

How to File Claims

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

Provider	Claims Process
EyeMed Network Provider Benefits	When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).
Out-of-Network Provider Benefits	You must file a claim. You may file electronically through EyeMed's website or you may mail in a claim form. Claim forms are available on **My Health** or through EyeMed's website. You can receive reimbursement up to specific dollar amounts for annual exams and eyewear if you use a non-network provider. You first pay the provider the full cost for services rendered and/or eyewear purchased, and then submit a claim to EyeMed. Please see "Where to Submit Claims" on page 211 for your claim administrator's phone and address information.

To have your claim considered for benefits, you need to file your claim by December 31 of the year following the year in which the services were provided. If you fail to meet this deadline, your claim will be denied. Be sure to attach itemized bills or receipts to your claim form, and keep copies for your records.

Your claim must include your receipts showing:

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

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

Where to Submit Claims

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

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

(833) 279-4363

Representatives can be reached from 7:30 a.m. to 11 p.m. Eastern time, Monday through Saturday; 11 a.m. to 8 p.m. Eastern time, Sunday

Time Frames for Processing Claims

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

Appealing a Claim

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

Help Pursuing Claims

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

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

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

Defined Terms

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

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

The Spending Accounts

Effective 1/1/21

The Spending Accounts allow you to set aside before-tax money to help pay for eligible health care, dependent care and work-related transportation expenses. This means that the money you set aside in the accounts to pay for these expenses comes out of your pay before federal (and most state and local) income, Social Security and Medicare taxes are calculated, which saves you money!

JPMorgan Chase offers three spending accounts:

- ***Health Care Spending Account** — for your eligible out-of-pocket health care expenses;*
- ***Dependent Care Spending Account** — for eligible child or elder care expenses that let you (and your spouse, if you're married) work, or let your spouse attend school full-time; and*
- ***Transportation Spending Accounts** — for eligible commuting and parking expenses to and from work at JPMorgan Chase.*

The Health Care Spending Account is an ERISA plan. The Dependent Care Spending Account and the Transportation Spending Account are not ERISA plans and are therefore not governed by the rules and procedures of ERISA. This document is a description of those Plans for informational purposes only. This section will provide you with a better understanding of how the Spending Accounts work, including how and when expenses are paid.

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

Questions?

If you still have questions after reviewing this Guide, you can contact the appropriate administrator for your spending account: Your Medical Plan carrier — Aetna/PayFlex 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. The Transportation Spending Accounts are administered by Health Equity (formerly WageWorks)

- Aetna/PayFlex: (888) 678-8242
- Cigna: (800) 790-3086
- Health Equity: (877) 924-3967

For additional resources, consult the *Contacts* section.

About this Summary Plan Description

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

This section is also a summary of the Dependent Care Spending Account and the Transportation Spending Account, though it is not an SPD or plan document, as these plans/programs do not require an SPD or plan document.

This summary does 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 this SPD/plan document/summary, the insurance contract will control.

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

The facts below cover the spending accounts in general. Please see the start of each account section, for more detailed highlights specific to each account.

How You Save	The accounts help you save money because you contribute to the accounts on a before-tax basis. This means that the money in the accounts that you use to pay for eligible expenses is not subject to most income taxes. See "How You Save: Spending Accounts and Taxes" on page 217 for an example of these savings.
How You Might Lose Your Contributions	For the Health Care and Dependent Care Spending Accounts, if you don't use your contributions to cover eligible expenses by the deadlines, your contributions can be forfeited. Please plan carefully to ensure you apply for reimbursement on time. For the Health Care Spending Account, please see "The "Use It or Lose It" Rule" on page 228. For the Dependent Care Spending Account, please see "The "Use It or Lose It" Rule" on page 235. For the Transportation Account, please see "Unused Before-Tax Dollars" on page 242.
Accounts Are Not Transferrable	The contributions you make to one of the accounts cannot be transferred to another one of the accounts, and they can only be used for eligible expenses under that account. For example: ▪ You cannot transfer Dependent Care Spending Account funds to your Health Care Spending Account. ▪ You cannot cover eligible Health Care Spending Account expenses with funds from your Dependent Care Spending Account.
Health Care Spending Account	You can contribute between $240 and $2,750 a year (as of 2021) on a before-tax basis to pay for eligible out-of-pocket health care expenses for you or your tax dependents, provided those expenses are incurred during the plan year (January 1 – December 31). Eligible expenses include many medical, prescription drug, dental and vision expenses. You have until March 31 of the year following the plan year to submit eligible claims for reimbursement. Internal Revenue Service rules provide that you can carry over to the following plan year up to $550 (as of 2021) of any balance not used for eligible expenses. Any additional balance over $550 will be **forfeited** and may not be used for expenses incurred in the following plan year. **Please Note:** If you are enrolled in the JPMorgan Chase Medical Plan, funds in your Medical Reimbursement Account (MRA) will be used to pay for eligible medical and prescription drug out-of-pocket expenses *before* your Health Care Spending Account funds are used. You need to carefully consider the amount you plan to contribute to the Health Care Spending Account in order to avoid having to forfeit a leftover balance that exceeds $550.
Dependent Care Spending Account	You generally can contribute between $240 and $5,000 a year on a before-tax basis, subject to certain limits required under the Internal Revenue Code (IRC) with respect to before-tax contributions for highly compensated employees (for 2021, W-2 compensation $130,000 or more in 2020). The contributions can be used to pay for eligible dependent care expenses incurred during the plan year (January 1 – December 31). You have until March 31 of the year following the plan year to submit eligible claims for reimbursement. You must provide the taxpayer identification number or Social Security number of any day care provider that you may use for an eligible tax dependent. Any balance not used for eligible expenses incurred during the plan year (January 1 – December 31) will be **forfeited** and may not be used for expenses incurred in the following plan year.

Transportation Spending Accounts

The Transportation Spending Accounts include a Transit Account and a Parking Account. You can participate in either or both accounts.

- **Transit Account.** You can generally contribute up to $270 a month (for 2021) on a before-tax basis for eligible mass transit passes (for example, commuter bus, train, subway, ferry passes, tickets and vouchers) or vanpooling expenses.
- **Parking Account.** You can contribute up to $270 a month (for 2021) on a before-tax basis for eligible parking expenses if you drive directly to work or to a location from which you commute to work at JPMorgan Chase (for example, park and ride).

You can contribute on a before-tax basis to either account.

If your commuting/parking costs exceed the legal before-tax monthly limits under the Transportation Spending Accounts, those additional costs will automatically be deducted through payroll deductions on an after-tax basis.

Contribution Limits May Change

The maximum before-tax contribution amounts shown here are legal limits for the calendar year 2021. The limits may change periodically subject to Internal Revenue Service (IRS) regulations.

No Impact on Your Other JPMorgan Chase Benefits

Your before-tax contributions to your spending accounts do not affect your other pay-related benefits at JPMorgan Chase. Your benefits under the 401(k) Savings Plan, Life and Accident Insurance Plans, Short-Term Disability Plan and Long-Term Disability Plan will continue to be based on your full, unreduced benefits pay.

How You Save: Spending Accounts and Taxes

Spending accounts save you money because the money that goes into the account on a before-tax basis reduces your taxable income. You use the money in the account to reimburse yourself for eligible expenses. You save because you owe less in taxes, and in most locations the savings apply to state and local income taxes, as well as federal income taxes and Social Security and Medicare taxes.

Remember, if you pay for expenses using a spending account, you can't take a tax deduction or credit for those expenses when you file your taxes.

JPMorgan Chase cannot offer tax advice. You should consult your tax advisor about whether you are better off using spending accounts or tax deductions and/or credits.

Participating in the Spending Accounts

This section describes the general guidelines for participating in the Spending Accounts. Participating in the Spending Accounts is optional.

Who's Eligible?

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

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

Whose Expenses Are Eligible?

There's a difference between being eligible to participate (contribute) and whose expenses are eligible.

- For the Dependent Care Spending Account, the account must be to pay for care for a dependent child under age 13 or for an adult who is your tax dependent. For non-child dependents, this includes any dependent (including your spouse) who is physically or mentally incapable of self-care and who lives with you for more than six months out of the year, or who otherwise meets the definition of a dependent under the Internal Revenue Code (IRC) definition during the period of coverage.
- For the Health Care Spending Account, you can use the account to cover your eligible expenses, and it can also be used to cover eligible expenses for your tax dependents.
- For the Transportation Spending Accounts, only your commuter expenses to and from work at JPMorgan Chase are eligible.

Who's Not Eligible?

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

Examples of such individuals include an:

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

Cost to Participate

There is no administrative cost to participate in any of the Spending Accounts. Your cost is really the amount you choose to contribute to the accounts. The factor to consider is how much you should contribute, based on your eligible expenses you expect to incur and how much you can afford.

See the "Your Contributions" section in the description of each account for more details.

How to Enroll

Health Care and Dependent Care Spending Accounts

To participate in the Health Care and Dependent Care Spending Accounts you must actively enroll each year.

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

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

Transportation Spending Accounts

For the Transportation Spending Accounts, if you have already enrolled, your elections will continue until you change them. You do not need to actively enroll each year or each month.

Enrolling if You Are an Employee

Health Care and Dependent Care Spending Accounts

During Annual Benefits Enrollment, you can make your elections through the Benefits Web Center on **My Health** or through HR Answers. At the beginning of each Annual Benefits Enrollment, you'll receive instructions on how to enroll. You must re-enroll each year to continue participating in the Health Care Spending Account and/or Dependent Care Spending Account for the following year.

Transportation Spending Accounts

You can enroll in the Transportation Spending Accounts at any time during the year through the Transportation Spending Accounts Web Center via **My Rewards**. To enroll by phone, contact the Transportation Spending Accounts Call Center. Unless you make a change to your contribution amount, your elections will automatically carry forward from month to month and to the next calendar year. Please see "Enrolling in the Transportation Account" on page 243 for detailed enrollment information.

Enrolling if You Are a Newly Hired Employee

Health Care and Dependent Care Spending Accounts

If you've just joined JPMorgan Chase and are enrolling for the first time, you need to make your choices through the Benefits Web Center on **My Health** or through HR Answers as follows:

- **If you are a full-time employee** (regularly scheduled to work 40 hours per week)**,** will have 31 days from your date of hire to enroll in these plans.
- **If you are a part-time employee** (regularly scheduled to work at least 20 but less than 40 hours per week), your benefits effective date will be the first of the month following your 60-day waiting period, and you will receive your enrollment materials within 31 days before becoming eligible for coverage. You need to enroll within 31 days before your eligibility date.

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

Late Year Enrollments

Special restrictions may apply concerning the processing of spending account enrollments and payroll contributions during December of any year. Please contact HR Answers for more information.

Transportation Spending Accounts

You can enroll in the Transportation Spending Accounts at any time during the year through the Transportation Spending Accounts Web Center via **My Rewards**. To enroll by phone, contact the Transportation Spending Accounts Call Center. Unless you make a change to your contribution amount, your elections will automatically carry forward from month to month and to the next calendar year. Please see "Enrolling in the Transportation Account" on page 243 for detailed enrollment information.

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

Health Care and Dependent Care Spending Accounts

If you're enrolling for the Health Care or Dependent Care Spending Accounts during the year because you're a newly eligible employee due to a work status change or you have a Qualified Status Change (QSC), you'll have 31 days from the date of the change in status to make your new choices through the Benefits Web Center on **My Health** or through HR Answers (90 days if status change is due to birth or adoption of a child). Please see "Qualified Status Change" on page 221 for more information.

Transportation Spending Accounts

You can enroll in the Transportation Spending Accounts or change your participation at any time during the year — you don't need to have a change in status of any kind.

If You Do *Not* Enroll

Health Care and Dependent Care Spending Accounts

If you do not enroll for the Health Care or Dependent Care Spending Accounts when you first become eligible, you won't be able to enroll until the next Annual Benefits Enrollment unless you have a Qualified Status Change (QSC). Please see "Qualified Status Change" on page 221 for more information.

Transportation Spending Accounts

You can enroll in the Transportation Spending Accounts at any time during the year.

When Participation Begins

Health Care and Dependent Care Spending Accounts

For the Health Care and Dependent Care Spending Accounts, this table explains when your participation begins, depending on when you enroll.

If You:	When Participation Begins:
Are an Employee	The contributions you elect during Annual Benefits Enrollment take effect at the beginning of the following plan year (January 1).
Are a Newly Hired or Newly Eligible Employee**	The elections you make as a new hire take effect as follows: • If you are a full-time employee (regularly schedule to work 40 hours per week), participation begins on the first of the month following your date of hire. • If you are a part-time employee (regularly scheduled to work at least 20 but less than 40 hours per week), participation begins on the first of the month following 60 days from your date of hire. Any contributions you make will be deducted from your pay in equal installments throughout the remainder of the year.* For example, if you are hired on June 1 and you elect $1,200, the $1,200 contribution will be divided by the number of pay periods left in the year and an equal amount will be deducted from each paycheck.
Experience a Qualified Status Change**	The contributions you elect as a result of a Qualified Status Change (QSC) (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, as long as the changes are made within 31 days of the event and you have already met the Plan's eligibility requirements (90-day window in the case of the birth/adoption of a child, or your death or death of an eligible dependent). Otherwise, you will not be able to make the change in coverage until the following Annual Benefits Enrollment. Please see "Qualified Status Change" on page 221 for more information.

* Special restrictions may apply concerning the processing of spending account enrollments and payroll contributions after mid-December of any year. Please contact HR Answers for more information.

** Your Health Care and Dependent Care Spending Accounts are administered by your Health Care Company (Aetna/PayFlex or Cigna). If you do not participate in a JPMC Medical Plan then your Spending Account Administrator is Cigna. Generally, if you make a Medical Plan Carrier change after January 31 or any given year, the administration of your Spending Accounts will remain with the Health Care Company you chose at the beginning of that year.

Transportation Spending Accounts

For the Transportation Spending Accounts, you can enroll or change your elections at any time. Please see "Enrolling in the Transportation Account" on page 243 for detailed enrollment information.

Changing Your Contributions During the Year

Health Care and Dependent Care Spending Accounts

In accordance with Internal Revenue Service (IRS) guidelines, you may change your contribution amount to the Health Care and/or Dependent Care Spending Account during the year only if you have a Qualified Status Change (QSC). Please see “Qualified Status Change” on page 221 for more information.

If you are a highly compensated employee (HCE) (for 2021, if you had compensation in excess of $130,000 for 2020), you will not be able to increase your contributions to the Dependent Care Spending Account above the HCE limit in any given year.

Qualified Status Change

The Health Care Spending Account and/or Dependent Care Spending Account elections you make during Annual Benefits Enrollment will stay in effect through the next plan year (or the current plan year if you enroll during the year as a newly eligible employee). However, you may be permitted to change your elections before the next Annual Benefits Enrollment if you have a Qualified Status Change (QSC). **Please Note**: Any changes you make during the year must be consistent with your QSC.

You need to make your changes through the Benefits Web Center on **My Health** or through HR Answers **within 31 days of the qualifying event** (90 days if the qualifying event is the birth or adoption of a child) for the changes to be effective the date of the event. (Please contact HR Answers if this situation applies to you.)

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

Your changes will take effect as of the day of the qualifying event. Eligible expenses are those incurred on or after the effective date of the qualifying event. For example, if you get married on April 15 and, as a result, increase your Health Care Spending Account from $300 to $2,750, you will only be allowed to claim $300 in expenses incurred from January 1 through April 14.

Please Note: Documentation of dependent eligibility will be required during enrollment when adding a dependent for coverage and may be requested at any time by JPMorgan Chase. JPMorgan Chase regularly conducts dependent eligibility verification to ensure that all covered dependents meet the current eligibility requirements of the JPMorgan Chase U.S. Benefits Program. For details, please see the “Important Note on Dependent Eligibility” under “Eligible Dependents” in the *Health Care Participation* section. When you file a claim form for a dependent’s expense, your dependent must be designated on the claim form, Also, if the debit card payment method is used and the carrier requires substantiation that the expense is valid under the Plan, you will need to provide the name of your dependent.

If you have questions about qualifying events and what the allowed benefits changes are, please visit **My Health**, or contact HR Answers and speak with a Service Representative. QSCs for eligible tax dependents under the Health Care and Dependent Care Spending Accounts are listed in the following table. Please remember that you can make changes to your participation in the Transportation Spending Accounts at any time.

This chart lists types of QSCs and what action is allowed with those events.

QSC	Health Care Spending Account	Dependent Care Spending Account
You get married, enter into a domestic partner relationship or civil union	Start or increase contributions (your domestic partner must be a qualified tax dependent for his or her expenses to be covered)	Start, change or stop contributions (your domestic partner must be a qualified tax dependent for his or her expenses to be covered)
You have, adopt, or obtain legal guardianship of a child*	Start or increase contributions	Start, change or stop contributions
You and/or your eligible dependents lose other benefits coverage	Start or increase contributions	Start, change or stop contributions
You get legally separated or divorced or end a domestic partner relationship or civil union	Decrease or stop contributions	Start, change or stop contributions
A child is no longer eligible for JPMorgan Chase benefits*	Decrease or stop contributions	Decrease or stop contributions
A covered family member dies*	Decrease or stop contributions	Decrease or stop contributions
Your Dependent Care costs significantly change or it's necessary to change caregivers	Not applicable	Start or change contributions

* Also applies to a domestic partner relationship.

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

Transportation Accounts

You can change your contribution amounts during the year, subject to the monthly limits. You must change your contribution amount by the first of each month so that deductions can begin and be used to purchase a pass or parking for the following month. However, in the event your circumstances change, you cannot be reimbursed for periods during which you are not commuting. You must cancel your contributions.

If You Have a Work Status Change

Your contributions to the Spending Accounts end if your work status changes and you are then scheduled to work fewer than 20 hours per week. In this case, you may continue to claim reimbursements from your account balances for any eligible expenses that were incurred before the date of your work status change.

For the Health Care Spending Account (but not for the Dependent Care or Transportation Spending Accounts), you may be able to continue to make contributions on an after-tax basis under COBRA if you have not used your entire account balance prior to the date your status changed. For more details on COBRA continuation for the Health Care Spending Account, see the *Health Care Participation* section. You will have until the claim filing deadline (March 31) in the year following your work status change to submit claims for any eligible expenses incurred up to the date of your work status change or the end of COBRA coverage. If your work status changes and you are then scheduled to work more than 20 hours per week, please see "How to Enroll" on page 218 for information on when you can newly enroll to participate.

When Participation Ends

In general, participation in the Spending Accounts will end on the last day of the month (Dependent Care Spending Account and Transportation Spending Account will end on the effective date) in which:

- Your employment with JPMorgan Chase is terminated for any reason (and, for the Health Care Spending Account, you don't elect COBRA coverage, if available);
- You cancel coverage or participation because of a Qualified Status Change (QSC) (cancellation must be consistent with the QSC);
- You no longer meet the eligibility requirements;
- You stop making required contributions;
- You choose not to re-enroll in the Health Care Spending Account or the Dependent Care Spending Account for the following year during the annual benefits enrollment period (in which case coverage will end on December 31 of the current year);
- You choose to discontinue your enrollment in the Transportation Spending Account;
- The accounts are discontinued; or
- You pass away.

If you go on an approved leave of absence, your participation in the Dependent Care Spending Account and the Transportation Spending Account ends on the effective start date of your leave.

Coverage for your dependents ends the earlier of when your coverage ends (such as if you leave JPMorgan Chase or otherwise become ineligible for JPMorgan Chase coverage) or when the dependent no longer meets the dependent eligibility requirements. Dependent eligibility requirements are available on **My Health** and within *Health Care Participation* section of this Guide.

Unused Spending Account Contributions

Health Care Spending Account

If you have an unused balance in your Health Care Spending Account when your participation ends, you can claim reimbursements from your account for any eligible expenses that were incurred *before* the date your participation ended. The deadline for filing these claims is March 31 of the following calendar year (for example, a claim with a date of service of April 2, 2021 must be submitted by March 31, 2022).

Because you cannot file claims for expenses incurred after your participation ended, if you have an unused balance, you may want to continue participating in the Health Care Spending Account through COBRA on an after-tax basis, to give you time to incur eligible expenses and make claims to recover the unused before-tax balance and any subsequent after-tax contributions. For more details, see “Continuing Health Coverage Under COBRA” in the *Health Care Participation* section, especially the subsection, “Special Rule for Health Care Spending Account Participants.”

Dependent Care Spending Account

If you have an unused balance in your Dependent Care Spending Account when your participation ends, you can claim reimbursements from your account for any eligible expenses that were incurred *before* the date your participation ended. The deadline for filing these claims is March 31 of the following calendar year (for example, a claim with a date of service of April 2, 2021 must be submitted by March 31, 2022).

There is no option to continue Dependent Care Spending Account contributions on an after-tax basis.

Transportation Spending Accounts

For the Transportation Spending Accounts, if your participation ends because your employment with JPMorgan Chase ends, you will have 90 days following your termination date in which you can use any remaining before-tax balances that remain on your commuter card. If you do not use the remaining balance within that 90-day period, the funds remaining at the end of 90 days will be forfeited.

You can incur eligible expenses through the date your participation ends. However, you must cancel your participation in the Transportation Spending Accounts promptly, to avoid forfeiting any contributions. Because your payroll deductions for a given month are used to fund eligible commuting expenses for the following month, cancelling participation before you leave is important. For example, October payroll contributions are used to pay for November expenses. If your employment is ending or you are going on a leave effective November 1, you should cancel your participation between September 2 and October 1 to avoid having Transportation Spending Account contributions for November deducted from your October pay. See the “Schedule of Monthly Enrollment Dates” on page 244 for details on when contributions would end.

If you participated in the Parking Account portion of the Transportation Spending Account Plan and have a balance in your “Pay Me Back” account, you have 180 days following the end of any month in which you participated to file a claim for reimbursement. You will forfeit any balance remaining after the claims filing deadline.

Any balance on the Parking Debit Card is forfeited as of your termination date.

If you receive a severance notice, please contact the Transportation Spending Accounts Call Center as soon as possible so that your participation in the account and your related deductions may be discontinued. Remember that your elections are effective for the first of the month. If you do not cancel timely, you will pay for benefits for the following month. Refunds cannot be given.

There is no option to continue Transportation Spending Account contributions on an after-tax basis after your participation ends.

The Health Care Spending Account

You can generally contribute up to $2,750 (2021 limit) a year on a before-tax basis to pay for eligible out-of-pocket health care expenses. ***If you are enrolled in the JPMorgan Chase Medical Plan, funds in your Medical Reimbursement Account (MRA) will be used to pay for eligible medical and prescription drug out-of-pocket expenses before your Health Care Spending Account funds are used****. Funds in the HCSA will not be used for eligible medical and prescription drug expenses until your MRA is completely depleted. You need to carefully consider the amount you plan to contribute to the Health Care Spending Account in order* ***to avoid having to forfeit a balance that exceeds $550****. MRA funds cannot be used to pay for dental or vision expenses. However, you can be reimbursed for these expenses from a Health Care Spending Account (HCSA).*

MRA Funds Used First

If you are enrolled in the JPMorgan Chase Medical Plan, funds in your Medical Reimbursement Account (MRA) will be used to pay for eligible medical and prescription drug out-of-pocket expenses before your Health Care Spending Account funds are used. Funds for these expenses in the HCSA will not be used until your MRA is completely depleted.

You may use your Health Care Spending Account for eligible expenses such as:

- *Medical and prescription drug deductibles, copayments and coinsurance*
- *Costs for non-covered prescription drugs, such as non-sedating antihistamines (e.g., Clarinex, Allegra) with a prescription from your doctor*
- *Dental deductibles and coinsurance not covered under any Dental Plan you may be enrolled in*
- *Eyeglasses and contact lenses for amounts not covered under any Vision Plan you may be enrolled in*
- *Over the counter (OTC) drugs without a prescription are now eligible for reimbursement under the HCSA. This includes all menstrual care products (including tampons, pads, liners, cups, sponges, or similar products for menstruation.*

Certain expenses, such as those for cosmetic surgery or health care premiums, are not reimbursable under the Health Care Spending Account.

Your health care company —Aetna/PayFlex or Cigna — will be the administrator of your Health Care Spending Account. If you do not enroll in medical coverage through JPMorgan Chase, Cigna will administer your Health Care Spending Account.

Health Care Spending Account Highlights

How Much You Can Contribute	You can contribute between $240 and $2,750 a year on a before-tax basis to pay for eligible out-of-pocket health care expenses for you and your eligible tax dependents incurred during the plan year (January 1 – December 31). The maximum before-tax contribution amounts shown here are legal limits for the calendar year 2021 The limits may change periodically subject to Internal Revenue Service (IRS) regulations.
Enrollment Required	To participate, you must actively enroll, either when you first become eligible, during Annual Benefits Enrollment each year, or after a Qualified Status Change (QSC).
Eligible Expenses	Eligible expenses generally can include medical, dental and prescription drug copayments, deductibles, and coinsurance; over the counter drugs and menstrual products, eyeglasses; frames; contact lenses; and certain other eligible health care expenses that aren't reimbursed by insurance. Insurance premiums are **not** considered eligible expenses. You can be reimbursed for your eligible tax dependents' expenses, as well as your own expenses. To be eligible, expenses must be incurred during the plan year (January 1 – December 31).
Coordinating with Your Spouse	If your spouse has a Health Care Spending Account at JPMorgan Chase or at another employer, by law you cannot claim reimbursement for any expenses your spouse has claimed.
Eligible Tax Dependent(s)	Your eligible tax dependents can include: ▪ Your spouse, ▪ A qualified adult dependent (including a domestic partner or extended family member who is your tax dependent) and ▪ Your dependent children, including the children of your domestic partner if they are your tax dependents. Documentation of dependent eligibility will be required during enrollment when adding a dependent for coverage.
Receiving Reimbursement	The claim processing method varies by the type of expense, whether or not you are enrolled in the Medical Plan, and your Medical Reimbursement Account (MRA) payment method election under the Medical Plan, if applicable. You can use the account's debit card to pay for eligible expenses, so you don't have to file claims to be reimbursed for those expenses. If you are enrolled in the Medical Plan, you may also elect the automatic payment method. When submitting a claim or using the debit card to pay for eligible expenses incurred by a covered dependent, be sure to include the dependent's name. You have until March 31 of the year following the plan year to submit eligible claims for reimbursement. See "Managing Your Accounts and Receiving Reimbursements" on page 245 for more information.
When You Can Be Reimbursed	You can be reimbursed for the amount of your or your covered dependent's eligible expenses, up to your annual contribution amount (minus any previous reimbursements) at any time, whether or not that amount has been contributed year-to-date.
Carry Over Up to $550	Internal Revenue Service rules provide that you can carry over to the following plan year $550 of any balance not used for eligible expenses. There is a $25 minimum carry over amount for employees who do not contribute to the Health Care Spending Account for the following plan year.
Forfeiting Contributions	Any additional balance over the $550 carry over limit (or less than $25 for participants who are not currently contributing) will be **forfeited**, and may not be used for expenses incurred in the following plan year.

Coordination with the Medical Reimbursement Account (MRA)	If you are enrolled in the JPMorgan Chase Medical Plan, funds in your Medical Reimbursement Account (MRA) will be used to pay for eligible medical and prescription drug expenses *before* your Health Care Spending Account funds are used. You need to carefully consider the amount you plan to contribute to the Health Care Spending Account in order **to avoid having to forfeit a balance that exceeds $550**.
If You Leave JPMorgan Chase	If you leave JPMorgan Chase before the end of the year, you can continue to be reimbursed for eligible expenses incurred up to the end of the month of your termination, as long as you submit the expenses by the applicable deadline (March 31 of the year after your termination) (Please see "Managing Your Accounts and Receiving Reimbursements" on page 245 for more information.) You can also elect through COBRA to continue contributing to your Health Care Spending Account on an after tax basis for eligible expenses incurred after your employment ends, but only until the end of the plan year in which you leave. Please see the *Health Care Participation* section for more information on COBRA continuation coverage.
Claims Administrators	Aetna/PayFlex and Cigna (depending on which carrier you elected for your Medical Plan coverage) are the claims administrators for the Health Care Spending Account for employees enrolled in the JPMorgan Chase Medical Plan. Cigna is the claims administrator for the Health Care Spending Account for employees not enrolled in the JPMorgan Chase Medical Plan.

Your Contributions

During enrollment, you decide how much to contribute. Contributions to the Health Care Spending Account are made on a before-tax basis. For 2021, you can contribute between $240 and $2,750. Any contributions you make will be deducted from your pay in equal installments throughout the year.

If you begin contributing during the year (as a newly eligible employee or if you have a Qualified Status Change), the maximum contribution you can make is $2,750, which will be taken in equal installments over the remaining pay periods for that year.

Please Note

A deduction for Health Care, Dependent Care, and/or Transportation Spending Accounts contributions cannot be taken and no contribution will be made in any pay period in which your compensation after taxes, adjustments and other Plan contributions does not cover the full deduction amount you elected during Annual Benefits Enrollment or as a result of a subsequent Qualified Status Change.

Contribution Deduction Examples

The following example illustrates how to determine your contributions if you contribute to the Health Care Spending Account. This example shows an employee who is paid on a semimonthly basis and who chooses to contribute $2,750 during Annual Benefits Enrollment. Generally, semimonthly deductions would be calculated as follows:

- $2,750 ÷ 24 pay periods = $114.58 per semimonthly pay period

If you are hired on April 1 and you elect $2,750, you will contribute $2,750 for the remainder of the year. If you are a full-time employee, this means your contributions will begin on May 1 and the amount deducted each pay period will be calculated as follows:

- $2,750 ÷ 16 pay periods = $171.88 per semimonthly pay period

MRA Funds Will Be Used Up First

If you are enrolled in the JPMorgan Chase Medical Plan, funds in your Medical Reimbursement Account (MRA) will be used to pay for eligible medical and prescription drug expenses *before* your Health Care Spending Account funds are used.

You need to carefully consider the amount you plan to contribute to the Health Care Spending Account in order to avoid having to forfeit a balance that exceeds $550.

The "Use It or Lose It" Rule

Under current U.S. tax law, unused balances in the Health Care Spending Account are subject to **forfeiture.**

The Carryover Exception

If you have a balance in the Health Care Spending Account after submitting all claims incurred during the plan year (January 1 – December 31), you can carry over $550 to the following plan year. **Any remaining balance that exceeds $550 will be forfeited after the claims filing deadline (March 31 of the year following the plan year).** This unused balance cannot be returned to you or carried forward for future use.

There is a $25 minimum carry over amount for employees who do not contribute to the Health Care Spending Account for the following plan year.

Example

- Assume you contribute $2,200 to the Health Care Spending Account and have $300 in your MRA (those funds are used first for eligible medical and prescription drug costs before your HCSA)
- Assume your eligible medical claims during the plan year (January 1 – December 31) are $400 and your dental/vision claims are $1,400. The $300 in your MRA is used first to pay your eligible medical claims. Your HCSA is used to pay the remaining $100 in medical claims plus the $1,400 in dental/vision claims.
- Assuming you submit all your claims by the deadline (March 31 of the year following the plan year), your unused balance in your HCSA would be $700.
- You would be able to carry over $550 of the unused balance to the following plan year (the plan year immediately following the one in which you contributed $2,200).
- **You would forfeit the remaining $150 balance.**

It's very important that you plan carefully before you decide how much to contribute to the Health Care Spending Account, because your MRA funds are used first for eligible medical and prescription drug expenses and that you file your claims by the claims filing deadline: March 31 of the year following the plan year.

For detailed instructions on how to submit claims, see "Paper Reimbursement Claims" on page 250.

Eligible Expenses

Eligible expenses are those incurred from the effective date of participation through the date participation ends. Participation means that you are contributing to the account.

Eligible expenses under the Health Care Spending Account include expenses that you pay out of your pocket and that you generally could also claim as health care deductions on your federal income tax return if you were not reimbursed through the Health Care Spending Account.

Expenses under the Internal Revenue Code (IRC) include, but are not limited to, deductibles, copayments and coinsurance, over the counter drugs and menstrual products, certain dental and vision services, certain equipment and supplies, hospital services, lab exams and tests, and medical treatments (including smoking cessation programs).

Please Note: Insurance contributions (i.e., premiums) are not reimbursable under the Health Care Spending Account.

The specific expenses listed under "Examples of Eligible Expenses," below are generally considered by the Internal Revenue Service (IRS) to be eligible medical care expenses for federal income tax purposes. Therefore, they're eligible for reimbursement through the Health Care Spending Account. Because the tax treatment of these expenses is always subject to IRS review, JPMorgan Chase can't guarantee that the same expenses will always be eligible (or ineligible) for reimbursement from the Health Care Spending Account.

If the IRS changes its ruling concerning the eligibility of a particular expense, JPMorgan Chase will accept that ruling effective on the date prescribed by the IRS.

Please Note: Changes by the IRS to the eligibility of an expense do not allow you to stop or start contributions to the Health Care Spending Account.

Examples of Eligible Expenses

Please Note: This list is subject to change at any time based on Internal Revenue Service (IRS) guidance.

Dental Services

- Cleaning teeth
- Dental Implants
- Dental X-rays
- Filling teeth
- Gum treatment
- Oral surgery
- Orthodontia

Equipment and Supplies

- Abdominal supports
- Ambulance hire
- Arches
- Artificial teeth or eyes, to the extent they are not deemed to be cosmetic
- Automobile device for a physically disabled person, but not for travel to work
- Back supports
- Blood pressure monitors
- Braces
- Contact lenses and supplies
- Crutches
- Diabetic supplies
- Elastic hosiery
- Eyeglasses
- Fluoridation unit in the home
- Hearing aids
- Installation of stair-seat elevator for a person with a heart condition
- Invalid chair
- Iron lung
- Orthopedic shoes
- Over-the-counter medications and other OTC items without a prescription, including all menstrual care products (tampons, pads, liners, cups, sponges, etc). *
- Portable air conditioner if needed for relief from allergy or difficulty in breathing
- Prescriptions
- Reclining chair if prescribed by a physician
- Repair of telephone equipment for the deaf
- Sacroiliac belt
- Special mattress and plywood bed boards for relief of spinal arthritis
- Splints
- Truss
- Vision care items, such as contact lens solution
- Wig, if advised by a physician for the mental health of a patient because of hair loss from disease

Hospital Services

- Anesthetist
- Operating room usage
- Oxygen mask and tent
- X-ray technician

Laboratory Exams/Tests

- Blood tests
- Cardiographs
- Metabolism tests
- Spinal fluid tests
- Sputum tests
- Stool examination
- Urine analysis
- X-ray examinations

Medical Treatments

- Acupuncture
- Blood transfusion
- Diathermy
- Electric shock treatments
- Hearing services
- Injections
- Insulin treatments
- Organ transplants
- Pre-natal and post-natal care
- Psychotherapy
- Radium therapy
- Sterilization
- Ultra-violet ray treatments
- Vasectomy
- X-ray treatments

Professional Services

- Chiropodist
- Chiropractor
- Dentist
- Dermatologist
- Gynecologist
- Midwife
- Neurologist
- Nurse
- Obstetrician
- Oculist
- Optician
- Optometrist
- Orthopedist
- Osteopath
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Psychiatrist
- Psychoanalyst
- Psychologist
- Registered nurse
- Surgeon (except for cosmetic surgery)
- Virtual visits provide through Aetna (via Teladoc) or Cigna (via MDLive)

Miscellaneous

- Alcoholism inpatient and outpatient care
- Birth control pills or other birth control items prescribed by a physician
- Braille books (just the excess cost of Braille books and magazines over the cost of regular editions)
- Child-birthing classes
- Convalescent home, if for medical treatment
- Drug treatment center inpatient and outpatient care
- Guide for a blind person
- Hair transplant operation, if medically necessary
- Health institute fees, if services are prescribed by a physician to alleviate a physical or mental defect or illness
- Kidney donor's — or possible kidney donor's — expenses
- Legal fees that are necessary to authorize a medical treatment for a mentally ill dependent
- Nurse's board and wages, including Social Security taxes you pay
- Remedial reading for a child with dyslexia
- Sanitarium and similar institutions
- School costs for physically and mentally disabled children
- Seeing-eye dog and its maintenance
- Smoking cessation classes
- Telephone-teletype costs and television adapter for closed caption service for a deaf person
- Travel expenses related to medical treatment
- Weight-loss program if prescribed by a physician to treat a diagnosed medical condition such as obesity, hypertension, or heart disease

* These changes are retroactive to January 1, 2020.

Any other expense you can otherwise claim as a medical deduction on your federal income tax return, except insurance premiums, can also be reimbursed from your Health Care Spending Account. For more information about eligible expenses, visit the Internal Revenue Service (IRS) website at www.irs.gov, or call the Internal Revenue Service (IRS) at (800) TAX-FORM ((800) 829-3676) and ask for Internal Revenue Service (IRS) Publication 502, "Medical and Dental Expenses." While certain sections of the Publication do not apply for purposes of the Health Care Spending Account, you may find the section entitled "What Medical Expenses Are Includible" helpful in that it lists certain expenses eligible for the federal health care tax deduction, and which may be eligible for reimbursement from your Health Care Spending Account.

Expenses *Not* Eligible

You are not eligible to use the Health Care Spending Account for expenses that are:

- not incurred for you or your eligible tax dependents
- not incurred during the applicable plan year
- not incurred while you are participating (contributing) or had eligible carry over funds from a prior year

Expenses not eligible for reimbursement under the Health Care Spending Account include expenses that you generally cannot claim as medical deductions on your federal income tax return. Such ineligible expenses include, but are not limited to, cosmetic surgery, electrolysis, health club membership dues and insurance premiums. Therefore, they're not eligible for reimbursement through the Health Care Spending Account.

Examples of Expenses Not Eligible

Please Note: This list may change at any time based on Internal Revenue Service (IRS) guidance.

- Athletic or health club expenses to maintain or improve physical fitness
- Babysitting expenses incurred while you go to the doctor
- Boarding school fees paid for a child while the parent is recuperating from an illness
- Body piercing
- Bottled water
- COBRA continuation contributions
- Contributions to a retiree benefits plan
- Cosmetic surgery, treatment, or procedures (including prescription drugs used in cosmetic treatments or procedures)
- Dance lessons, even if advised by a physician
- Diaper service
- Divorced spouse's health care bills
- Domestic help, even if needed because of a spouse's illness
- Electrolysis or hair removal
- Food or beverage substitutes, except the cost of special foods over what would ordinarily have been spent on food, if necessary because of allergy
- Funeral and burial expenses
- Health and beauty supplies
- Illegal operations and drugs
- Insurance contributions (including contact lens insurance)
- Legal fees for divorce
- Life insurance contributions
- Marriage or family counseling
- Maternity clothes
- Patent medicines
- Rogaine/Minoxidil
- Scientology fees
- Shampoo (unless prescribed by a doctor, i.e., prescription shampoo)
- Tattooing
- Toothpaste
- Transportation costs of a disabled person to and from work
- Travel for reasons of health, even if prescribed by a physician
- Tuition and travel expenses to send a child to a particular school for a beneficial change in environment
- Veterinary fees
- Vitamins, tonics, etc., unless taken pursuant to a prescription and used to treat a specific medical condition
- Weight-loss program if not prescribed by a physician to treat a diagnosed medical condition such as obesity, hypertension, or heart disease

When Reimbursements Are Payable

Your Health Care Spending Account can reimburse your eligible health care expenses in full up to the total amount you're scheduled to contribute to the account for the year, no matter how much money you have actually contributed to your account at the time you request the reimbursement. Contributions will continue to be deducted from your pay throughout the year, up to the amount of your annual elected contribution. If your employment terminates, the full amount is available for eligible expenses incurred before your termination date.

Your account will only cover expenses for supplies and services that have actually been incurred, not future expected services or expenses. In addition, you may only receive reimbursement for expenses that have not been covered or reimbursed by insurance.

Please see "Managing Your Accounts and Receiving Reimbursements" on page 245 for details on how to use your Health Care Spending Account to pay for eligible health care expenses.

The Dependent Care Spending Account

You can generally contribute $240 to $5,000 a year on a before-tax basis to pay for eligible out-of-pocket expenses to provide care during working hours for eligible dependents.

- *Eligible expenses are those that provide care so that you and your spouse (if you are married) can work outside the home or so your spouse can attend school full-time.*
- *You must provide the Social Security number or tax identification number of the care provider when filing for reimbursements.*

You may use your Dependent Care Spending Account for eligible expenses including:

- *Child care expenses for dependent children under age 13, or older if disabled, and*
- *Adult care expenses for your tax-qualified adult dependents.*

Dependent Care Spending Account Highlights

How Much You Can Contribute

You generally can contribute between $240 and $5,000 a year on a before-tax basis.

If your spouse contributes to a Dependent Care Spending Account, your combined contributions are limited to $5,000. If you are married but file separate income tax returns, your maximum contribution amount is $2,500 a year.

If you are considered a highly compensated employee for a plan year (based on a prior year's W-2 compensation), your contributions may be subject to certain limits required under the Internal Revenue Code (IRC) with respect to before-tax contributions for highly compensated employees. (For instance, if your W-2 compensation for 2020 is $130,000 or more, you're considered a highly compensated employee for the 2021 plan year.)

The maximum before-tax contribution amounts shown here are legal limits for the calendar year 2021. The limits may change periodically subject to Internal Revenue Service (IRS) regulations.

Enrollment Required

To participate, you must actively enroll, either when you first become eligible, during Annual Benefits Enrollment each year, or after a Qualified Status Change.

If You Are Married

If you're married, you can participate in a Dependent Care Spending Account only if your spouse is:

- Employed, whether part-time, full-time, or self-employed;
- Looking for gainful employment;
- A full-time student; or
- Physically or mentally incapable of self-care and is the dependent for whom you're claiming expenses.

Eligible Expenses	Eligible expenses can include day care provided during the plan year (January 1 – December 31) for: ▪ dependent children under age 13 and ▪ Any dependent (including your spouse) who is physically or mentally incapable of self-care who lives with you for more than six months out of the year, or who otherwise meets the definition of a dependent under the Internal Revenue Code (IRC) definition during the period of coverage. The care must be provided to enable you and your spouse (if you're married) to work, or to enable your spouse to either look for work or attend school full time. **Special Rules** For the Dependent Care Spending Account, the Internal Revenue Service (IRS) requires that your claim include a receipt with the name, address, telephone number and taxpayer identification number (or Social Security number) of the caregiver. Without this information, the care generally won't qualify as an eligible Dependent Care Spending Account expense.
Eligible Tax Dependent(s)	Under the Dependent Care Spending Account, your eligible tax dependents can include: ▪ Your spouse, ▪ A qualified adult dependent (including a domestic partner or extended family member who is your tax dependent) and ▪ Your dependent children under age 13, including the children of your domestic partner if they are your tax dependents.
Receiving Reimbursement	When you incur an eligible expense, you must submit a claim for reimbursement from your account. You have until March 31 of the year following the plan year to submit eligible claims for reimbursement.
When You Can Be Reimbursed	You can only be reimbursed up to the amount that you have actually contributed to your account by the date of the claim (minus any previous reimbursements), and only for services that you have actually received before claiming reimbursement. If you have eligible expenses greater than your year-to-date contributions, those expenses can be reimbursed after additional contributions have been added to your account.
No Carry Over	Unlike the Health Care Spending Account, there is no provision for carrying over unused balances in your Dependent Care Spending Account.
Forfeiting Contributions	Any balance not used for eligible expenses incurred during the plan year (January 1 – December 31) will be **forfeited after the claims filing deadline (March 31)** and may not be used for expenses incurred in the following plan year.
If You Leave JPMorgan Chase	If you leave JPMorgan Chase before the end of the year, you can be reimbursed for eligible expenses incurred on or before your termination date, up to the balance in your account — as long as you submit the expenses by the applicable deadline (March 31 of the year after your termination). (Please see "Managing Your Accounts and Receiving Reimbursements" on page 245 for more information.)
Claims Administrators	Aetna/PayFlex and Cigna (depending on which carrier you elected for your Medical Plan coverage) are the claims administrators for the Dependent Care Spending Account for employees enrolled in the JPMorgan Chase Medical Plan. Cigna is the claims administrator for the Dependent Care Spending Account for employees not enrolled in the JPMorgan Chase Medical Plan.

Your Contributions

Contributions to the Dependent Care Spending Accounts are made on a before-tax basis.

You generally can contribute between $240 and $5,000 a year on a before-tax basis.

- IRS rules state that you cannot contribute more than your income or your spouse's income, whichever is less.
  - If your spouse is a full-time student or is incapable of self-care, his or her monthly income is assumed to be $250 in 2021 if you have one eligible tax dependent or $500 in 2021 if you have two or more eligible tax dependents.
  - Consequently, an employee with one child who requires care while a spouse attends school full-time for nine months of the year, would be limited to annual contributions of $2,250.
- If your spouse contributes to a Dependent Care Spending Account, your combined contributions are limited to $5,000.
- If you are married but file separate income tax returns, your maximum contribution amount is $2,500 a year.

Please Note

A deduction for Health Care, Dependent Care, and/or Transportation Spending Accounts contributions cannot be taken and no contribution will be made in any pay period in which your compensation after taxes, adjustments and other Plan contributions does not cover the full deduction amount you elected during Annual Benefits Enrollment or as a result of a subsequent Qualified Status Change.

Limits on Contributions for Highly Compensated Employees

Internal Revenue Service (IRS) rules impose limits on contributions to the Dependent Care Spending Account in certain situations that involve highly paid employees. In 2021, you are considered a highly compensated employee if your 2020 W-2 compensation was $130,000 or more.

These rules help ensure that the Plan doesn't unfairly favor highly compensated employees. As a result, it may be necessary to significantly reduce contributions for some participants under these rules.

You'll be notified if you're affected.

Payroll Deductions Example

If you begin contributing during the year (as a newly eligible employee), the maximum contribution you can make is $5,000, which will be taken in equal installments over the remaining pay periods for that year.

For example, if you are hired on June 15 and you elect $3,000, the $3,000 contribution will be divided by the number of pay periods left in the year and an equal amount will be deducted from each paycheck beginning July 1 (when coverage is effective). Assuming you are paid on a semimonthly basis, this would be $250 a paycheck from July 1 through December 31.

The "Use It or Lose It" Rule

Under current U.S. tax law, unused balances in the Dependent Care Spending Account are subject to **forfeiture**. If you have a balance left in the account after submitting all claims incurred during the plan year (January 1 – December 31), that balance will be forfeited after the claims filing deadline (March 31 of the year following the plan year). The unused balance cannot be returned to you or carried forward for future use.

It's very important that you plan carefully before you decide how much to contribute to the Dependent Care Spending Account, and that you file your claims by the claims filing deadline: March 31 of the year following the plan year.

For detailed instructions on how to submit claims, see "Paper Reimbursement Claims" on page 250.

Eligible Expenses

Eligible expenses are those incurred from the effective date of participation through the date participation ends. Participation means that you are contributing to the account.

The following specific expenses are currently considered by the Internal Revenue Service (IRS) to be deductible child or elder care expenses for federal income tax purposes. Therefore, they're eligible for reimbursement through the Dependent Care Spending Account. Because the deductibility of these expenses is always subject to IRS review, JPMorgan Chase can't guarantee that the same expenses will always be eligible (or ineligible) for reimbursement from the Dependent Care Spending Account.

You can use the Dependent Care Spending Account for eligible care expenses incurred for an eligible tax dependent.

Please Note: You must actually incur an eligible expense and receive the service prior to claiming reimbursement.

This list is subject to change at any time.

Your Provider's Tax Information

To be reimbursed for Dependent Care expenses, your claim must include the care provider's name, address and taxpayer identification number (or Social Security number). *Without this information, your expenses will not be eligible for reimbursement from the Dependent Care Spending Account.*

Eligible expenses under the Dependent Care Spending Account must also be incurred so that you — if you're married, you and your spouse — can work. Such expenses include, but are not limited to:

- Care at licensed nursery schools or day camps (excluding most expenses for grades kindergarten and above or overnight camps). To qualify, the school or center must comply with state and local laws and receive a fee for its services if it cares for seven or more children;
- Payment to a housekeeper who is primarily responsible for providing day care;
- Payment to someone who provides care in your home, as well as related taxes you pay on that person's behalf;
- Care provided at an adult day care facility (but not expenses for an overnight nursing home facility) for any eligible tax dependent;
- Day care provided by before-school or after-school programs;
- Day care provided inside or outside your home by anyone other than your spouse or a person you list as your dependent for income tax purposes, for your child under age 13;
- Household services related to the care of an eligible dependent who lives with you; and
- Any other qualified dependent care expense as defined by the IRS.

For more information about employment-related dependent care expenses that qualify for the federal tax credit, visit the Internal Revenue Service (IRS) website at www.irs.gov, or call the IRS at (800) TAX-FORM ((800) 829-3676) and ask for IRS Publication 503, "Child and Dependent Care Expenses."

If the IRS changes its ruling concerning the deductibility of a particular expense, JPMorgan Chase will accept that ruling effective on the date prescribed by the IRS.

Please Note: Any such change by the IRS to the tax-deductible status of an expense does not allow you to stop or start contributions to a Dependent Care Spending Account.

Care Outside Your Home

If you are submitting claims for dependent care expenses incurred outside your home, your dependent must spend at least eight hours a day in your home. If you're divorced or separated and have custody of an eligible child, you may be able to use the Dependent Care Spending Account even if you've agreed to let your spouse (or former spouse) claim your child as an exemption for tax purposes.

Expenses *Not* Eligible

You are not eligible to use the Dependent Care Spending Account for expenses that are:

- not incurred for eligible care for your eligible dependents
- not incurred during the plan year for which you opened the account
- not incurred while you are contributing to the account

The following expenses are not eligible for reimbursement through the Dependent Care Spending Account:

- After-school care provided coincidentally with a program for which the primary purpose is education — for example, an after-school religious training program;
- Care in unlicensed day care centers or care by providers who won't provide you with their taxpayer identification number or Social Security number;
- Care that's not needed for you to work — for example, babysitting fees during non-working hours;
- Child care expenses that enable you or your spouse to do volunteer work;
- Education expenses for a child in kindergarten or above;
- Expenses paid to one dependent you claim (or could claim) on your tax return to care for another dependent (for example, paying one child to care for a younger child) if the person you're paying is under age 19 or can be claimed as an exemption on your federal income tax return;
- Health care expenses for dependents (these are reimbursed through the Health Care Spending Account — not the Dependent Care Spending Account);
- Overnight summer camp expenses;
- Transportation expenses to or from a day care center;
- 24-hour nursing home care for a parent or spouse; and
- Otherwise eligible care that's not provided by an eligible provider.

Please Note: This list may change at any time based upon Internal Revenue Service (IRS) guidance.

When Reimbursements Are Payable

Unlike the Health Care Spending Account, the Dependent Care Spending Account covers your eligible expenses only up to the balance credited to your account through payroll deductions at the time you request reimbursement. As your contributions are deducted from your pay throughout the year, you'll automatically be reimbursed for any outstanding expenses you've submitted, up to the year-to-date amount already contributed (minus any previous reimbursements).

Please Note: If you fail to provide substantiation when requested by Aetna/PayFlex or Cigna, you will be required to repay the amount of unsubstantiated/ineligible expenses.

Your account will only cover expenses for services that have actually been incurred, not for future expected services or expenses.

The Transportation Spending Accounts

Under the JPMorgan Chase Transportation Spending Accounts, you pay for eligible transit and/or parking expenses related to commuting to and from work at JPMorgan Chase through before-tax payroll deductions.

Most participants choose options where your contributions are used to pay for your transportation expenses (such as purchasing passes and tickets that are mailed to you, and paying parking expenses) directly, without you having to file claims for reimbursement.

If your transportation needs vary, then instead of using your contributions to purchase passes/tickets and pay parking expenses in advance, you can use your contributions to purchase Commuter Cards that you can use to pay for transit expenses as needed. For parking expenses, you have a third option, called "Pay Me Back," where your contributions are held in an account and you file claims to be reimbursed for eligible parking expenses.

If you choose the automatic purchase/payment approach, and the cost for your commuter passes/tickets exceeds the monthly before-tax contribution limits, the additional costs will automatically be deducted through after-tax payroll deductions.

Important Note

By law, the maximum monthly contribution you can make to the Transportation Spending Accounts must be reduced by the value of any other transit/parking reimbursement or benefit that you may receive from JPMorgan Chase. Otherwise, the excess amount will be taxable income.

In deciding on the amount to contribute to the Transportation Spending Accounts, you will need to consider the value of any monthly transit/parking reimbursement that you may receive from JPMorgan Chase. If, in any month, the reimbursement from a Transportation Spending Account and the value of those other transit/parking benefits exceeds the maximum monthly legal limit, then the excess will represent taxable income to you. You may wish to consult a personal tax advisor to determine how participating in the Transportation Spending Accounts may affect your personal tax situation. JPMorgan Chase cannot provide you with tax advice.

Transportation Account Highlights

Two Accounts	The Transportation Spending Accounts include a Transit Account and a Parking Account. You can participate in either or both accounts.
Differences from Health Care and Dependent Care Accounts	While the Transportation Spending Accounts are similar in many ways to the Health Care Spending Account and the Dependent Care Spending Account, these accounts are subject to different rules under the Internal Revenue Code (IRC). The Transportation Spending Accounts are more flexible than the other Spending Accounts in several ways, including: ▪ You can choose to make before-tax and after-tax payroll deductions to pay for your eligible monthly commuter pass/ticket and/or parking expenses; and ▪ You can enroll in the Transportation Spending Accounts, change, or cancel your contribution rate at any time during the year on a monthly basis. You must make these elections by the first of the month **prior** to the month you wish to participate, stop or change your election.
***No* Annual Enrollment Required**	Unlike the Health Care and Dependent Care Spending Accounts, you do not need to re-enroll during each Annual Benefits Enrollment. Your elections will continue until you change them.
Transit Account	You can generally contribute up to $270 a month on a before-tax basis for eligible mass transit passes (for example, commuter bus, train, subway, ferry passes, tickets and vouchers) or vanpooling expenses. Unless you choose the Commuter Card option, your contributions will be used to purchase your passes/tickets, which will be mailed to you by Health Equity.
Parking Account	You can contribute up to $270 a month on a before-tax basis for eligible parking expenses if you drive directly to work or to a location from which you commute to work at JPMorgan Chase (for example, park and ride). When you enroll, you will choose either: ▪ the “Pay My Provider” option, where your contributions are used by Health Equity to pay your garage directly, or ▪ the “Pay Me Back” option, where you file claims to be reimbursed by Health Equity from your account, for eligible parking expenses, or ▪ a parking Commuter Card that you can use to pay for parking as needed, so you don’t have to file claims to be reimbursed.
Automatic After-Tax Contributions	You can contribute on a before-tax basis to either account. If your commuting/parking costs exceed the legal before-tax monthly limits under the Transportation Spending Accounts, those additional costs will automatically be deducted through payroll deductions on an after-tax basis.
Contribution Limits May Change	The maximum before-tax contribution amounts shown here are legal limits for the calendar year 2021. The limits may change periodically subject to Internal Revenue Service (IRS) regulations.
Eligible Expenses	Eligible expenses can include expenses that you incur in your commute (such as mass transit costs and parking expenses) between your home and work at JPMorgan Chase that can be paid for under federal tax law with money you’ve contributed to the Transit Account and/or Parking Account. These expenses are subject to monthly maximums under federal law. **Please Note:** Any eligible expenses that exceed monthly before-tax maximums will be deducted on an after-tax basis. The Transportation Spending Accounts do not cover commuting or parking expenses for dependents.
Claims Administrators	Health Equity (formerly known as WageWorks) is the claims administrator for the Transportation Spending Accounts.

How the Transportation Accounts Work

In most cases, your contributions to the Transportation Spending Accounts are deducted from your pay each pay period and used to pay for your eligible monthly transit commuter pass/ticket and/or parking expenses for the next month. You order your commuter passes/tickets and/or authorize payment directly to your parking facility at the time of your enrollment, and your contributions are automatically deducted each pay period and used to pay these expenses.

If your commuting pattern varies, there are two other options for the accounts:

- For transit and parking expenses, you can use your contributions to purchase a Commuter Card. See "How Commuter Cards Work" on page 241 for more details.
- For parking expenses, instead of the "Pay My Provider" option you can choose the "Pay Me Back" option. With "Pay Me Back," there is no automatic purchase or payment for parking, and you don't receive a Commuter Card for parking. Instead, you pay for parking yourself, and then submit a claim for reimbursement to Health Equity. See "How the "Pay Me Back" Parking Option Works" on page 242 for more details.

Please Note

A deduction for Health Care, Dependent Care, and/or Transportation Spending Accounts contributions cannot be taken and no contribution will be made in any pay period in which your compensation after taxes, adjustments and other Plan contributions does not cover the full deduction amount you elected during Annual Benefits Enrollment or as a result of a subsequent Qualified Status Change.

Please Note: Generally, if you are not using a Commuter Card for the Transit Account and the cost of your commuter pass/ticket increases, your payroll deductions will automatically increase to cover the increased cost. In contrast, if your parking expenses increase, you will need to make changes online or by contacting the Transportation Spending Accounts Call Center.

About Your Contributions

Contributions to the Transportation Spending Accounts can be made on a before-tax and after-tax basis.

Before-Tax Contributions

- **Transit Account.** You can generally contribute up to $270 a month on a before-tax basis for eligible mass transit passes (for example, commuter bus, train, subway, ferry passes, tickets and vouchers) or vanpooling expenses.
- **Parking Account.** You can contribute up to $270 a month on a before-tax basis for eligible parking expenses if you drive directly to work or to a location from which you commute to work at JPMorgan Chase (for example, park and ride).

After-Tax Contributions

If your commuting/parking costs exceed the legal before-tax monthly limits under the Transportation Spending Accounts, those additional costs will automatically be deducted through payroll deductions on an after-tax basis. For example, let's say you have a monthly train ticket that costs $325. If you have this ticket purchased for you through the TSA plan, $270 will be deducted from your pay on a before-tax basis (legal limit) and the other $65 will be taken on an after-tax basis, so that there are enough funds in your account to buy the monthly pass for you.

The after-tax limits are currently $1,050 for Transit and $700 for Parking.

How the Purchase of Transit Passes/Tickets Works

Unless you choose the Commuter Card option (see “How Commuter Cards” on page 241):

- Your contributions withheld from your pay in a given month are used to pay for your monthly commuter pass/ticket for the next month, and
- Your pass, ticket, or voucher is generally mailed to you at your home address (unless prohibited by the individual transit agency).
- This means that you don’t have to buy your commuter pass, ticket, or voucher separately (i.e., at the station).

Make Sure You Get Your Pass Each Month!

If you do not receive your order by the first day of the benefit month, you must contact Health Equity to report the missing order **within the first three business days of that month**.

- Health Equity will only pay for up to two lost passes per employee, per lifetime.
- If you do not report an undelivered order in a timely manner, you may not qualify for reimbursement.

How Commuter Cards Work for Parking/Transit

If your commuting pattern varies, you have the option to use your contributions to purchase transit and/or parking Commuter Cards.

- The transit Commuter Card is available to participants in a location where the associate transit agency (e.g., MetroCard, NJ Transit Rail) accepts a debit card and/or credit card.
- The parking Commuter Card can be used to pay for parking directly (at participating garages), eliminating the need to pay for parking yourself and file claims or submit receipts for reimbursement. Check with Health Equity to see if your garage is participating.

With the Commuter Cards, you decide how much money to load onto your card each month to cover your monthly commuting costs. As with every payment option, be sure to save your receipts for all Health Equity Commuter Card transactions.

Please Note: The Commuter Card is intended for use each month. If Health Equity determines that the outstanding card balance exceeds a certain threshold, contributions to that account will be suspended until the balance on your card is below that threshold.

Three Ways to Pay for Parking

There are three ways you can pay for eligible parking expenses with the Parking Account:

- **Commuter Card:** With the Commuter Card, your contributions go to purchase prepaid cards, and you use these to pay for parking each time you park. See “How Commuter Cards Work” on page 241.
- **Pay My Provider:** With the Pay My Provider option, Health Equity sends payment (using your contributions) directly to the garage. You must ensure that the payment information is accurate and that your garage will accept payment from a third party.
- **Pay Me Back:** With the Pay Me Back option, you pay your garage, and then you file a claim to be reimbursed from your Parking Account. See “How the “Pay Me Back” Parking Option Works” on page 242.

Parking Permits Coordinated by JPMorgan Chase

One of the advantages of enrolling in the Parking Account option is that you can benefit from before-tax payroll deductions. By electing the "Pay My Provider" option, before-tax and after-tax deductions will be taken from your pay and Health Equity will pay your garage directly.

If you choose this option, you should advise your JPMorgan Chase parking coordinator to discontinue any current after-tax payroll deductions that are not part of the Transportation Spending Accounts — this will help avoid the possibility of overpayment to the garage.

Alternatively, if you continue to have your JPMorgan Chase parking coordinator pay the garage and then file for reimbursement through Health Equity, you should elect to participate in the "Pay Me Back" option. **Please Note:** Payroll deductions for the "Pay Me Back" option are limited to before-tax legal limits.

How the "Pay Me Back" Parking Option Works

If you don't want to have Health Equity coordinate paying for your parking, but you want the savings from using the Parking Account, you can use the "Pay Me Back" option. With this option, your pay for parking yourself and then file claims for reimbursement from your Parking Account.

Under the "Pay Me Back" option, you have 180 days following the end of the benefit month to file claims for reimbursement. After the claims filing deadline, the unclaimed balance will be applied toward future payroll deductions.

The month in which a claim is reimbursed under this option depends on the day of the month on which the claim is submitted. This determination is made following the same election period schedule as that which determines when payroll deductions are taken as outlined under "Schedule of Monthly Enrollment Dates" on page 244. For example, a claim filed from September 2 – October 1 would be reimbursed in October, while a claim filed from October 2 – November 1 would be reimbursed in November.

Cash Flow When You First Enroll

The Transportation Spending Accounts allow you the convenience of pre-electing your eligible monthly commuter pass/ticket/voucher and/or parking expenses for the coming month. As a result, your payroll deductions for a given month will be used to fund eligible commuting expenses for the following month. Because of this, you should be aware of certain short-term effects on your personal financial situation when you first enroll in the program.

For example, if you elect to participate for the month of June, you may need to pay out-of-pocket for May commuting expenses, in addition to having payroll deductions taken in May for your pre-elected June commuting expenses. For instance, if your monthly train ticket costs $125 and you enroll by May 1, during the month of May you'll have payroll deductions of $125 taken on a before-tax basis. These deductions will be used to pay for your June ticket. You'll need to purchase your May ticket separately. Please plan accordingly.

Unused Before-Tax Dollars

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, retirement, or death. This can result in forfeitures in those circumstances.

To avoid forfeitures, under the "Pay Me Back" option, you have 180 days following the end of the benefit month to file claims for reimbursement. After the claims filing deadline, the unclaimed balance will be applied toward future payroll deductions.

Enrolling in the Transportation Accounts

You can enroll in the Transportation Spending Accounts at any time. You must enroll by the first of the month so that payroll deductions can begin and be used to purchase a pass or parking for the following month. For instance, you must enroll by June 1 in order for your June payroll contributions to be withheld, which will be used to purchase your July 1 pass or parking. See “When Participation Begins” on page 244 for more information. Generally, you should wait to enroll for about 10 business days after your date of hire or other status change, such as a return from a leave of absence, to allow for necessary administrative processing.

- To enroll online, visit the Transportation Spending Accounts Web Center via **My Rewards**, or via the internet at www.healthequity.com.
- To enroll via phone, contact the Transportation Spending Accounts Call Center.

Once you enroll in the Transportation Spending Accounts, you will be responsible for updating your delivery mailing address changes through Health Equity, the Transportation Spending Accounts administrator. In addition, certain transit agencies (i.e., the Long Island Railroad and MetroNorth Railroad) require that you first set up an account with the agency before you can use this benefit. You must manage your ticket choices directly through these agencies, and your payroll elections through Health Equity, who will make the before-tax (and after-tax, if applicable) deduction from your pay and send your payment to the applicable transit agency (see “MetroNorth Railroad and Long Island Railroad (LIRR)” on page 243 for more information).

Please Note: By enrolling in the JPMorgan Chase Transportation Spending Accounts, you authorize JPMorgan Chase to reduce your base salary on a before-tax and after-tax basis to pay for eligible commuting and parking expenses incurred after the date of your enrollment. The contribution amount you elect is a monthly amount that will be divided based on 24 pay periods a year. Your election will automatically renew from month to month unless you make a change or elect a one-time contribution. In most instances, if the cost of your commuter pass/ticket increases, your payroll deductions will automatically increase to cover the cost.

MetroNorth Railroad and Long Island Railroad (LIRR)

If you live in the Metropolitan New York area and you commute to work using either MetroNorth Railroad or the Long Island Railroad, setting up your Transportation Spending Accounts is a two-step process:

1. You must first set up a Mail & Ride Account through the www.mta.info website. When you get to the home page, select either “MetroNorth Railroad” or “Long Island Railroad” and select “Travel” then “Mail and Ride.” You should also indicate whether you want to pay by credit card or check (to be used for any costs above your before-tax payroll deductions).
2. Once you have set up your Mail & Ride account, you can then set up your before-tax election by logging onto the Transportation Spending Accounts Web Center (see access information under “Enrolling in the Transportation Account” on page 243). You can elect an amount up to the before-tax legal monthly limit or the full amount of your commuting cost. Your deductions will then be forwarded directly to the agency to pay for your ticket.

If your payroll deductions do not cover the full cost of your transit election, then the agency will either charge your credit card or request payment by check depending on the payment option you selected with the Metropolitan Transportation Authority (MTA).

Please remember if you need to change your ticket (such as a home address change, origination station or destination station change), you must contact either MetroNorth or the Long Island Railroad. If the change you make results in a change in fare, you can enter the new amount on the Transportation Spending Account Web Center or contact the Transportation Spending Accounts Call Center (see “Enrolling in the Transportation Account” on page 243 for contact information).

In the event you no longer commute using MetroNorth or LIRR, you must:

- Cancel your commuter pass directly with MetroNorth or the LIRR; and
- Contact Health Equity to discontinue your contributions.

This must be done by the first of the month before the month you wish the change to take effect.

When Participation Begins

If you choose to contribute, your contributions will begin to be deducted from your pay based on your election period as shown in the following chart:

Schedule of Monthly Enrollment Dates

Election Periods:	Payroll Deductions Taken:	For Expenses Incurred In:
January 2 - February 1	February	March
February 2 - March 1	March	April
March 2 - April 1	April	May
April 2 - May 1	May	June
May 2 - June 1	June	July
June 2 - July 1	July	August
July 2 - August 1	August	September
August 2 - September 1	September	October
September 2 - October 1	October	November
October 2 - November 1	November	December
November 2 - December 1	December	January
December 2 - January 1	January	February

Please Note: You must have a valid U.S. ZIP code for your home address on file with JPMorgan Chase to be able to participate in the Transportation Spending Accounts.

Eligible Expenses

The specific expenses listed below are currently considered by the Internal Revenue Service (IRS) to be eligible commuting expenses. **Please Note:** This list is subject to change at any time based upon IRS guidance.

Eligible Transit Account Expenses

- **Transit Passes.** Your cost for any pass, token, fare card, voucher, or similar item that entitles you to transportation on mass transit facilities to and from work.
- **Vanpooling.** Your cost for transportation provided to you between your home and work by a person in the business of transporting people for compensation, in a commuter vehicle that seats six or more adults (excluding the driver).

Eligible Parking Account Expenses

- Your cost of parking provided to you at or near your JPMorgan Chase work location; or
- Your cost of parking at or near a location from which you commute between your home and work by vanpooling, carpooling, or mass transit. (This does not include parking at or near your home, for example, in an apartment building's parking garage.)

In calculating the cost of your monthly expenses, you should take into account any discounts that you receive. If you fail to do so, you may be in receipt of taxable income.

Expenses *Not* Eligible

The following expenses do not qualify as eligible expenses under the Transportation Spending Accounts. This list may change at any time.

Ineligible Transit Account Expenses

- Car and/or vanpooling expenses with seating for fewer than six passengers (excluding the driver);
- Taxicab fares (including ride-sharing services, such as Uber and Lyft);
- Valet;
- Highway, bridge, or tunnel tolls;
- Non-work-related transportation;
- Reimbursed expenses incurred for business travel, such as traveling from the office to a business or client meeting, or traveling from one job to another;
- Transit expenses incurred by other household members; and
- Parking expenses. (These are covered under the Parking Account.)

Ineligible Parking Account Expenses

- Non-work-related parking;
- Parking paid for by JPMorgan Chase;
- Parking costs incurred at a temporary work location (one year or less);
- Parking at or near an employee's residence;
- Parking expenses incurred by other household members;
- Gasoline or mileage expenses;
- Valet; and
- Transit expenses. (These are covered under the Transit Account.)

Managing Your Accounts and Receiving Reimbursements

This section explains how you can track the status of your accounts and cover your eligible expenses.

The ways expenses are covered varies between the different accounts.

Ask Your Claims Administrator
You can also contact your claims administrator if you have a question about the spending accounts (see contact information in the *Contacts* section).

Tracking Your Spending Accounts

Health Care Spending Account

You can check your Health Care Spending Account Balance (even if you are not enrolled in the Medical Plan) on the Aetna/PayFlex or Cigna websites, which are accessible via **My Health**.

Dependent Care Spending Account

You can check your Dependent Care Spending Account balance on the Aetna/PayFlex or Cigna websites, which are accessible via **My Health**.

Transportation Spending Accounts

Information about your Transportation Spending Accounts is available online at the Health Equity website, which is accessible from the Transportation Spending Accounts Web Center link on **My Rewards**.

Receiving Health Care Spending Account Reimbursements

The claim processing method for your Health Care Spending Account differs by the type of expense and your Medical Reimbursement Account payment method under the Medical Plan, as described in the following sections. When submitting a claim for eligible expenses for a covered dependent, please include the dependent's name.

Please be mindful of the claim filing deadline: you have until March 31 of the year following the plan year (January 1 – December 31) to submit claims for the Health Care Spending Account incurred during the plan year. If you are submitting your claim by mail, the postmark date must be no later than March 31.

Medical Expenses: If You Are Enrolled in the JPMorgan Chase Medical Plan

If you are enrolled in the JPMorgan Chase Medical Plan, the funds in your Medical Reimbursement Account (MRA) will be used to pay for eligible out-of- pocket medical and prescription drug expenses *before* your Health Care Spending Account funds are used. The claim processing method that applies to your MRA (i.e., Automatic Claim Payment or Debit Card) will apply to your Health Care Spending Account for Medical Plan expenses.

Using Automatic Claim Payment for Medical Plan Expenses

If you elected or were assigned (if applicable) Automatic Claim Payment for your MRA, that method will also apply to your Health Care Spending Account. With Automatic Claim Payment, you do not have to submit a paper claim form to be reimbursed from your Health Care Spending Account for medical expenses.

- **In-network providers** will generally submit your Medical Plan claim electronically to your health care company; you will not be asked to pay at the point of service. Your health care company will pay your provider for the Plan's share of the expense and will make payment to your provider for your share of the expense first from your MRA and then from your Health Care Spending Account. If your MRA and Health Care Spending Account have been depleted, your provider will bill you for the remaining balance.
- **In the case of an out-of-network provider**, you should ask if they will submit the claim for you. If they agree to do so, your claim will be processed as described above for an in-network provider. If you are required to pay in full at the point of service, you would need to file a Medical Claim Form to be reimbursed for the Medical Plan's share of the expense.

  Medical claims can be filed online with your health care company, at www.mycigna.com or www.aetna.com, as appropriate. You can also file paper claims, if you prefer. (See "Paper Reimbursement Claims" on page 250.) For any claims, you can sign up for direct deposit with your health care company, so that any reimbursements are deposited directly into your account, instead of having a check mailed to you.

  In addition to processing the claim to determine the amount the Medical Plan should have paid, your health care company will determine what amount can be reimbursed to you from your MRA and/or Health Care Spending Account. Your health care company will make payment first from your MRA and then from your Health Care Spending Account.

- **When you fill a prescription** at a network pharmacy or use Maintenance Choice® (including mail order), your claim will be submitted to CVS Caremark. After CVS Caremark pays its share of the cost, your health care company will pay your share of the expense first from your MRA and then from your Health Care Spending Account. If your MRA and Health Care Spending Account do not have enough money to cover your share of the cost, you will need to pay the amount you owe out-of-pocket.

  If you purchase your prescription drugs through a non-network pharmacy or do not show your CVS Caremark ID card at network pharmacy, you will have to pay for the prescription drug and then file a CVS Caremark Claim Form to be reimbursed for the amount owed by the Plan. After you receive your Explanation of Benefits you can submit the MRA and/or HCSA Claim Form to request reimbursement for your share of the expense from your MRA and/or Health Care Spending Account. (See “Paper Reimbursement Claims” on page 250).

Using the Debit Card for Medical Plan Expenses

If you elected or were assigned (if applicable) the Debit Card for your MRA, that method will also apply to your Health Care Spending Account. When you receive a service you have a choice whether to pay the expense out-of-pocket or with your debit card. When using the debit card to pay for eligible expenses incurred by a covered dependent, be sure to include the dependent’s name.

- **In-network providers** will submit a claim to your health care company, which will pay your provider for the Medical Plan’s share of the expense. Your doctor will bill you for your share. You can then decide whether to use your debit card to pay your bill or pay out-of-pocket.

  If you use your debit card to pay your share of the expense, you would give your provider your debit card number and the card would use funds first from your MRA and then from your Health Care Spending Account to pay the provider. You should keep your receipt in case you are asked to substantiate your expense; see “Error! Reference source not found.” on page Error! Bookmark not defined..

  If you pay out-of-pocket, you may request reimbursement from your MRA and Health Care Spending Account by submitting the MRA and/or HCSA Claim Form (see “Paper Reimbursement Claims” on page 250).

- **When you visit an out-of-network provider**, you should show the provider your Medical Plan ID card and ask if they will submit the claim for you. If they agree to do so, your claim will be processed as described above for in- network providers (your health care company will pay your provider for the Medical Plan’s share of the expense and your doctor will bill you for your share). You can then decide whether to use your debit card to pay your bill or pay out-of-pocket. If you wish to use your debit card and if the provider will accept your debit card as payment, your claim will be processed in the same way as with an in-network provider – the card would use funds first from your MRA and then from your Health Care Spending Account to pay the provider. You should keep your receipts in case you are asked to substantiate your expense; see “Debit Card General Information" on page 249.

  If an out-of-network provider will not accept your debit card, you will need to pay the full expense out-of-pocket and file a Medical Claim Form to be reimbursed for the Medical Plan’s share of the expense. You can then request reimbursement from your MRA and Health Care Spending Account for your share of the expense by submitting the MRA and/or HCSA Claim Form (see “Paper Reimbursement Claims” on page 250).

  Medical claims can be filed online with your health care company, at www.mycigna.com or www.aetna .com, as appropriate. You can also file paper claims, if you prefer. (See “Paper Reimbursement Claims” on page 250.) For any claims, you can sign up for direct deposit with your health care company, so that any reimbursements are deposited directly into your account, instead of having a check mailed to you.

- **When you fill a prescription** at a network retail pharmacy or use Maintenance Choice® (including mail order), your claim will be submitted to CVS Caremark. After CVS Caremark pays its share of the cost, you can decide whether to use your debit card to pay your share of the cost or pay out-of-pocket at the pharmacy. If you use your debit card, the card will use funds first from your MRA and then from your Health Care Spending Account. If you pay out-of-pocket, you can submit the MRA and/or HCSA Claim Form to request reimbursement for your share of the expense from your MRA and Health Care Spending Account (see “Paper Reimbursement Claims” on page 250). You should keep your receipt in case you are asked to substantiate your expense; see “Debit Card General Information" on page 249.

  If you purchase your prescription drugs through a non-network pharmacy or do not show your CVS Caremark ID card at a network pharmacy, you will have to pay for the prescription drug and then file a CVS Caremark Claim Form to be reimbursed. After you receive your EOB you can submit the MRA and/or HCSA Claim Form to request reimbursement for your share of the expense from your MRA and Health Care Spending Account. (See “Paper Reimbursement Claims” on page 250).

Medical Expenses: If You Do Not Participate in the JPMorgan Chase Medical Plan

You will automatically receive a debit card from Cigna for your Health Care Spending Account if you do not participate in the JPMorgan Chase Medical Plan. This card maintains your Health Care Spending Account balance and can be used to pay for eligible expenses at the point of purchase. By using the card, you minimize the need to file claims and wait for reimbursement.

At the point of service, you may use your debit card to pay the provider directly, or you may pay out-of-pocket and then submit the Health Care Spending Account Claim Form to request reimbursement from your Health Care Spending Account (see “Paper Reimbursement Claims” on page 250). You should keep your receipt in case you are asked to substantiate your expense; see “Debit Card General Information" on page 249.

Dental and/or Vision Expenses

If You Have Automatic Claim Payment (from the JPMorgan Chase Medical Plan)

The Automatic Claim Payment method that is available to JPMorgan Chase Medical Plan participants cannot be used with dental/vision expenses. If you elected or were assigned Automatic Claim Payment, you will need to pay your provider out-of-pocket for dental/vision expenses that are not covered by any dental/vision plan you have elected. You can then submit the MRA and/or HCSA Claim Form to request reimbursement from your Health Care Spending Account. See “Paper Reimbursement Claims” on page 250 for more information.

Claims can be filed online with your health care company, at www.mycigna.com or www.aetna.com, as appropriate. You can also file paper claims, if you prefer. (See “Paper Reimbursement Claims” on page 250.) For any claims, you can sign up for direct deposit with your health care company, so that any reimbursements are deposited directly into your account, instead of having a check mailed to you.

If You Have the Debit Card

You can use your debit card to pay at the point of service for a dental/vision expense or you can pay out-of-pocket. If you pay out-of-pocket, you can then submit the MRA and/or HCSA Claim Form (if you are enrolled in the Medical Plan) or the Health Care Spending Account Claim Form (if you are not enrolled in the Medical Plan) to receive reimbursement from your Health Care Spending Account. You should keep your receipt in case you are asked to substantiate your expense; see “Debit Card General Information" on page 249.

Claims can be filed online with your health care company, at www.mycigna.com or www.aetna.com, as appropriate. You can also file paper claims, if you prefer. (See “Paper Reimbursement Claims” on page 250.) For any claims, you can sign up for direct deposit with your health care company, so that any reimbursements are deposited directly into your account, instead of having a check mailed to you.

Debit Card General Information

Debit card transactions will be processed at valid vendors only. Some examples of valid vendors are doctors' offices, pharmacies, hospitals, laboratories, dentists, and vision care providers. Generally, if you participate in the Health Care Spending Account (HCSA) and elect this payment method, in most cases your medical and/or dental claims may be automatically substantiated if you participate in a medical or dental plan option with the same carrier that administers your HCSA. For example, if you participate in the Cigna DHMO and Cigna administers your HCSA, if your dentist submits an invoice for services that are not otherwise covered at 100% by the plan, your debit card payment to the dentist would be automatically substantiated.

Please Note: Not all providers accept the debit card as a form of payment. In those instances, you will need to pay out-of-pocket and then submit an MRA and/or HCSA Claim Form for reimbursement (if you are enrolled in the Medical Plan) or the Health Care Spending Account Claim Form (if you are not enrolled in the Medical Plan) to request reimbursement (see "Paper Reimbursement Claims" on page 250).

When the vendor processes your transaction, the funds will be transferred from your Health Care Spending Account directly to the vendor. Although the card functions like a debit card, you should always choose the "credit card" option if asked what type of card it is.

The IRS requires proof of qualified purchases made with a spending account card. Your debit card transactions will be automatically substantiated when the card is used at businesses that utilize IRS "Inventory Information Approval System (IIAS) swipe technology" to identify and substantiate eligible health care expenses as per Section 213(d) of the Internal Revenue Code. The IIAS technology allows you to use your debit card to pay for eligible expenses without having to provide additional documentation, as transactions are verified at the point of sale. In addition, IIAS compatibility allows you to use your debit card to pay for both ineligible expenses and eligible health care expenses in the same transaction (eligible health care expenses are approved for payment via the debit card and remaining ineligible expenses may be paid using another form of payment). When you use your card at participating retailers, eligible health care expenses will be identified and noted on your receipt. You will generally not have to submit receipts for reimbursement if your purchases are made at a participating retailer. You can see a full list of participating IIAS-compliant retailers at: http://www.sig-is.org.

If you go to a retailer that is not IIAS-compliant you can still purchase eligible health care expenses with your debit card. You should save your receipts, as you will be asked to substantiate the expense.

Even if you use your debit card at a vendor that utilizes IIAS, it is still recommended that you keep your itemized receipts as part of your tax records. If you are required to provide proof of a qualified purchase, you will receive a request for substantiation. Failure to provide the required substantiation will result in the temporary deactivation of your Health Care Spending Account debit card, and you will be required to repay the amount of the unsubstantiated/ineligible expense before the card is reactivated.

Federal tax law requires that unsubstantiated claims be offset against subsequent substantiated claims. If you remain indebted after these steps, JPMorgan Chase will be required to treat the overpayment as it would any other indebtedness owed to the Company. Your case will be referred to an internal JPMorgan Chase Fraud Recovery unit that will follow their procedures to bring your case to closure.

Receiving Dependent Care Spending Account Reimbursements

When you incur an eligible expense under the Dependent Care Spending Account, you must pay out-of-pocket for the expense and file the Dependent Care Spending Account (DCSA) Claim Form to receive reimbursement from your Dependent Care Spending Account. See "Paper Reimbursement Claims" on page 250 for more information.

Please be mindful of the claim filing deadline: you have until March 31 of the year following the plan year to submit eligible claims for the Dependent Care Spending Account incurred during the plan year (January 1 – December 31). If you are submitting your claim by mail, the postmark date must be no later than March 31.

Paper Reimbursement Claims

You can download and print the claim forms needed to request reimbursement from your Health Care and Dependent Spending Accounts via **My Health** or on your carrier's website (Aetna/PayFlex or Cigna).

Please Note: The Dependent Care Spending Account requires that your receipt include the care provider's name, address and taxpayer identification number (or Social Security number). Without this information, the care usually won't qualify as an eligible Dependent Care Spending Account expense.

Send your completed claim form and supporting receipts to the appropriate address or fax number:

Claim Form	Address
Aetna/PayFlex	***For Health Care and MRA Claims*** Aetna P.O. Box 14079 Lexington, KY 40512-4079 Phone: (800) 468-1266 Monday through Friday, 8 a.m. to 8 p.m., Eastern time ***For Spending Account Claims (Health Care and Dependent Care)*** Payflex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 (888) 678-8242 Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Cigna	Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 Fax: (859) 410-2432 Toll-Free Fax: (877) 823-8953

You must submit claims incurred during the plan year (January 1 – December 31) by the claim filing deadline, March 31 of the year following the plan year. If you are submitting your claim by mail, the postmark date must be no later than March 31.

Transportation Spending Accounts Reimbursements

In most cases, you do not need to file a claim to be reimbursed for transit expenses. Your payroll deductions under the Transportation Spending Accounts are deducted from your account each pay period and used to pay for your eligible monthly commuter pass/ticket and/or parking expenses. You order your commuter passes/tickets and/or authorize payment directly to your parking facility at the time of your enrollment. Generally, there is no reimbursement feature under the Transit Account.

Filing a Claim for Parking Expense Reimbursement ("Pay Me Back" Option)

If your eligible monthly parking expenses are unpredictable, you may be eligible to receive reimbursement for your before-tax expenses by enrolling in the "Pay Me Back" option. With this option, you will need to pre-elect the estimated amount of your expenses for the upcoming month, pay for your expenses, and then submit a claim for reimbursement.

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; otherwise, it will be applied as a credit toward future payroll deductions.

There are two ways you can submit a claim for reimbursement for eligible Parking Account expenses:

- Print out and complete a claim form from the Transportation Spending Accounts Web Center via **My Rewards**. Then fax the form with any parking receipts to the Transportation Spending Accounts Call Center at (877) 353-9236, or mail the form to the address printed on the form. You can also have a claim form faxed or mailed to you by contacting the Transportation Spending Accounts Call Center at (877) 924-3967.
- If your parking provider does not provide receipts (for example, a parking meter) you can submit the claim online without any receipts. Visit the Transportation Spending Accounts Web Center via **My Rewards**, click on the "Pay Me Back" account link and then click "File Online Claim" for the month you want to submit your claim.

You can check the claim filing deadline for each month by visiting the Transportation Spending Accounts Web Center via **My Rewards** and clicking the "Account Activity" page for your account. If you have a balance remaining after the claim filing deadline, it will be applied towards future payroll deductions.

Please Note: Payroll deductions for the "Pay Me Back" option are limited to the before-tax legal limits. Reimbursements for "Pay Me Back" are made through direct deposit or check on a monthly basis.

Reimbursement Processing

Health Care and Dependent Care paper claims are processed on a timely basis and are paid either through direct deposit or check. Reimbursements for the "Pay Me Back" option for the Transit Account and Parking Account are made through direct deposit or check on a monthly basis by Health Equity.

Uncashed Reimbursement Checks

Any amounts for which paper checks were issued and not cashed under the Health Care and/or Dependent Care Spending Accounts, or under the "Pay Me Back" option under the Transportation Spending Account Parking Account, will be treated as forfeited and will become the property of JPMorgan Chase no later than 24 months following the year in which the check was originally issued.

Appealing a Claim

If a claim under any of the Spending Accounts is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the *Plan Administration* section.

Defined Terms

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

After-Tax Contributions	After-tax contributions are contributions that are taken from your pay after federal, state and local income taxes are withheld.
Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical, Dental, Vision and Spending Accounts Plans payroll contributions are generally taken on a before-tax basis.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Spending Accounts. JPMorgan Chase is not involved in deciding appeals for any benefit claim denied under the Spending Accounts. All fiduciary responsibility and decisions regarding a claim for a denied benefit under the Plan rest solely with the claims administrator. **Please Note**: Claims and appeals relating to eligibility to participate in the Health Care Spending Account are decided by the plan administrator. Consult the *Plan Administration* section for details.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise end. The *Health Care Participation* section provides details on COBRA coverage.
Publications 502, 503 and 15B	Publications 502, 503 and 15B are Internal Revenue Service (IRS) publications that can be used as a guide to determine eligible and ineligible expenses under the Health Care Spending Account, Dependent Care Spending Account and Transportation Spending Accounts. You can request a copy by calling the Internal Revenue Service (IRS) at (800) 829-FORM ((800) 829-3676), or you can view these publications by logging on to www.irs.gov.
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. Any changes you make during the year to your Health Care and Dependent Care Spending Accounts must be consistent with your QSC. Please see "Qualified Status Change" on page 221 for more information. For the Transportation Spending Accounts, you are not limited on when you can begin, end, or change your contributions, so QSCs do not apply for those accounts. **Please Note:** Regardless of whether you experience a qualified change in status, you cannot change your health care company during the year.

Disability Coverage

Effective 1/1/21

The JPMorgan Chase U.S. Benefits Program includes plans that can pay you benefits to replace lost income if you become disabled and cannot work. The plans include:

- *The Short Term Disability (STD) Plan;*
- *The Long-Term Disability (LTD) Plan (which includes the JPMorgan Chase Long-Term Disability Plan's Individual Disability Insurance (IDI)).*

The Short-Term Disability Plan

Effective 1/1/21

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

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

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

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

About This Summary Plan Description

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

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

Questions?

For questions about the STD Plan or to report a claim, contact *Sedgwick Claims Management Services, Inc.*

- (888) 931-3100

Service Representatives are available 24/7, Sunday through Saturday.

You can also obtain answers to your questions 24 hours a day, seven days a week online at claimlookup.com/jpmc.

For More Information on Time Off Policies

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

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

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

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STD Plan Highlights

Your Coverage

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

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

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

Right to Recovery (Effective 5/1/2019)

If the STD Plan provides pay for approved periods of disability that are later determined to be as a result of an illness or injury for which another person or entity is legally responsible, the STD Plan has the right to recover payment from you or from the person or entity who is determined to be legally responsible. Assignment of your claim to a third party does not exempt you from your responsibility for repaying the STD Plan. You must notify the STD Plan promptly of any circumstance in which a third party may be responsible for compensating you with respect to an illness or injury that results in the STD Plan providing financial protection for approved periods of disability.

Participating in the STD Plan

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

Eligibility

You are eligible for short-term disability leave if:

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

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

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

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

Short-Term Disability Leave Duration and Pay

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

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

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

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

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

Cost of Coverage

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

How the STD Plan Works

Length and Amount of Benefits

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

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

The Long-Term Disability Plan

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

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

Short-Term Disability Pay Schedule*

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

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

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

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

Statutory Benefits

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

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

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

State Disability Benefits

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

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

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

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

Important Note About California and Rhode Island Disability Benefits

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

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

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

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

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

Recurrent Disabilities

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

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

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

Multiple Short-Term Disability Leaves

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

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

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

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

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

What Is Not *Covered*

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

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

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

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

Claiming Benefits

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

How to File Claims

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

Filing a Claim for a Non-Occupational Illness or Injury

Reporting a Leave

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

Submitting Required Information

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

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

  Note: The Genetic Nondiscrimination Act of 2008 (GINA) generally prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual. Your health care provider should not provide any genetic information when responding to requests for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
- You should only provide your personal health information to Sedgwick — it should not be provided to your manager, Human Resources Business Partner, or any other JPMorgan Chase employee. Any personal health information that you submit to Sedgwick is treated as confidential and used only for appropriate purposes.

Return to Work Determination

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

Filing a Claim for an Occupational Illness or Injury

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

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

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

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

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

Appealing Short-Term Disability Claim Denials

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

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

Sedgwick National Appeals Unit
PO Box 14748
Lexington, KY 40512

Fax: (855) 673-2488

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

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

For Employees Who Work in the State of New Jersey

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

Send your written appeal to:

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

Telephone: (609) 292-6135

Right of Recovery (Effective 5/1/2019)

If the STD Plan provides pay for approved periods of disability that are later determined to be as a result of an illness or injury for which another person or company is legally responsible, the STD Plan has the right to recover payment from you or from the person or company who is determined to be legally responsible. Assignment of your claim to a third party does not exempt you from your responsibility for repaying the STD Plan. You must notify the STD Plan promptly of any circumstance in which a third party may be responsible for compensating you with respect to an illness or injury that results in the STD Plan providing financial protection for approved periods of disability.

Subrogation of Benefits (Effective 5/1/2019)

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

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

Right of Reimbursement (Effective 5/1/2019)

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

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

When Coverage Ends

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

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

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

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

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

Additional Plan Information

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

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

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

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

Right to Amend

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

JPMorgan Chase also reserves the right to amend any of the plans and policies, to change the method of providing benefits, to curtail or reduce future benefits, or to terminate at any time for any reason any or all of the plans and policies described in this Guide. Neither this Guide nor the benefits described in the Guide create a contract of employment or a guarantee of employment between JPMorgan Chase and any employee.

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

Defined Terms

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

Actively-at-Work or on an Active Employment Basis	Performing all the duties that pertain to your work on a regular basis at the place where they are normally performed or where they're required to be performed by JPMorgan Chase.
Claims Administrator	Sedgwick Claims Management Services, Inc. (herein referred to as "Sedgwick") is the claims administrator for the STD Plan, a self-insured plan, as it pertains to non-work-related (non-occupational) illnesses or injuries. Sedgwick also administers the statutory disability plans in New York and New Jersey and is the claims administrator in all states for time off approved under the Family and Medical Leave Policy. For additional information, please refer to the Family and Medical Leave Policy, available at **me@jpmc** > HR Policies > Leaves of Absence.
Disability	For purposes of the STD Plan, "disability" is defined as a period of illness or injury that continues for eight or more consecutive calendar days during which you are unable to perform the material and substantial duties of your position on an active employment basis, and you are not working more than 80% of your normal work schedule. **For Medical Conditions:** A medical certification (see the definition of Medical Certification, below) by a licensed physician must show that you are disabled with objective documentation that your medical condition disables you from performing your job, and you must be under the care of a licensed physician during your period of illness or injury. **For Behavioral Health Conditions (Effective 5/1/2019):** A behavioral health certification (see the definition of Behavioral Health Certification, below) by a registered or licensed behavioral health provider must show that you are disabled based on clinical findings that your condition limits you from performing your job. You must seek treatment with a registered or licensed behavioral health provider within 10 days of your first date of absence and be seen by a registered or licensed behavioral health provider at least every 30 days throughout the duration of your leave. **For All Conditions:** You must also be determined to be disabled by Sedgwick, the claims administrator for the STD Plan, for non-work-related illnesses or injuries or you must be approved as disabled in accordance with the applicable state Workers' Compensation law for work-related illnesses or injuries. The claims administrator may use any appropriate information, including surveillance information, to determine whether you are disabled. Furthermore, you are not eligible for leave or pay covered under the STD Plan if the sole reason you cannot report to work is due to your inability to commute to the workplace. (If this is an issue that affects you, please see the Accommodating Disabilities and Temporary Work Restrictions Policy, available at **me@jpmc** > HR Policies > Employee Assistance.)

Eligible Compensation	For purposes of the STD Plan, Eligible Compensation generally means your annual base salary plus applicable job differential pay (e.g., shift pay). It does not include any annual incentives, overtime, special recognition, or other incentive awards you might receive. In certain situations, your eligible compensation may include other cash earnings (e.g., commissions and draws) paid under certain non-annual incentive plans that provide compensation in lieu of base salary. Separate definitions other than what is described here may apply to employees in certain positions who are paid on a draw-and-commission basis. If this situation applies to you, you will be notified.
Full-Time Employee	For purposes of the STD Plan, a full-time employee is an employee paid through a U.S. payroll of the firm, subject to FICA withholding, and regularly scheduled to work 40 hours per week. Full-time employees include employees who are paid on a salaried basis or an hourly basis, as well as employees who are eligible for draws or commissions. Employees who are eligible for draws or commissions are paid according to line of business commission plans. Full-time employees are generally eligible to participate in the firm's benefits programs and for paid time off, subject to such programs' eligibility criteria. ▪ *Full-time salaried employees* are exempt employees paid on a salaried basis. ▪ *Full-time hourly-paid employees* are overtime-eligible employees paid on an hourly basis.
Introductory Period	The first 90 days of employment for newly hired and re-employed employees at JPMorgan Chase.
Licensed Physician	A person who is not your relative or family member and: ▪ Is determined by the plan administrator or its delegate to be qualified to render an opinion about your physical condition as it relates to your claim of disability; ▪ Is a healthcare provider licensed in the jurisdiction in which he or she practices and is determined by the claims administrator, in its sole discretion, to be qualified and appropriate under the circumstances to provide medical certification; and ▪ Whose primary practice is treating patients.
Registered or Licensed Behavioral Health Provider	A person who is not your relative or family member and: ▪ Is determined by the plan administrator or its delegate to be qualified to render an opinion about your mental condition as it relates to your claim of disability; ▪ Is a behavioral health provider registered or licensed in the jurisdiction in which he or she practices and is determined by the claims administrator, in its sole discretion, to be qualified and appropriate under the circumstances to provide behavioral health certification; and ▪ Whose primary practice is treating patients.
Medical Certification	Certification from your licensed physician confirming the status of your medical condition as it relates to your claim of disability and objective documentation that your medical condition disables you from performing your job. **Note:** A certification that is based largely or entirely on self-reported symptoms, without objective documentation of inability to perform the job, will not be considered sufficient to support a finding of disability.
Behavioral Health Certification	Certification from your registered or licensed behavioral health provider confirming the status of your mental condition as it relates to your claim of disability and clinical documentation that your condition disables you from performing your job. **Note:** A certification that is based largely or entirely on self-reported symptoms, without clinical documentation of inability to perform the job, will not be considered sufficient to support a finding of disability.
Non-Occupational Injury/Illness	A non-occupational injury/illness means an injury, sickness, or disease not related to your employment.
Occupational Injury/Illness	An occupational injury or illness extends to all injuries or diseases that arise out of and are in the course and scope of employment. If you have an occupational illness or injury, you may be eligible for Workers' Compensation benefits, including paid medical expenses and compensation for lost work time.

Recognized Service

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

If employed as of July 1, 2004:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Temporary Employee

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

Under the Care of a Licensed Physician

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

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

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

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

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

Wait Period

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

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

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

Please Note:

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

Workers' Compensation Insurance Program

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

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

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

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

The Long-Term Disability Plan

Effective 1/1/21

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

The LTD Plan has two components:

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

About This Summary Plan Description

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

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

Employees who meet the LTD Plan's eligibility requirements and who have TACC of less than $60,000 in effect for the plan year are automatically enrolled in Group LTD coverage for that plan year at JPMorgan Chase's expense – no employee contributions are required.

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

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

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

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

Important Information for Residents of Certain States

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

Questions?

Claim related questions for Group LTD: Prudential, Monday – Friday from 8 a.m. to 11 p.m. Eastern time at (877) 361-4778

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

General coverage questions: HR Answers:

- (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.

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

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

Your Choices

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

Group LTD Coverage

Group LTD coverage provides you with a monthly benefit based upon a percentage of your TACC, less certain other disability benefits (see "Defined Terms" on page 301 for the definition of "Benefits Offset"). Prudential is the claims administrator for Group LTD coverage.

If your TACC in effect for a plan year is less than $60,000, you are automatically enrolled in the LTD Plan for that given plan year. If you meet the plan's definition of disabled, the plan would provide:

- Replacement of 60% of TACC, to a maximum monthly benefit of $3,000.

If your TACC in effect for a plan year is $60,000 or more, you can choose long-term disability protection from among the following options:

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

Individual Disability Insurance Coverage

If your TACC is greater than $400,000, you generally can choose additional LTD coverage under fully portable Individual Disability Insurance, insured and administered by Unum. You do not need to be enrolled in Group LTD coverage to elect IDI coverage, You are eligible for IDI if your TACC is from $400,000 to $700,000 if you elect the LTD 60% option (or from $480,000 to $840,000, if you elected the 50% option) and provides an additional maximum monthly benefit of up to $15,000. If you do not enroll in Group LTD coverage, then you are defaulted to the 60% option for IDI. If you are eligible, you will receive separate information regarding IDI. Unum is the claims administrator for Individual Disability Insurance.

Benefits Eligibility

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

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

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

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

Duration of Benefits	Your Long-Term Disability Plan benefits may continue until you are determined not to be disabled, reach the maximum time period for benefits, or pass away. Generally, if you continue to meet the definition of disability, benefits paid under the LTD Plan for a disability occurring before age 60 (or age 61, in the case of IDI) continue until you recover or you reach age 65, whichever occurs first. Benefits paid under the LTD Plan for a disability occurring after age 60 (or age 61, in the case of IDI) continue for a specified length of time as long as you are continuously disabled, based on the age at which you become disabled. Please see "**Limitations on Certain Benefits**" on page 288 under "When Participation Ends" beginning on page 283 and "When Benefits Begin and End" on page 295 under the "How Individual Disability Insurance ("IDI") Works" on page 292.
How You Pay for Coverage	If your TACC in effect for a plan year is less than $60,000, Group LTD coverage is fully paid by JPMorgan Chase and any benefits you receive if you become disabled would therefore be taxable. If your TACC in effect for a plan year is $60,000 or more, you pay the premiums for your elected Group LTD coverage on an after-tax basis. As a result, any future benefits you receive if you become disabled would be tax-free. Your cost per pay period depends on your TACC, the level of coverage you choose, and your status as a tobacco user or non-tobacco user. Please see "Defined Terms" beginning on page 301 for the definition of "Total Annual Cash Compensation." Please see the definition of "Tobacco User Status" on page 280. As with Group LTD coverage, if you are eligible for and elect IDI coverage, you pay for it on an after-tax basis, so any benefits you receive if you become disabled would be tax-free. Your cost depends on your TACC, the level of coverage you choose, age, state of residency, and your status as a tobacco user or non-tobacco user.

Participating in the Long-Term Disability Plan

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

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

Advantages of Electing LTD Coverage

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

In addition, if you do not enroll for LTD coverage when you are first eligible and then later choose to elect and are approved for coverage, you will not be covered for a claim due to a condition that predates your coverage effective date (see "Pre-Existing Condition Exclusion" on page 286).

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

Eligibility

Who's Eligible

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

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

Who's Not Eligible

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

Examples of such individuals include an:

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

Cost of Coverage

Group LTD

If your Total Annual Cash Compensation (TACC) in effect for a plan year is less than $60,000 a year, coverage for that plan year is fully paid for by JPMorgan Chase and as a result, any benefits you receive if you become disabled would be taxable. TACC is recalculated as of each August 1 to take effect the following January 1 and will remain unchanged throughout the year.

If your TACC in effect for a plan year is $60,000 or more and you elect Group LTD, you pay for coverage on an after-tax basis, and as a result, any benefits you receive if you become disabled would be tax-free. Your cost depends on your TACC, the level of coverage you choose, and your status as a tobacco user or non-tobacco user. (Please see "Defined Terms" beginning on page 301 for the definition of "Total Annual Cash Compensation". Please see the definition of "Tobacco User Status" on page 280.) Your contributions toward the cost of coverage begin on or near the first day of the pay period in which your coverage begins or after your coverage has been approved if Evidence of Insurability is required. Your contributions are automatically deducted from your paycheck in equal installments (unless retroactive payments are required).

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

Individual Disability Insurance ("IDI")

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

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

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

Tobacco User Status

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

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

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

For IDI coverage, you will declare your tobacco user status in your enrollment materials. You will be assigned rates based on your self-reported tobacco use. For those assigned tobacco user rates, your rates will only be changed to non-tobacco user rates if you have been tobacco-free for 12 continuous months (as of January 1).

How Tobacco User Is Defined

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

Evidence of Insurability

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

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

Limited Continuation of Other Benefits

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

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

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

Important Note Regarding Eligibility for Other Benefits

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

If You Became Disabled Before 2011

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

Termination of Employment After 24 Months of LTD Benefit Payments

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

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

When Participation Ends

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

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

Please see "If Your Situation Changes" on page 299 for details on how coverage is affected in certain situations.

How Group LTD Coverage Works

This section explains how Group LTD coverage works. IDI coverage is discussed under "How Individual Disability Insurance ("IDI") Works" beginning on page 292.

Group LTD coverage provides a level of income replacement should you continue to be disabled for more than 182 days. If approved by Prudential, the claims administrator, Group LTD coverage provides you with a monthly benefit of up to $20,000 based upon a percentage of your Total Annual Cash Compensation (TACC), less certain other disability benefits. TACC under the plan is limited to $400,000 if you elect the 60% option (or $480,000, if you elect the 50% option described in "If You're An Employee" with TACC $60,000 or more). If your TACC in effect for a plan year is less than $60,000, you would receive company-paid coverage if you become disabled with a replacement of 60% of TACC, to a maximum monthly benefit of $3,000.

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

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

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

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

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

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

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

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

If Your TACC is less than $60,000

If you meet the eligibility requirements, whether you are currently an employee, a newly eligible employee, or a newly hired employee and if your Total Annual Cash Compensation (TACC) in effect for a plan year is less than $60,000, you are **automatically** enrolled in Group LTD coverage, which is fully insured under a policy issued by The Prudential Insurance Company of America. You would receive company-paid coverage if you become disabled with a replacement of 60% of TACC, to a maximum monthly benefit of $3,000.

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

- **If you are a full-time employee** (regularly scheduled to work 40 hours per week), your coverage will begin on the first of the month after your hire date, as long as you enroll before your hire date or within 31 days after your hire date.
- **If you are a part-time employee** (regularly scheduled to work at least 20 but less than 40 hours per week), your coverage will begin on the first of the month following your 60-day waiting period,

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

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

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

If Your TACC is $60,000 or more

If your TACC in effect for a plan year is $60,000 or more, enrollment is optional. Please give serious consideration to the advantages of LTD coverage before deciding not to enroll, see “Advantages of Electing LTD Coverage” on page 279.

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

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

Your Group LTD benefit is subject to offset by other disability-related income benefits. Please see “Defined Terms” beginning on page 301 for the definition of “Benefits Offset.”

If you elect “No Coverage” and your employment subsequently ends due to total disability, your participation in certain JPMorgan Chase benefits plans will end (see “If You Do Not Enroll” on page 286). If you do not enroll in Group LTD coverage, you may still elect Individual Disability coverage, if eligible.

How to Enroll If Your TACC is $60,000 or more

If You Are an Current Employee Already Enrolled

If your TACC in effect for a plan year is $60,000 or more and you meet the requirements outlined under “Eligibility” on page 279 and you don’t want to make any changes, you do not need to take action during Annual Enrollment.

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

Please Note: Evidence of Insurability (EOI) will be required if you increase your coverage amount, see “Evidence of Insurability” on page 281. If your EOI is approved by Prudential, your new coverage amount is effective as of January 1, assuming it has been approved as of that date. This coverage amount will remain in effect unless you elect to change it during a subsequent annual benefits enrollment (a future election to increase your coverage level would also be subject to EOI).

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

If you do not enroll for LTD coverage when you are first eligible and then later choose to elect and are approved for coverage, you will not be covered for a claim due to a condition that predates your coverage effective date (see “Pre-Existing Condition Exclusion” on page 286).

If You Are a Newly Eligible or Newly Hired Employee

If you’ve just joined JPMorgan Chase, or you are newly eligible due to a work status change, your TACC is $60,000 or more and you are enrolling during your initial eligibility period, you can make your elections through the Benefits Web Center on **My Health** or through HR Answers. You must meet the actively-at-work definition in “Defined Terms” beginning on page 301 and the requirements outlined under “Eligibility” on page 279, No Evidence of Insurability is required in these situations.

Your coverage effective date depends on whether you are a full-time or part-time employee. If you are a full-time employee, you need to make your choices within 31 days of your date of hire. If you are a part-time employee, you need to make your choices within 31 days before becoming eligible.

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

You can access your benefits enrollment materials online at **My Health** > New Hire Information.

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

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

If You Do Not Enroll

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

- Your total annual cash compensation is $60,000 or more and you choose not to enroll in Group LTD coverage (or the IDI Plan, if you are eligible), or
- You enroll in Group LTD coverage but are denied benefits under the plan,
- You do not elect Group LTD but enroll in IDI coverage and are denied disability benefits, or
- You are not on approved additional leave as a reasonable accommodation under the Accommodating Disabilities and Temporary Work Restrictions Policy. For details, go to **me@jpmc** > HR Policies > Leaves of Absence > Short-Term Disability

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

In addition, if you do not enroll for Group LTD coverage when you are first eligible and then later choose to elect and are approved for coverage, you will not be covered for a claim due to a condition that predates your coverage effective date (see “Pre-Existing Condition Exclusion” on page 286).

Pre-Existing Condition Exclusion

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

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

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

Offsets for Disability Benefits from Other Sources

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

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

With the exception of certain retirement payments, Prudential will only subtract sources of income that are payable as a result of the same disability. Prudential will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

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

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

Mental Illness and Substance Abuse Benefits

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

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

Important Plan Definitions

Please see "Defined Terms" on page 301 for the definition of "Hospital" and "Mental/Nervous Condition."

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

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

Limitations on Certain Benefits

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

When Disability Benefits Begin and End

Benefits can begin after your elimination period has been satisfied if Prudential determines that you are disabled. Please see "Defined Terms" on page 301 for the definition of "Elimination Period" and "Disabled."

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

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

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

- You are no longer disabled (as determined by Prudential);
- You fail to provide satisfactory evidence of your disability;
- You refuse to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by an independent doctor;
- You are no longer under the care of a physician;
- Your disability earnings exceed the amount allowable;
- During the first 24 months of payments, you are able to return to your regular occupation on a part-time basis and choose not to;
- After 24 months of payments, you are able to work in any gainful occupation on a part-time basis but choose not to;
- When you are able to work in your regular occupation on a ***part-time basis*** but you choose not to (applies only to employees whose TACC is greater than $200,000);
- No further benefits are payable under any provision of the plan that limits benefit duration (e.g., mental illness and substance abuse); or
- You pass away.

Benefits Provided to Your Family If You Pass Away

When Prudential receives proof that you have passed away, it will pay your eligible survivor a benefit equal to 3 months of your gross disability payment.

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

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

Return-to-Work Program

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

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

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

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

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

How Your Benefits Are Determined If You Are Disabled and Working

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

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

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

- **During the first 12 months of working while disabled,** you'll receive the regular monthly Group LTD benefit you're eligible to receive from Prudential, unless your earnings while disabled plus your "gross disability payment" exceed 100% of your indexed monthly earnings. (Your "gross disability payment" is your monthly Group LTD benefit from Prudential before any *other income benefits* are deducted.) If the amount exceeds 100%, Prudential will subtract the amount over 100% from your monthly Group LTD benefit.

- **After the first 12 months of working while disabled,** you'll receive Group LTD benefits from Prudential based on the percentage of income you are losing due to your disability. While you are working and receiving Group LTD benefits, Prudential requires that you provide them with proof of your earnings while disabled. Proof of earnings includes any appropriate financial records that Prudential believes are necessary to determine your earnings while disabled.

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

Social Security and Group LTD Benefits

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

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

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

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

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

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

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

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

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

Prudential
Disability Management Services
PO BOX 13480
Philadelphia, PA 19176

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

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

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

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

Social Security Offset Example	
The following example shows how Social Security disability benefits would affect your benefit under Group LTD coverage.* It assumes that when you became disabled, you:	
Earned this monthly base salary:	$2,500
Chose this plan coverage option:	60% of Total Annual Cash Compensation (TACC)
Were eligible to receive this monthly Group LTD benefit:	$1,500
Were eligible to receive this monthly Social Security disability benefit:	$800
Given these assumptions, Group LTD coverage would pay a monthly benefit of $700 ($1,500 minus $800).	

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

Overpayment of Group LTD Benefits

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

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

What Is Not Covered

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

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

Please Note

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

Claiming Benefits

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

How to File Claims

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

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

Group LTD Claims Process	
If You Have a Non-Occupational Total Disability	**If You Have an Occupational Disability**
• If your disability under the Short-Term Disability Plan could potentially continue beyond 26 weeks, your claim is automatically referred to Group LTD administrator, if you were automatically enrolled for Group LTD or you elected this coverage; and • Prudential will determine whether you're eligible for benefits under Group LTD.	• Prudential is notified of an occupational disability (workers' compensation) claim for Group LTD benefits; and • Prudential determines your eligibility under Group LTD, and works with the workers' compensation carrier.

Prudential will stay in contact with you through the duration of your disability, requiring updates on your medical information. When your licensed practitioner determines you may return to work, you should immediately notify your Prudential disability claim manager.

How Individual Disability Insurance ("IDI") Works

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

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

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

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

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

Eligibility

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

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

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

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

How to Enroll

If your TACC is more than $400,000 and you meet the requirements outlined under “Eligibility” on page 279, you will receive separate IDI enrollment information regarding the IDI coverage after the Group LTD enrollment period concludes. In order to receive Individual Disability Insurance, you must complete the IDI enrollment forms and authorize Unum to issue your policy.

If you are a current employee and did not elect IDI coverage when you were first eligible and later wish to enroll, you will be required to submit evidence of insurability, see “Evidence of Insurability” on page 281. Please contact Covala to request the appropriate Unum EOI forms. Your contributions toward the cost of coverage will begin on or near the first day of the pay period after your coverage has been approved. If you elect to reduce or discontinue your IDI coverage during Annual Benefits Enrollment, your election will take effect the following January. If you become newly eligible for IDI due to a change in TACC (set in August of each year), you will receive IDI enrollment materials during the fall. No EOI is required if you elect coverage when you are first eligible for the plan.

If you are a newly hired employee, or newly eligible due to a work status change, and want to elect IDI coverage, and meet the actively-at-work definition as stated under “Defined Terms” beginning on page 301, your IDI coverage is guaranteed and no EOI is required as long as you elect coverage during this first eligibility period. Coverage takes effect as follows:

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

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

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

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

If You Do Not Enroll

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

- Your total annual cash compensation is $60,000 or more and you choose not to enroll in Group LTD coverage (or the IDI Plan, if you are eligible), or

- You enroll in Group LTD coverage but are denied benefits under the plan,
- You do not elect Group LTD but enroll in IDI coverage and are denied disability benefits, or
- You are not on approved additional leave as a reasonable accommodation under the Accommodating Disabilities and Temporary Work Restrictions Policy. For details, go to **me@jpmc** > HR Policies> Leaves of Absence > Short-Term Disability

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

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

Differences from Group LTD coverage

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

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

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

  — coordination of physical rehabilitation and medical services;

  — financial and business planning;

  — vocational evaluation and transferable skills analysis;

  — career counseling and retraining;

  — labor market surveys and job placement services; and

  — evaluation of necessary worksite modifications and adaptive equipment.

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

Recovery Benefit

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

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

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

When Benefits Begin and End

Individual Disability Insurance has an elimination period of 180 days. This means that no benefits are payable under IDI until you have been disabled for 180 days. Benefits can begin after your elimination period has been satisfied if Unum determines that you are disabled. Please see “How to Enroll” on page 293 for the definition of “Disabled” under IDI.

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

If You’re This Age When Disability Begins…	Benefits Are Payable up to…
Under 61	Age 65
61	48 months
62	42 months
63	36 months
64	30 months
65 - 74	24 months
75 or older	12 months

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

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

Benefits Provided to Your Family If You Pass Away

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

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

Continuation of Coverage

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

How Your Benefits Are Determined If You Are Disabled and Working

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

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

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

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

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

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

Overpayment of Plan Benefits

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

What Is Not Covered

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

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

Claiming Benefits

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

Right of Recovery for the Long-Term Disability Plan

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

Subrogation

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

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

Right of Reimbursement

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

- You must reimburse the plan in first priority from any recovery from a third party for the full amount of the benefits the plan paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- Regardless of any allocation or designation of your recovery made in a settlement agreement or court order, the plan shall have a right of full reimbursement, in first priority, from the recovery.

- You must hold in trust for the benefit of the plan the gross proceeds of a recovery, to be paid to the plan immediately upon your receipt of the recovery. You must reimburse the plan, in first priority and without any set-off or reduction for attorney fees or other expenses. The “common fund” doctrine does not apply to any funds recovered by any attorney you retain regardless of whether the funds recovered are used to repay benefits paid by the plan.
- If you fail to reimburse the plan, the plan may deduct any unsatisfied portion of the amount of benefits the plan has paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plan.
- If you fail to disclose the amount of your recovery from a third party to the plan, the plan shall be entitled to deduct the full amount of the benefits the plan paid on your behalf from any future benefits payable under the plan.

Additional Long-Term Disability Plan Information

Your primary contact for all matters relating to the general administration of the JPMorgan Chase Long-Term Disability Plan is HR Answers.

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

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

Recurrent Periods of Disability

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

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

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

If Your Situation Changes

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

Situation	Provision
If Your Work Status Changes	If your work status changes and you become newly eligible for benefits, you will receive enrollment information. You will have 31 days to enroll in Long-Term Disability Plan coverage. No evidence of insurability is required if you enroll during this initial offering. Your coverage begins on the date of your status change. Your Long-Term Disability Plan coverage will end if your work status change changes and you are then scheduled to work fewer than 20 hours per week. Your coverage will end on the date of the work status change.
If You Go on Disability Leave	Under the Short-Term Disability Plan, you may have the financial protection of full or partial pay for up to 25 weeks. For the approved period of your disability leave, you'll remain eligible to be covered under the Long-Term Disability Plan. JPMorgan Chase will deduct any required contributions for long-term disability coverage from the pay you receive during this leave period. If your TACC is $60,000 or greater and your STD leave is denied at any point during the 182 day elimination period, you must continue to pay your LTD premiums on a direct bill basis to be considered for the LTD benefits by Prudential. Payments made on a direct bill basis made on an after tax basis. Note: If you wish to continue certain benefits, you must make the necessary contributions on a timely basis, even if you do not receive a bill.
If You Qualify for Long-Term Disability Benefits	If you receive long-term disability benefits, your contributions for Long-Term Disability Plan coverage are waived for the duration of your approved LTD leave. **Please Note:** Your employment with JPMorgan Chase will end immediately after you have received 24 months of payments under the Long-Term Disability Plan, unless you have requested and been approved for additional leave time as a reasonable accommodation (please see "Termination of Employment After 24 Months of LTD Benefit Payments" on page 283 for more information). You will continue to be eligible for LTD benefits provided you meet all contractual provisions outlined in the plan; however you will cease to be eligible for many of the U.S. benefits plans. If you were on an approved disability leave prior to January 1, 2011, your benefits coverage will continue at active employee rates while you receive benefits under the Long-Term Disability Plan.

Situation	Provision
If You Go on Leave	Your participation in the Long-Term Disability Plan will end after 16 weeks if you go on: • An approved, non-medical paid or unpaid leave of absence, paid or unpaid personal leave of absence; or • Military leave (paid or unpaid). For any unpaid approved leave of absence, you'll still be covered by the Long-Term Disability Plan. JPMorgan Chase will directly bill you for any required contributions on an after-tax basis. However, regardless of whether or not you receive a bill, if you do not make the required contributions to continue your LTD coverage or your approved leave exceeds 16 weeks, your coverage will be canceled. Note: If you wish to continue certain benefits while on any unpaid leave, you must make the necessary contributions on a timely basis, even if you do not receive a bill. Please note your coverage will be automatically reinstated when you return to work if your LTD is company paid (earn less than $60K in Total Annual Cash Compensation). If you pay for your LTD coverage (earn $60K or more in Total Annual Cash Compensation) and your coverage is cancelled, you must re-elect LTD coverage within 31 days of your return to work and you must satisfy Evidence of Insurability before your coverage will be reinstated. Please see the *What Happens If…* section of this Guide for more Information about what happens to your benefits during unpaid Leave of absence (i.e., FMLA, Military Leave).
If You Work Past Age 65	If you continue to work for JPMorgan Chase after you reach age 65, you can continue to be covered under the Long-Term Disability Plan as long as you continue to meet the eligibility requirements and pay the required premiums.
If You Leave JPMorgan Chase	Your participation in the Long-Term Disability Plan will end on the date your employment with JPMorgan Chase terminates. If you elected to be covered by Individual Disability Insurance, you may retain it upon leaving JPMorgan Chase by continuing to pay premiums directly to the insurer.

Appealing Claims

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

Right to Amend

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

JPMorgan Chase also reserves the right to amend any of the plans and policies, to change the method of providing benefits, to curtail or reduce future benefits, or to terminate at any time for any reason any or all of the plans and policies described in this Guide. Neither this Guide nor the benefits described in this Guide create a contract of employment or a guarantee of employment between JPMorgan Chase and any employee.

If you have any questions about this plan, contact HR Answers (please see "Questions?" on page 275 under this LTD section for contact information).

Defined Terms

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

IDI Definitions Differ

For the items marked below with an asterisk, Individual Disability Insurance ("IDI") uses a different definition or has different rules regarding this term. Please see "Differences from Group LTD coverage" on page 294 for information about how this term applies to IDI.

Actively-at-Work	Performing all the duties that pertain to your work on a regular basis at the place where they're normally performed or where they're required to be performed by JPMorgan Chase. A person who works at home must be able to report to a place of employment outside the home. You must be actively-at-work on the date designated by Prudential and/or Unum for either your new coverage or your newly approved increase in your coverage to take effect. Prudential and/or Unum may have additional actively-at-work requirements that are specific to their plans.
After-Tax Contributions	Contributions that are taken from your pay after federal (and in most cases, state and local income taxes) have been withheld. By paying for the plan with after-tax contributions, any benefits you receive from the plan if you become disabled would be tax-free.
Benefits Offset*	Under Group LTD coverage, a reduction for any benefits that could be paid by other disability programs (for example, Social Security or workers' compensation). As a result, your disability benefits paid by other disability programs and Group LTD coverage combined, equal the replacement percentage of Group LTD coverage option you chose (up to the maximum monthly benefit for that option).
Claims Administrator	The company, or its affiliate, that provides certain claims administration services for the Long-Term Disability Plan. The Prudential Insurance Company of America and Unum are the claims administrators for Group LTD coverage and Individual Disability Insurance coverage, respectively.
Group LTD Elimination Period	A period of 182 days before benefits are paid, in which you're prevented from performing the material and substantial duties of your occupation because of an occupational or non-occupational injury or illness. If during an elimination period you recover and are able to return to work as an active employee, the period of time before your return to work will count toward satisfying the requirements for the elimination period if your return to work is for 60 days or less. However, the days that you work as an active employee will not count toward satisfying the requirements for the elimination period.
Evidence of Insurability*	Under Group LTD, information that must be provided to Prudential, the claims administrator, before you can be approved for certain levels of coverage under the plan or if you increase your coverage amount. Evidence of insurability is also required if you apply for Group LTD or Individual Disability Insurance benefits after you are first eligible.
Hospital	Under the LTD Plan, an accredited facility licensed to provide care and treatment for the condition causing the covered person's disability.
Indexed Monthly Earnings	Your monthly pre-disability earnings adjusted on the first of July or following the date of disability by the lesser of 10% or the current annual percentage increase in the Consumer Price Index (CPI). Your indexed monthly earnings may increase or remain the same, but they will never decrease.
Material and Substantial Duties of Your Occupation	Under The Group LTD Plan, a duty that is normally required for the performance of your regular occupation, either because of an occupational or non-occupational injury or sickness, and you are unable to perform the duties of any gainful occupation for which you're reasonable fitted by training, education, and experience.

Mental/Nervous Condition*	Under Group LTD, mental, nervous, substance abuse, or emotional disease or disorders of any type. Conditions that are found to be organic in nature are not considered mental illness.
Other Income Benefits*	Under Group LTD, long-term disability benefits are reduced by certain "Other Income Benefits." These may include other income you may be eligible to receive as a result of the same disability for which the plan benefit is payable or income associated with employment in the same or different occupations. Please see "Offsets for Disability Benefits from Other Sources" on page 287 for examples.
Pre-Existing	Under Group LTD, you have a pre-existing condition if both 1 and 2, below, are true: 1. You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 6 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available. 2. Your disability begins within 12 months of the date your coverage under the plan becomes effective. Please Note: Special rules apply to pre-existing conditions, if this LTD Plan replaces a prior JPMorgan Chase LTD Plan and you were covered by the former plan on the day before this Plan became effective and you became covered under this Plan within 31 days of its effective date.
Total Annual Cash Compensation	Generally, your Total Annual Cash Compensation (TACC) is your annual rate of base salary/regular pay plus any applicable job differential pay (e.g., shift pay) as of each August 1, plus any cash earnings from any incentive plans (e.g., annual incentive, commissions, draws, overrides, and special recognition payments or incentives) that are paid to or deferred by you for the previous 12-month period ending each July 31. Overtime is not included. It is recalculated as of each August 1 to take effect the following January 1 and will remain unchanged throughout the year. For most employees hired on or after August 1, it will be equal to base salary/regular pay plus applicable job differentials. **Please Note:** If you are not actively-at-work as of January 1 on any given year, your Total Annual Cash Compensation for purposes of the Long-Term Disability Plan will be the TACC amount that was in effect for the previous calendar year, and your long-term disability contributions and benefit will be calculated using that amount. Once you are actively-at-work, your TACC will change to the amount that was communicated to you during the fall Annual Benefit Enrollment.

Life and Accident Insurance

Effective 1/1/21

The JPMorgan Chase Life and Accident Insurance Plans ("Plans") provide eligible employees with the security that comes from knowing you have a complete package of insurance protection suited to your personal situation. You're automatically provided with certain company-paid life and business travel accident insurance to help provide financial protection to your beneficiaries if you become injured or die. You can also purchase employee and dependent supplemental term life insurance and accidental death and dismemberment (AD&D) insurance at group rates.

This section will provide you with a better understanding of how your coverage under the Life and Accident Insurance Plans works, including how and when benefits are paid.

Be sure to see important additional information about the 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 Life and Accident Insurance 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 this insurance, contact Metropolitan Life Insurance, Co., (MetLife), the Plans' claims administrator:

(800) MET-LIFE ((800) 638-5433)

Representatives are available from 8 a.m. to 8 p.m. Eastern Time, Monday – Friday.

For additional resources, including information on how to contact the Business Travel Accident plan administrator, 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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Life and Accident Insurance Highlights

Automatic, Company-Provided Coverage

If you're an eligible employee, you are automatically covered with basic life insurance that pays benefits to your designated beneficiary(ies) if you die while actively employed and business travel accident insurance if you die or are injured while traveling on business for JPMorgan Chase. You don't need to enroll or provide evidence of insurability (EOI), and JPMorgan Chase pays the full cost of this coverage.

Optional Coverage

You can elect to purchase supplemental term life and accidental death and dismemberment insurance for yourself and/or your eligible dependents through MetLife, the insurance carrier on an after-tax basis. You may have to provide EOI before certain levels of life insurance become effective.* Your choices for supplemental life and accident insurance include:

- **Employee supplemental term life insurance.** You can purchase coverage in $10,000 increments up to 10 times your Total Annual Cash Compensation (TACC) (rounded to the next $10,000) to a maximum of $3 million. **Please Note:** If your TACC decreases in the future, your maximum insurance amount of 10 times your TACC will be likewise reduced. Also please note that you cannot waive the company-provided basic life and enroll for employee supplemental term life coverage — you must have the basic coverage to purchase the supplemental coverage.
- **Dependent supplemental term life insurance.** Generally, you can purchase coverage in $10,000 increments up to a maximum of $300,000 for your spouse/domestic partner and/or $5,000, $10,000, $15,000 or $20,000 in coverage for each child. **Please Note:** You do not have to elect supplemental coverage for yourself in order to purchase dependent supplemental term life insurance.
- **Employee accidental death and dismemberment (AD&D) insurance.** You can purchase AD&D insurance for financial protection in case of accidental death or certain accidental injuries. Coverage is available in $10,000 increments up to 10 times your Eligible Compensation (rounded to the next $10,000) to a maximum of $3 million. **Please Note:** If your Eligible Compensation decreases in the future, your maximum insurance amount of 10 times your Eligible Compensation will be likewise reduced.
- **Dependent accidental death and dismemberment (AD&D) insurance.** You can purchase coverage between $10,000 and $600,000 (in increments of $10,000) for your spouse/domestic partner and/or $10,000 increments up to a maximum of $100,000 for each child. To purchase AD&D insurance for your dependent child(ren), you must elect either employee coverage or spouse/domestic partner AD&D coverage, or both.

Different Compensation Definitions

Your employee coverage is based on your compensation, but there are two different definitions used – Total Annual Cash Compensation (TACC) and Eligible Compensation:

- Basic Life insurance is based on Total Annual Cash Compensation (TACC).
- The maximum amount of supplemental term life insurance you can purchase is based on TACC.
- AD&D insurance is based on Eligible Compensation.

See the definitions in "Defined Terms" on page 331.

Name Your Beneficiaries

The Online Beneficiary Designations site provides a convenient way to name, review and update your beneficiary information for your life and accident coverage, You can access the site:

- From work: **My Health** > Dental, Vision, and Other Insurance > Online Beneficiary Designation
- From home: beneficiary.jpmorganchase.com

You can also contact HR Answers.

Costs

JPMorgan Chase pays the full cost of your basic life insurance and business travel accident insurance.

You pay the full cost of the supplemental term life insurance and accidental death and dismemberment (AD&D) insurance you elect for yourself, your spouse/domestic partner, and your eligible dependents on an after-tax basis.

Additional Basic Life Benefits	In addition to life insurance coverage, the company-provided basic life insurance includes the Identity Theft (ID) Assistance Program, Travel Assistance and Emergency Evacuation services, funeral concierge services, and SurvivorSupport® Financial Counseling Services. See "Additional Benefits" on page 316 for more information.
Convertibility and Portability of Coverage	If you leave JPMorgan Chase, generally employee and dependent supplemental term life and AD&D insurance coverage is generally convertible, portable, or both — meaning you can continue coverage through a direct billing arrangement with MetLife at a higher rate. More details are found within each insurance section.

* Certain states have additional, specific requirements. Please refer to MetLife for state-specific rules.

Eligibility and Enrollment

The general guidelines for participating in the JPMorgan Chase Life and Accident Insurance Plans are described in this section.

Insurance Rules Govern

Because most benefits described here are provided by insurance, the terms of the insurance policy or certificate will control eligibility for benefits. If there is a discrepancy between this description and the policy or certificate, the policy or certificate will control.

Who's Eligible?

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

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

However, in the case of the Business Travel Accident Insurance Plan, all employees of JPMorgan Chase or a participating company are automatically covered by this insurance.

Who's Not Eligible?

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

Examples of such individuals include an:

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

Eligible Dependents

For details about your eligible dependents under the Dependent Supplemental Term Life Insurance Plan and the Dependent Accidental Death and Dismemberment (AD&D) Insurance Plan, please see "Eligible Dependents" in the *Health Care Participation* section.

Cost of Coverage

JPMorgan Chase pays the full cost of your coverage under the Basic Life Insurance Plan and the Business Travel Accident Insurance Plan.

You pay the full cost of any employee and dependent coverage you elected on an after-tax basis under the Supplemental Term Life Insurance Plan and the Accidental Death and Dismemberment (AD&D) Insurance Plan.

Your cost for coverage for supplemental term life insurance for a plan year depends on your and/or your spouse's/domestic partner's age as of December 31 of that plan year, tobacco user status, and elected amount of coverage. The cost you pay for your children is the same, regardless of the number of children you have. The cost you pay for AD&D insurance for yourself and/or your dependents, including your spouse/domestic partner or children, depends on the amount of coverage you elect.

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.

From time to time, refunds or adjustments of contributions and proceeds from demutualizations are received, which are associated with these and other plans and prior plans of heritage companies. These funds will be placed in trust and will be used solely for the employee plan purposes for which employees pay the costs, including the reduction of contributions for life, AD&D, disability, or other employee-paid insurance. Or, these funds will be used to provide benefits under such plans or prior plans.

Imputed Income

You must pay income taxes on the value of your company-provided basic life insurance above $50,000. This value is called "imputed income" and becomes part of your taxable income reported on your W-2. If your Total Annual Cash Compensation (TACC) is greater than $50,000, you can choose to limit your basic life coverage to $50,000. However, if you later wish to increase your coverage, evidence of insurability (EOI) rules will apply. Contact HR Answers for more information.

Tobacco User Status

Employees and their covered spouses/domestic partners who do not use tobacco products pay less for supplemental term life insurance coverage. Your contribution(s) may be greater if you or your covered spouse/domestic partner was a tobacco user during the prior calendar year. Use of tobacco means use of tobacco in any form including cigarettes, cigars, pipes, or smokeless tobacco (dip, chewing). Each year, employees must verify their status as a non-tobacco user or tobacco user, as well as the status of their covered spouse/domestic partner under the applicable Plans.

To be considered a non-tobacco user and pay lower, non-tobacco user rates for a plan year, you and/or your covered spouse/domestic partner must either:

- Be tobacco-free for at least 12 months as of January 1 of that plan year; or
- Complete an approved tobacco cessation program.

If you continue to use tobacco, you will need to complete an approved tobacco cessation course annually to continue to qualify for the lower, non-tobacco user rates. If you and/or your covered spouse/domestic partner meet the definition of a tobacco user but fail to declare your tobacco user status, you may be subject to disciplinary action.

How Tobacco User Is Defined

Under the JPMorgan Chase Benefits Program, a person who has used any type of tobacco product, smoked or not smoked (e.g., cigarettes, cigars, pipes, chewing tobacco, snuff, etc.) regardless of the frequency or location (this includes daily, occasionally, socially, at-home only, etc.) in the 12 months preceding any January 1 is considered a "tobacco user."

First Year Opportunity

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

If you were hired on or after October 1, for the current plan year and in the following plan year, you will be assigned non-tobacco user rates for your and your covered spouse's/domestic partner's coverage even if you declare yourself and/or your covered spouse/domestic partner as a tobacco user, because you may not have had an opportunity to complete a tobacco cessation program in order to qualify for the lower, non-tobacco user rates.

You'll receive more information regarding the opportunity to update your tobacco user status during each annual benefits enrollment period.

For more information on the Tobacco Cessation Program, please go to **My Health**.

How to Enroll

Participation in the Basic Life Insurance Plan and Business Travel Accident Insurance Plan is automatic — you don't need to enroll. The Basic Life Insurance Plan also includes the following additional benefits:

- Identity (ID) Theft Assistance Program;
- Travel Assistance and Emergency Evacuation Services;
- Funeral Concierge Services; and
- SurvivorSupport® Financial Counseling Services.

Participation in the Supplemental Term Life Insurance Plan and Accidental Death and Dismemberment (AD&D) Insurance Plan is optional. You must enroll during an enrollment period to have coverage.

EOI May Be Required

Depending on your Supplemental Term Life Insurance Plan election, you may be required to provide evidence of insurability (EOI). (Please see "Evidence of Insurability" on page 319 for more information.) **Please Note:** There are no EOI requirements for AD&D insurance. Life insurance changes made during Annual Benefits Enrollment (following your new hire election period) will require EOI. Your new coverage — and any associated contributions — will not take effect until it is approved by the insurance carrier.

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

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

Enrolling if You Are an Employee

During Annual Benefits Enrollment, you can make your elections through the Benefits Web Center on **My Health** or through HR Answers. At the beginning of each enrollment period, you'll receive instructions on how to enroll.

You'll also receive information about the choices available to you and their costs at that time. You need to review your available choices carefully and enroll in the option that best meets your needs. You can't change your choices during the year unless you have a Qualified Status Change (QSC). Please see "Changing Your Coverage Midyear" on page 313 for more information.

Enrolling if You Are a Newly Hired Employee

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

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

If you enroll for supplemental term life insurance when you are a newly hired employee, you are allowed to enroll for supplemental term life insurance for an amount up to the lesser of three times your Total Annual Cash Compensation (TACC) or up to $500,000 without having to submit EOI. You can enroll a spouse/domestic partner for an amount up to $50,000 without having to submit EOI. Elected amounts above these guaranteed issue amounts will be subject to EOI and will not be effective until approved by MetLife. Please see "Evidence of Insurability" on page 319 for more information. Note that special enrollment periods may be offered from time to time, and the insurance carrier may have slightly different EOI rules during that special enrollment period.

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

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

If you're enrolling during the year because you're a newly eligible employee due to a work status change or you have a Qualified Status Change (QSC), you'll have 31 days from the date of the change in status to make your new choices through the Benefits Web Center on **My Health** or through HR Answers. Please see "Changing Your Coverage Midyear" on page 313 for more information.

Beneficiaries

A beneficiary is the person, people, estate, or entity you name to receive benefits from the Life and Accident Insurance Plans if you die. You can name anyone as your beneficiary — including a trust — or you can name more than one person to share the benefit. You can also change your beneficiary at any time, and you can have different beneficiaries for each separate benefit plan.

Keep in mind that if you name more than one person as your primary beneficiary, you should specify what percentage of your benefit each primary beneficiary would receive and these amounts must total 100%. You may also name contingent beneficiaries; these beneficiaries are entitled to receive a benefit only in the event the primary beneficiary(ies) predecease the employee. (The distribution across contingent beneficiaries must total 100%.) If you do not specify what percentage of your benefit should be distributed to each named beneficiary, the allocation occurs equally within each category.

If you do not have a designated beneficiary (or all of your named beneficiaries die before you), benefits will be paid in the following order:

- **For company-paid life and business travel accident insurance, employee supplemental term life insurance and employee accidental death and dismemberment (AD&D) insurance:**
  - — Surviving spouse
  - — Surviving children (in equal shares)
  - — Surviving parents (in equal shares)
  - — Surviving siblings (in equal shares)
  - — Your estate

To designate a beneficiary (including a domestic partner), you must submit an online beneficiary designation form. The form is available:

- **From the intranet:** me@jpmc > Benefits & Rewards > View or Update Beneficiaries
- **From the internet:** beneficiary.jpmorganchase.com
- A paper form is also available by calling HR Answers.

Note: The beneficiary information you provide online or through a paper form must be completed correctly. Please note that MetLife has been delegated responsibility to review beneficiary designations. In the event MetLife rejects a beneficiary election, the most recent prior designation on file, if any, will remain in effect until receipt of a new valid election. All questions concerning the status of an individual as beneficiary under the Plan shall be referred to MetLife for review, with MetLife making the final decision. A beneficiary designation form will remain in force until a new valid form is received. Therefore, if you have designated your spouse by name as your beneficiary on a Beneficiary Designation form, and you subsequently divorce, your beneficiary designation of your former spouse remains in effect until you designate a new beneficiary(ies) even if you were to remarry. If you would like to designate your new spouse as your beneficiary, you must complete a new Beneficiary Designation Form.

- **For dependent supplemental term life insurance, and dependent accidental death and dismemberment (AD&D) insurance:** You're automatically the beneficiary for your spouse/domestic partner and/or children. If you and your spouse/domestic partner both work for JPMorgan Chase, the parent who covers the child(ren) is the beneficiary.
- **For Business Travel Accident Plan:** If your spouse/domestic partner and/or dependent child pass away while they accompany or are on their way to accompany you on an authorized, company-paid business trip while you are covered under the plan, you are the beneficiary for that covered individual. If you and your spouse/domestic partner both work for JPMorgan Chase, and your dependent child passes away while accompanying either parent or on their way to accompany either parent on an authorized business trip, the beneficiary is the parent whose business travel was involved when the dependent child's death occurred.

Assignment of Benefits

You're entitled to transfer your basic and supplemental term life insurance and accidental death and dismemberment (AD&D) insurance ownership rights to another person, people, trust, or estate. Generally, the primary reason for making an assignment (i.e., transfer ownership) of your life insurance is estate planning. For more information, please contact MetLife at (800) MET-LIFE [(800)-638-5433].

If You Do *Not* Enroll

Coverage if You Do Not Enroll and You Are an Employee

If you're already participating in the life and accident insurance plans and do not change your elections or cancel coverage during Annual Benefits Enrollment, you'll generally keep the same coverage you had before Annual Benefits Enrollment for the next year. However, you'll be subject to any changes in the Plan and coverage costs.

Please Note: If you are participating at the maximum level of employee supplemental term life insurance and/or employee accidental death and dismemberment (AD&D) insurance and your Total Annual Cash Compensation and/or Eligible Compensation decreases, your employee supplemental term life insurance and/or AD&D insurance will also decrease.

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

If you're a newly hired or newly eligible employee and do not enroll before the end of the designated 31-day enrollment period, you will not be able to make the change in coverage until the following annual benefits enrollment period. Supplemental term life insurance elections will require you to provide evidence of insurability (EOI) at that time. Please see "Changing Your Coverage Midyear" on page 313 for more information.

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

If you have a Qualified Status Change (QSC) that allows you to enroll in supplemental term life insurance and/or accidental death and dismemberment (AD&D) insurance midyear and you do not actively enroll within the designated 31-day period, you won't be able to choose supplemental term life insurance and/or AD&D insurance until the next annual benefits enrollment period.

Please see "Changing Your Coverage Midyear" on page 313 for more information. Supplemental term life insurance elections will require you to provide evidence of insurability. Please see "Evidence of Insurability" on page 319 for more information.

When Coverage Begins

Basic life insurance begins on the first day of the month following your date of hire, if you are a full-time employee. Coverage for part-time employees begins on the first of the month following 60 days from your date of hire. In either case, you must be actively-at-work on the date that your coverage is scheduled to begin.

Business travel accident insurance begins on your date of hire for both full-time and part-time employees. You must be actively-at-work on the date that your coverage is scheduled to begin.

Supplemental Term Life Insurance

Coverage begins based on how you enrolled in the Plan:

- If you complete the enrollment process within 31 days of becoming eligible for insurance, coverage begins as follows:
  - If you **are not required** to give Evidence of Insurability (EOI), your coverage will begin on the date you become eligible if you are actively at work on that date. Payroll deductions will begin as soon as administratively possible.
  - If you **are required** to give EOI and MetLife approves your EOI, your coverage will begin on the date MetLife states in writing, provided you are actively at work on that date. Payroll deductions begin as soon as administratively possible.
  - If you are not actively at work on your coverage begin date, coverage will begin on the day you resume active work. Payroll deductions begin as soon as administratively possible.
- If you enroll or make changes during an annual enrollment period, coverage begins as follows:
  - For any amount for which you **are not required** to give EOI, coverage begins on the first day of the calendar year following the annual enrollment period, if you are actively at work on that date. Payroll deductions occur in first payroll cycle.
  - For any amount for which you **are required** to give EOI and MetLife approves that amount, coverage begins on the date MetLife states in writing, if you are actively at work on that date.
    - If EOI is approved before the beginning of the year, payroll deductions begin with first pay cycle of the year.

- If EOI is approved after the first of the year, then payroll deductions begin as soon as administratively possible after approval.

— If you are not actively at work on the date coverage would begin, coverage will begin on the day you return to active work. Payroll deductions begin as soon as administratively possible.

- If your coverage changes due to a Qualified Status Change (QSC), coverage will begin as follows:

— For any amount for which you **are not required** to give EOI, your coverage will begin on the date of your QSC, if you are actively at work on that date. Payroll deductions begin as soon as administratively possible.

— For any amount for which you **are required** to give EOI and MetLife approves, coverage begins on the date MetLife states in writing, if you are actively at work on that date. Payroll deductions begin as soon as administratively possible.

- If you are not actively at work, then coverage and payroll deductions will begin when you return to work.

Accidental Death and Dismemberment (AD&D) Insurance

The coverage you elect during Annual Benefits Enrollment generally takes effect the beginning of the following plan year (January 1) as long as you are actively-at-work on your first scheduled day on or after this effective date. There is no EOI required for AD&D insurance.

If you are newly eligible for coverage and complete the enrollment process within 31 days of becoming eligible for insurance, your coverage will begin on the date you become eligible if you are actively at work on that date. Payroll deductions will begin as soon as administratively possible. If you are not actively at work, coverage and payroll deductions begin when you return to active work. There is no EOI required for AD&D insurance.

If you have a change in work status, or experience a Qualified Status Change (QSC), and you elect to change your AD&D elections based on that status change, your coverage will begin on the date of the status change. Payroll deductions begin as soon as administratively possible. There is no EOI required.

Changing Your Coverage Midyear

The Supplemental Term Life Insurance Plan and/or Accidental Death and Dismemberment (AD&D) Insurance Plan elections you make during Annual Benefits Enrollment will stay in effect through the following plan year (or the current plan year if you enroll during the year as a newly eligible employee). However, you may be permitted to change your elections before the next Annual Benefits Enrollment if you have a Qualified Status Change (QSC). **Please Note:** Any changes you make during the year must be consistent with your QSC.

You need to enroll, add and/or drop your eligible dependents **within 31 days of the qualifying event** for benefits to be effective on the date of the event. **Please Note:** See "*If You Do Not Enroll*" on page 311 for details on what happens if you miss the 31-day enrollment period.

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

You and/or your eligible dependents may need to satisfy certain evidence of insurability (EOI) requirements for the Supplemental Term Life Insurance Plan, as determined by the claims administrator, before coverage due to a QSC can begin. (Please see "Evidence of Insurability" on page 319 for more information.) See "When Coverage Begins" on page 312 for details.

Qualified changes in status under the Supplemental Term Life Insurance Plan and Accidental Death and Dismemberment (AD&D) Insurance Plan are listed in the following table.

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

When Coverage Ends

Generally, your coverage for Basic Life, Supplemental Term Life Insurance, AD&D, and BTA ends on the last day of active employment with JPMorgan Chase. Your coverage can also end when:

- You stop paying applicable premiums; or
- After you have been receiving long-term disability benefits for 24 months
  - For the Business Travel Accident Insurance, coverage ends the first day you begin receiving long-term disability benefits, unless you are temporarily approved for additional leave under another JPMorgan Chase Policy, such as the Disability and Reasonable Accommodation Policy.

When Dependent Coverage Ends

Coverage for your dependents ends when your coverage ends (such as if you leave JPMorgan Chase or otherwise become ineligible for JPMorgan Chase coverage).

Your dependents' coverage can end sooner, when the dependent(s) no longer meet the eligibility requirements for the applicable plan.

- For your spouse, this means the last day of the month in which you pass away or you divorce.

- For your domestic partner, this means the last day of the month in which the domestic partner ceases to meet the eligibility requirements described the descriptions of domestic partner eligibility.
- For your child, this means the last day of the month in which he or she turns age 26.
  - **Please Note:** You can continue child life insurance coverage beyond age 26 for an unmarried child who is enrolled for that coverage and is deemed not capable of supporting himself or herself due to a mental or physical disability that began before the age limits described above and who is dependent on you for financial support and this has been verified by the claims administrators.

Continuing Coverage After It Ends

When employee group coverage for certain insurance plans ends, the insurer may offer ways to continue coverage. The two most common options for continuing coverage are “conversion” and “portability” (also known as “porting” coverage).

- With conversion, you transfer the coverage to non-group coverage without having to meet any eligibility requirements.
- Portability allows you to continue your coverage after it ends, under a separate group policy with group rates. When you port a policy, you must provide proof of insurability to receive preferred, or less expensive, premiums.

The options to continue coverage are described in each of the plan-specific sections that follow.

Please Note: Your coverage under the Business Travel Accident Insurance Plan ends on your termination date. You may not convert or port this coverage to an individual policy.

Company-Paid Basic Life Insurance

Your company-paid basic life insurance is equal to one times your Total Annual Cash Compensation (TACC), up to $100,000. If your TACC is not an even multiple of $1,000, your coverage will be raised to the next higher $1,000. JPMorgan Chase pays the full cost of this coverage.

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

Upon termination of employment, your company-paid Basic Life Insurance is cancelled.

Your basic life insurance benefit is paid to your beneficiary upon your death, regardless of the reason for your death. Please see “Beneficiaries” on page 310 for more information about naming a beneficiary.

The Basic Life Insurance Plan is provided through an insurance policy issued by Metropolitan Life Insurance Company (MetLife).

Imputed Income

Under the Internal Revenue Code, JPMorgan Chase must report as income the value of any company-provided basic life insurance in excess of $50,000. This value is called “imputed income,” and it becomes part of your taxable income reported on your W-2. If your Total Annual Cash Compensation (TACC) is greater than $50,000, you can choose to limit your basic life insurance amount to $50,000 to avoid imputed income. If you do that, your coverage amount will remain fixed at $50,000 even if your TACC increases. Please contact HR Answers if this applies to you.

Please Note: If you choose to limit the amount of your basic life insurance, you will need to satisfy evidence of insurability (EOI) to increase coverage at a later date. Please see “Evidence of Insurability” on page 319 for more information.

When Benefits Are Paid

Employee basic life insurance is paid to your beneficiary. Payment is made after MetLife, the claims administrator, receives satisfactory evidence of a covered person's death (e.g., a certified death certificate).

Accelerated Benefit Option

If you are diagnosed with a terminal illness that's expected to result in death within 12 months, you can apply for an accelerated benefit option equal to 80% of your basic life coverage amount, not to exceed $80,000.

Upon payment of this benefit, your life insurance is reduced by the amount approved for payment. Accelerated benefit option payments are excluded from your gross income and, therefore, are exempt from federal income tax. Please see your tax advisor regarding any other tax consequences. Upon your death, the reduced amount of life insurance will be paid to the beneficiary. Please see "Beneficiaries" on page 310 for more information.

If you elect the Accelerated Benefit Option, you may still receive SurvivorSupport® Financial Counseling Services.

Converting Basic Life Insurance

Your company-paid coverage under the Basic Life Insurance Plan ends on your termination date. You have the ability to convert your coverage to a policy with MetLife. Upon receipt of your conversion package at your address on record, and within 31 days of your termination date, you may convert any portion of your Basic Life Insurance to an individual policy by contacting MetLife. 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.

Additional Benefits

As an added benefit of your company-paid Basic Life Insurance Plan, you are entitled to the following programs. **Please Note:** You cannot port or convert coverage under the following programs following your termination date.

SurvivorSupport® Financial Counseling Services

If you die while actively employed or while receiving long-term disability (LTD) benefits (please see "You Go on Long-Term Disability" in the *What Happens If …* section, the Plan provides your surviving spouse or other key adult survivor with free financial planning services for a period of six months following your date of death. These services are provided by Ayco Company, a nationally recognized financial consulting firm. (Ayco does not sell any products or services.) Ayco is not an affiliate of MetLife. Services include assistance with:

- Settling the estate;
- Cash-flow planning;
- Income-tax counseling; and
- Insurance and estate planning.

Participants receive comprehensive, objective financial counseling from experienced Ayco counselors familiar with JPMorgan Chase's benefits. The counselor coordinates the efforts of the participant's attorney, accountant, insurance agent, and/or broker to develop a strategy and implement it. Participants receive:

- A telephone counseling session with an Ayco counselor in which financial concerns will be identified and resolved. Family members, attorneys, and other support people are encouraged to attend. Additional meetings may be scheduled, depending on the complexity of the issues.

- A personalized financial plan to help organize the steps to take now and in the future.
- The SurvivorSupport® Reference Guide — an interactive workbook that includes step-by-step worksheets, tables, and illustrations to help the participant evaluate relevant aspects of his or her financial situation.
- Direct toll-free telephone access to financial counselors for six months from the date of death.
- Monthly telephone follow-up.

This list is subject to change at any time.

Identity (ID) Theft Assistance Program

You are entitled to identity theft protection, provided at no cost to you, offered by AXA Assistance. The ID Theft Assistance Program educates you about the threats of identity theft and how you and your eligible dependents can ensure the security of your personal information. AXA Assistance can help guide you through the recovery process if your identity or that of your eligible dependents is compromised. The service can be accessed 24 hours a day, 365 days a year. (AXA is not an affiliate of MetLife.) This benefit is also available to your family members.

Travel Assistance and Emergency Evacuation Services

Travel Assistance and Emergency Evacuation Services are administered by AXA Assistance, and are provided to you and your family members at no cost. Services include direct, worldwide access to prompt assistance in the event of an unexpected medical emergency when you are traveling 100 miles (100 kilometers outside the United States) or more from home, up to certain dollar limits and a 120-day limit. These services can also provide you with domestic and international legal referrals. This benefit is also available to your family members. Your family members do not need to be enrolled in coverage (as long as you are an active employee enrolled in Basic Life Insurance).

A full range of emergency assistance services is available to you, including:

- Emergency medical evacuation;
- Political and natural disaster evacuation;
- Medically necessary repatriation;
- Transportation of mortal remains;
- Transportation of escort;
- Family visitation;
- Minor children return/escort;
- Vehicle return;
- 24-hour information service;
- Medical monitoring;
- Medical referral;
- Guarantee of medical expenses;
- Insurance coordination;
- Lost document service;
- Legal assistance;
- Emergency delivery of prescription items;

- Emergency cash transfers and advances; and
- Language assistance.

This list is subject to change at any time.

The Travel Assistance and Emergency Evacuation Services Center's multilingual staff (including physicians and nurses) is available 24 hours a day, 365 days a year to provide prompt assistance when you have an emergency.

For more information or to secure services please contact:

Within the United States: (800) 454-3679
Outside the United States Call Collect: (312) 935-3783
Or log onto:
www.metlife.com/travelassist

Funeral Concierge Services

Funeral Planning Services, offered by Dignity Memorial, (the largest U.S. funeral network) is available to the insured, their spouse and extended family (children, parents, grandparents and great-grandparents) and provides discounts of up to 10% off of funeral, cremation and cemetery services. This service provides unlimited access to Dignity Memorial's planning website, a comprehensive end-of-life planning tool, a funeral planning resource library, a Dignity Memorial funeral home locator tool, bereavement travel services, catering, floral arrangements, Compassion Helpline®, as well as veteran's burial benefits and military funeral honors.

Additional Services: Grief counseling, assistance with locating a funeral home and cemetery, and cost comparisons for funeral planning options is available through LifeWorks. LifeWorks is not a concierge service.

Supplemental Term Life Insurance

The Supplemental Term Life Insurance Plan is provided through an insurance policy issued by Metropolitan Life Insurance Company (MetLife). You may elect to obtain supplemental term life insurance for yourself, as well as your spouse/domestic partner and your eligible children. The following information describes your options under the Supplemental Term Life Insurance Plan.

Employee Supplemental Term Life Insurance

The Supplemental Term Life Insurance Plan lets you choose amounts of employee coverage according to your own needs. You can enroll for coverage in $10,000 increments up to 10 times your Total Annual Cash Compensation (TACC) (rounded up to the next $10,000) to a maximum of $3 million. **Please Note:** If you enroll for the maximum amount of coverage and your TACC subsequently decreases, your coverage will decrease accordingly.

Dependent Supplemental Term Life Insurance

JPMorgan Chase also offers dependent supplemental term life insurance for your spouse/domestic partner and each of your eligible children. Your options include:

- Spouse/domestic partner coverage in $10,000 increments up to a maximum of $300,000; and/or
- Child coverage of $5,000, $10,000, $15,000 or $20,000 per child.

Please Note: You may choose supplemental term life insurance for your spouse/domestic partner and child(ren) even if you do not elect coverage for yourself.

If your spouse is also a JPMorgan Chase employee, he or she can elect coverage as an employee and be also covered as your spouse.

Evidence of Insurability

In certain instances, you may need to provide evidence of insurability (EOI) if you want to elect supplemental term life insurance above a certain amount for yourself and/or your spouse/domestic partner. (There are no EOI requirements to cover children.) EOI may be required for coverage elected during your designated enrollment period if:

- You're electing new coverage or increasing employee supplemental term life insurance; or
- You're electing new coverage or increasing adult dependent supplemental term life insurance.

You can access and complete the EOI form online on the Benefits Web Center.

If you do not complete the form online, you will be mailed a paper copy by Metropolitan Life Insurance Company (MetLife), the claims administrator, after you enroll. If you do not complete and return the EOI form, or if your application is not approved by the claims administrator, only elected coverage amounts not requiring EOI, if any, will be effective.

If you cancel or decrease coverage for yourself or your spouse/domestic partner and choose to increase coverage at a later date due to a Qualified Status Change (QSC) or during Annual Benefits Enrollment, all new coverage will be subject to EOI requirements at the time you make the new election.

When you are first eligible for coverage, evidence of insurability is generally required:

- If employee coverage is greater than the lesser of three times your Total Annual Cash Compensation (TACC) or $500,000; and
- If spouse/domestic partner coverage exceeds $50,000.

Special Enrollment Opportunities

Note that special enrollment periods may be offered from time to time, and the insurance carrier may have slightly different EOI rules during that special enrollment period. Special enrollments will be communicated by the plan administrator.

When Benefits Are Paid

Employee supplemental term life insurance is paid to your beneficiary. Dependent supplemental term life insurance benefits are paid to you in the event of a covered person's death. In all cases, payment is made after Metropolitan Life Insurance Company (MetLife), the claims administrator, receives satisfactory evidence of a covered person's death (e.g., a certified death certificate).

Accelerated Benefit Option

If you are diagnosed with a terminal illness that's expected to result in death within 12 months, you can apply for an accelerated benefit equal to 80% of your supplemental life insurance coverage amount, not to exceed an accelerated benefit of $500,000.

Accelerated benefits for supplemental term life insurance are also available for:

- Dependent spouse supplemental term life insurance, at 80% of your coverage, not to exceed $240,000; and
- Child supplemental term life insurance, at 80% of your coverage, not to exceed $16,000.

Upon payment of this benefit, the covered person's supplemental term life insurance contributions will be reduced to reflect the new lower coverage amount. Accelerated benefit option payments are excluded from gross income and, therefore, are exempt from federal income tax. Please see your tax advisor regarding any other tax consequences. Upon the covered person's death, the reduced amount of life insurance will be paid to the beneficiary. Please see "Beneficiaries" on page 310 for more information

If you elect the Accelerated Benefit Option, you may still receive SurvivorSupport® Financial Counseling Services.

Converting or Porting Supplemental Term Life Insurance

Coverage under the Supplemental Term Life Insurance Plan for active employees ends on your termination date. Within 31 days of your termination date, you have the option to convert your employee and/or dependent life insurance coverage to an individual policy or port that coverage following your termination of employment as follows:

- Employee Supplemental Life Insurance:
  - You may convert the coverage to an individual policy; or
  - You may port the lesser of your total life insurance in effect at date of termination or up to $2 million (in increments of $25,000)
  - You must provide MetLife evidence of insurability for the additional coverage amount
  - If you are already at the $2 million maximum you may not increase your coverage.
- Dependent Spouse/Domestic Partner 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/Domestic Partner Life Insurance alone) to a maximum of the lesser of your total dependent spouse/domestic partner 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.

Accidental Death and Dismemberment (AD&D) Insurance

The Accidental Death and Dismemberment (AD&D) Insurance Plan is provided through an insurance policy issued by Metropolitan Life Insurance Company (MetLife). You may elect to obtain AD&D coverage for yourself, as well as your spouse/domestic partner and your eligible children under this Plan. The following information describes your options under the AD&D Insurance Plan.

Employee AD&D Insurance

Employee accidental death and dismemberment (AD&D) insurance will pay the full amount of your coverage to your beneficiary if you die as a result of an accident. You'll receive a portion of the benefit if you sustain certain injuries, such as the loss of a limb.

You can enroll for coverage in $10,000 increments up to 10 times your Eligible Compensation (rounded up to the next $10,000) to a maximum of $3 million.

Employee AD&D Insurance Limit Due to Age
When you are age 75 or older, but less than age 80, your amount of Employee AD&D Insurance will be reduced to a maximum amount of $200,000. When you are age 80 or older, your amount of insurance will be further reduced to a maximum amount of $100,000. If you reach age 75 or 80 while insured, this limit will not apply until the January 1 following the date you reach that age.

Dependent AD&D Insurance

Like employee accidental death and dismemberment (AD&D) insurance, dependent AD&D insurance will pay the full benefit in the event of your dependent's accidental death. You'll receive a percentage of the benefit if your dependent sustains certain injuries, such as the loss of a limb. Your options include:

- Spouse/domestic partner coverage in $10,000 increments up to $600,000; and/or
- Child coverage in $10,000 increments up to a maximum of $100,000 per child.

Please Note: As long as you have company-paid Basic Life, you may choose dependent AD&D insurance for your spouse/domestic partner and eligible children/domestic partner's children even if you do not elect AD&D coverage for yourself.

If your spouse is also a JPMorgan Chase employee, he or she can elect coverage as an employee and be also covered as a spouse.

Employee and dependent AD&D insurance will pay benefits for any of the losses listed in the following chart. However, the loss must be caused by accidental means and must be the result of the injury — directly and independently of all other sources.

How the Plan Pays Benefits

Type of Loss	Benefit Amount Payable
Loss of life Disappearance will be considered as loss of life after one year, and "exposure to the elements" will be treated as an accidental injury	100%
Loss of a hand permanently severed at or above the wrist but below the elbow	100%
Loss of a foot permanently severed at or above the ankle but below the knee	100%
Loss of an arm permanently severed at or above the elbow	75%
Loss of a leg permanently severed at or above the knee	75%
Loss of sight in one eye	50%
Loss of sight in both eyes	100%
Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.	
Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of the thumb and index finger of same hand or loss of four fingers on the same hand	25%
Loss of thumb or other finger means that the finger is permanently severed at or above the point at which it is attached to the hand.	
Loss of all toes on one foot	25%
Loss of the big toe	13%
Loss of big toe or other toe means that the toe is permanently severed at or above the point at which it is attached to the foot.	
Loss of speech and loss of hearing in both ears	100%
Loss of speech or loss of hearing in both ears	50%
Loss of hearing in one ear	25%

Type of Loss	Benefit Amount Payable
Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury. **Loss of hearing** means the entire and irrecoverable loss of hearing that continues for 6 consecutive months following the accidental injury.	
Paralysis of both arms and both legs	100%
Paralysis of both legs	75%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%
Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.	
Brain Damage	100%
Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.	
Coma	1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 100 months
Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.	

Additional Plan Benefits

Employee and dependent AD&D insurance also includes these additional benefits, except as noted below:

- **Seat Belt Benefit:** Your beneficiary will receive an additional 10% of the principal sum (to a maximum of $25,000) if you die as a result of an automobile accident while wearing a seat belt.
- **Air Bag Benefit:** Your beneficiary will receive an additional 10% of the principal sum (to a maximum of $10,000) if you die as a result of an automobile accident while in an automobile containing an air bag.
- **Workplace Felonious Assault Benefit (Note: Does not apply to dependent AD&D coverage):** For an assault committed during the commission of a felony as defined by the laws of the jurisdiction in which the act was committed, you or your beneficiary will receive an amount equal to the lesser of 20% of the AD&D insurance on the employee or $25,000, if the accidental injury was caused by a felonious assault committed at a JPMorgan Chase place of business or while you are engaged in business for JPMorgan Chase.
- **Surviving Spouse Benefit:** If you or your spouse/domestic partner dies as a result of an accidental injury
  - The Plan will pay an additional amount equal to the lesser of 3% of the full amount of insurance or $1,000 under the AD&D insurance for each of the 6 months immediately following the date of such person's death.
  - If this benefit is in effect on the date of death and there is no spouse who could qualify for payment, the Plan will pay $1,000 to your beneficiary in one sum.

- **Hospital Confinement Benefit:** If the Plan received proof that you or your dependent are confined in a hospital as a result of an accidental injury, which is the direct cause of such confinement independent of other causes; and benefit is in effect on the date of the injury, the Plan will pay:
  - 1% of the full amount of your AD&D coverage; and
  - $2,500; on a monthly basis beginning on the 5th day of confinement for up to 12 months of continuous confinement.
- **Child Education Benefit:** If you or your covered spouse/domestic partner dies as a result of an accidental injury, this feature pays for each child who qualifies for this benefit, an amount equal to the tuition charges incurred for a period of up to four consecutive academic years, not to exceed:
  - an academic year maximum of $10,000;
  - an overall maximum of 20% of full amount of your benefit;

  In the event that both you and your spouse/domestic partner die such that each death would cause a payment to be made for a child under the Additional Benefit, the following rules apply:
  - The academic year maximum will be 2 times the amount stated above;
  - The overall maximum will be equal to the stated percentage applied to the sum of the full amounts shown in MetLife's Schedule of Benefits for both you and your spouse; and
  - In no event will the amount paid under all Child Education benefits exceed the amount of tuition incurred.

  MetLife will pay the above additional Child Education benefit if:
  - A benefit is paid for loss of such person's life under the AD&D section;
  - The paid benefit is in effect on the date of the injury; and
  - Proof is received that on the date of death a Child was:
    - Enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or
    - At the 12th grade level and, within one year after the date of death, enrolls as a full-time student in an accredited college, university or vocational school.

  The child tuition benefit is paid semi-annually.
- **Spouse/Domestic Partner Education Benefit for Employee AD&D Coverage (does not apply to dependent AD&D coverage):** In the event of your death, this feature will pay an amount equal to the tuition charges incurred for a period of up to one academic year, not to exceed:
  - An academic year maximum of $5,000; and
  - An overall maximum of 5% of the full amount of your AD&D insurance.
- **Child Care Benefit:** In the event of your or your covered spouse/domestic partner's death, this feature pays an amount equal to the child care center charges incurred for a period of up to four consecutive years for each child under the age of 13 who qualifies for this benefit, not to exceed:
  - An annual maximum of $5,000; and
  - An overall maximum of 12% of the full amount of the AD&D insurance on the insured.

  In the event that both you and your spouse/domestic partner die such that each death would cause a payment to be made for a child under this Child Care Benefit, the following rules apply:
  - The annual maximum will be two times the amount stated above;
  - The overall maximum will be equal to the stated percentage applied to the sum of full amount of coverage for both you and your spouse/domestic partner;

— In no event will the amount paid under all Child Care benefits exceed the amount of Child Care charges incurred; and

— Child Care Center charges incurred after the date a Child attains age 13 will not be covered.

For purposes of this benefit, a child care center is a facility or individual which operates pursuant to state law, is not a family member, and primarily provides care and supervision to children in a group setting on a regular, daily basis. In order to qualify, the child must be wholly dependent on you for support and maintenance on the date of the death and must either be enrolled in a child care center at date of death or must become enrolled at a child care center within 12 months of the date of death.

- **Common Carrier Benefit:** A common carrier is a government-regulated entity that is in the business of transporting fare paying passengers. It does not include 1) chartered or other privately arranged transportation; 2) taxis; or 3) limousines. If you or a dependent die as a result of an accidental injury while traveling in a common carrier, the Common Carrier Benefit pays a full amount of the covered person's AD&D benefit (in addition to the regular benefit paid for loss of live, as shown above, under "How the Plan Pays Benefits" on page 321). To receive the benefit, you must provide proof that the injury resulting in the death occurred while traveling in a common carrier.
- **Therapeutic Counseling Benefit:** For a loss resulting from an accidental injury to you or a dependent, this benefit covers therapeutic counseling that has been prescribed for you, your spouse/domestic partner or your children within 90 days of the covered loss by an attending physician to treat an emotional or psychological condition resulting from the covered loss. This benefit will pay an amount equal to the least of:

  — the actual charges incurred for the therapeutic counseling;

  — 10% of the full amount of AD&D coverage; or

  — $10,000

  This benefit will be paid in the month when you provide proof that you have paid charges for therapeutic counseling. Payment will be made to the person who paid such charges. Such therapeutic counseling must be provided within one year of the prescription by a physician, therapist or counselor licensed to provide the counseling in the jurisdiction where such services are performed.
- **Common Disaster Benefit:** If you and your spouse/domestic partner are injured in the same accident and die within 365 days as a result of injuries in such accident, the benefit paid for your spouse's/domestic partner's loss of life will be increased to equal the full amount payable for your loss of life.

For additional information about the benefits described above, please contact Metropolitan Life Insurance Company (MetLife) from 8 a.m. to 8 p.m. Eastern Time, Monday – Friday.

What Is *Not* Covered

Accidental death and dismemberment (AD&D) insurance benefits are not payable for loss or death that results from:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Service in the armed forces of any country or international authority for more than 30 days. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;

- Any incident related to:
  - Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; however this exclusion will not apply to a loss sustained by you as a pilot or a crew member if you were hired by JPMorgan Chase as a pilot or crew member and the loss is sustained while you are acting in that capacity;
  - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self preservation;
  - Travel in an aircraft or device used:
    - For testing or experimental purposes;
    - By or for any military authority; or
    - For travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
  - Any drug, medication or sedative, unless it is:
    - Taken or used as prescribed by a Physician; or
    - An "over the counter" drug, medication or sedative taken as directed;
  - Alcohol in combination with any drug, medication, or sedative; or
  - Poison, gas, or fumes; or
- War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

This list is subject to change at any time.

Exclusion for Intoxication

The Plan will not pay AD&D benefits for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

When Benefits Are Paid

Your employee accidental death and dismemberment (AD&D) benefit is paid to your beneficiary upon your death. If you suffer a covered loss other than death, your benefit will be paid to you. Dependent AD&D benefits are paid to you in the event of a covered person's death or other covered loss. Applicable benefits are paid after MetLife receives notice of the covered loss (e.g., certified death certificate, or accident report).

Porting Your Coverage

You may port up to $2 million of your employee AD&D coverage with 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.
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.

Business Travel Accident Insurance

Business Travel Accident (BTA) Insurance, provided under an insurance policy with the AIG-National Union Fire Insurance Company of Pittsburgh, PA, is designed to protect you in the event of accidental death or serious covered injury caused by an accident that occurs while traveling on approved business for the company. In addition, this insurance covers you if accidental death or a serious covered injury occurs as a result of a criminal act of violence directed at you on JPMorgan Chase's premises or as a result of a criminal act of violence against you while you're traveling on company business.

Note: Your spouse/domestic partner and children are also covered if they accompany you or are on their way to accompany you on an authorized, company-paid business trip while you are covered under the Plan.

Business Travel Accident Insurance pays the full benefit amount in the event of an accidental death. A portion of the benefit amount is payable in the event of certain injuries.

Employee Coverage

JPMorgan Chase automatically provides you with business travel accident insurance equal to six times your annual salary, with a minimum benefit of $50,000 and a maximum of $3 million, at no cost to you. However, if you're paid on an hourly basis, annual salary is based on the monthly average of amounts paid to you by JPMorgan Chase as hourly wages and/or commissions during the previous 36 months. The monthly average is then multiplied by 12 to determine your annual salary. Annual salary excludes any overtime earnings, incentive compensation, or other extra compensation arrangements.

You are covered for business travel accident insurance benefits until your last day of active employment at JPMorgan Chase.

Dependent Coverage

Business Travel Accident Insurance includes coverage for your spouse/domestic partner and/or children if they accompany or are on their way to accompany you on an authorized, company-paid business trip while you are covered under the Plan.

- Your spouse/domestic partner coverage is covered for a maximum benefit of $150,000; and
- Your children are covered for $20,000 per child in the event of death or dismemberment.

How BTA Insurance Pays Benefits

Business Travel Accident Insurance pays full or partial benefits depending on the extent of loss, as shown in the chart below.

Type of Loss	Benefit Amount Payable
Life	100%
Quadriplegia	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and the sight of one eye	100%
One foot and the sight of one eye	100%
Speech and hearing in both ears	100%
Paraplegia	75% of the full amount
Hemiplegia	50% of the full amount

Type of Loss	Benefit Amount Payable
One hand or one foot	50% of the full amount
Sight of one eye	50% of the full amount
Speech or hearing in both ears	50% of the full amount
Hearing in one ear	25% of the full amount
Thumb and index finger of same hand	25% of the full amount

Benefits are also payable in the event of severe burns. Business Travel Accident Insurance pays a percentage of the full benefit amount depending on the extent of the burn injury.

Additional Plan Benefits

Business Travel Accident Insurance may provide additional benefits to you and to your spouse/domestic partner and/or children in the event of a covered accident. These additional benefits include, but are not limited to:

- **Seat Belt and Air Bag Benefit:** If you (or a covered family member) is in an accident that causes death while operating or riding as a passenger in an automobile while wearing a properly fastened, original, factory-installed seat belt, an additional seat belt benefit is payable if an accidental death benefit is payable under the Business Travel Accident Insurance Plan. The seat belt benefit is equal to the lesser of $50,000 or 10% of the maximum BTA Insurance benefit for the covered individual. An additional air bag benefit is also payable if the seat belt benefit is payable and if at the time of the accident the covered individual is positioned in a seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact. The additional air bag benefit is equal to the lesser of $25,000 or 5% of the maximum BTA Insurance benefit for the covered individual.
- **Felonious Assault Benefit:** Coverage for an additional $5,000 in the event of death as the result of a felonious assault while on a business trip or while you are at work on JPMorgan Chase's premises.
- **Hospitalization Benefit:** If you, your spouse/domestic partner and/or child requires hospitalization as a result of a covered accident, an additional amount equal to the lessor of $5,000 or 5% of the applicable benefit amount is payable.
- **Common Accident Benefit:** In the event that both you and your spouse/domestic partner die in the same accident, the maximum benefit amount for your spouse/domestic partner will increase from $150,000 to the amount equal to your maximum benefit.
- **Rehabilitation Benefit:** In the event of dismemberment or paralysis from a covered accident, this feature pays an additional amount, up to a maximum payment of $50,000, for rehabilitation expenses in connection with the injury.
- **Trauma and Bereavement Counseling Benefit:** In the event of your, your spouse's/domestic partner's, or your child's injury or death, this feature pays up to $250 per session for trauma or bereavement counseling for up to 20 sessions.
- **Emergency Evacuation:** If you (or your spouse/domestic partner or children) are outside a 100 mile radius from your place of primary residence and suffer an injury or emergency sickness that warrants emergency evacuation, this feature will pay the reasonable expense (up to $5,000,000) for such evacuation. The expense must not exceed the usual charge for similar transportation in the location where the expense is incurred and must not include charges that would not have been made if no insurance existed.
- Additional benefits, including psychological therapy, day care, and tuition benefits, are described in the insurance policy for the Plan.

What Is *Not* Covered

Business travel accident insurance benefits are not payable for loss or death that results from:

- Suicide or any attempt at suicide, or intentional self-inflicted injury or attempt at intentionally self-inflicted injury;
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a passenger, pilot, operator or crew member, unless specifically provided by this policy
- Declared or undeclared war, or any act of declared or undeclared war unless specifically provided by this policy
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these;
- Infection of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- Full-Time active duty in the Armed Forces, National Guard or organized reserve corps of any country or international authority;
- Commission of or attempt to commit a felony
- Normal commuting between your residence and place of employment

This list is subject to change at any time.

Claiming Benefits

The following information explains when and how to file claims for Life and Accident Insurance Plans benefits.

When Benefits Are Paid

- **Basic Life Insurance** benefits are paid to your beneficiary when Metropolitan Life Insurance Company (MetLife), the claims administrator, receives satisfactory evidence of your death (e.g., a certified death certificate).
- **Supplemental term life insurance** benefits are paid to your beneficiary when Metropolitan Life Insurance Company (MetLife), the claims administrator, receives satisfactory evidence of your death (e.g., a certified death certificate). Dependent supplemental term life insurance benefits are paid to you in the event of a covered person's death when MetLife receives satisfactory evidence of the covered person's death.
- **Accidental death and dismemberment (AD&D) insurance** benefits are paid to your beneficiary when Metropolitan Life Insurance Company (MetLife), the claims administrator, receives satisfactory evidence of your death (e.g., a certified death certificate). If you suffer a covered loss other than death, your benefit will be paid to you when MetLife receives proof of your loss (e.g., medical reports or accident/police reports). Dependent AD&D benefits are paid to you in the event of a covered person's death or other covered loss when MetLife receives proof of the death/loss.
- **Business travel accident** benefits are paid to your beneficiary when AIG-National Union Fire Insurance Company of Pittsburgh, PA receives satisfactory evidence of your accidental death. If you suffer a covered loss other than death, your benefit will be paid to you when AIG-National Union Fire Insurance Company of Pittsburgh, PA receives proof of your loss.

How Benefits Are Paid by MetLife

Benefit payments by MetLife on behalf of the Plans are made in the method chosen by the beneficiary, and can include:

- A Total Control Account (TCA), which is an interest bearing account similar to a checking account that MetLife would open for you to hold your claim proceeds. MetLife pays the full amount owed to you by placing the proceeds into the TCA and providing you with a book of drafts. You can use the draft as you would use checks.
- A check that MetLife mails to you; or
- An Electronic Funds Transfer (EFT) where MetLife would transfer the funds directly to a bank account provided by you via electronic funds transfer. This requires completion of an EFT form.

AIG makes payments for the Business Travel Accident Plan.

How to File Claims

If you or your beneficiary need to file a claim for Life and Accident Insurance Plans benefits, please contact HR Answers and speak with a Service Representative (please see the table entitled “Questions” under the “Life and Accident Insurance” section on page 303 for information). If you or a covered dependent dies, a certified copy of the death certificate is required before death benefits can be paid. You will also be required to provide satisfactory evidence of a covered loss under the AD&D Insurance Plan.

Important Claims Addresses

To discuss payment options, claims procedures, or other Plan details, please use the appropriate address and phone numbers from the following chart:

Claims Administrators’ Contact Information

Claims Administrator	Address and Telephone Number
Basic Life Insurance	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166-0188 (800) 673-9582 8 a.m. to 8 p.m. Eastern Time Monday – Friday
SurvivorSupport® Financial Counseling Services	The Ayco Company, LP P.O. Box 15073 Albany, NY 12212-5073 (800) 235-3417 8 a.m. to 5 p.m. Eastern Time Monday – Friday; appointments may also be scheduled outside of normal business hours
Identity (ID) Theft Assistance Program	AXA Assistance 122 S. Michigan Avenue Suite 1100 Chicago, IL 60603 (800) 454-3679 24 hours a day, 365 days a year www.metlife.com/travelassist

Claims Administrator	Address and Telephone Number
Travel Assistance and Emergency Evacuation Services	AXA Assistance 122 S. Michigan Avenue Suite 1100 Chicago, IL 60603 (800) 454-3679 or outside the United States, call collect at (312) 935-3783 24 hours a day, 365 days a year www.metlife.com/travelassist
Funeral Concierge Services	Dignity Memorial 1929 Allen Parkway Houston, TX 77019 (866) 853-0954 24 hours a day, 365 days a year www.finalwishesplanning.com
LifeWorks Funeral Planning Services	LifeWorks (888) 319-7819 24 hours a day, 365 days a year
Business Travel Accident Insurance	AIG-National Union Insurance Fire Company of Pittsburgh, PA Accident & Health Claims Department 17200 West 119 Street Shawnee Mission, Kansas 66225 (800) 551-0824 8 a.m. to 5 p.m. Central time Monday – Friday If needed, the FAX number is: (866) 893-8574.
Supplemental Term Life Insurance	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166-0188 (888) 673-9582 8 a.m. to 8 p.m. Eastern Time Monday – Friday
Accidental Death and Dismemberment (AD&D) Insurance	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166-0188 (888) 673-9582 8 a.m. to 8 p.m. Eastern Time Monday – Friday

Appealing a Claim

If a claim for payment under the JPMorgan Chase Life and Accident Insurance Plans is denied, either in whole or in part, you or your beneficiary can appeal the denial by following the appropriate procedures described in the *Plan Administration* section.

Defined Terms

As you read this summary of the JPMorgan Chase Life and Accident Insurance Plans, you'll come across some important terms related to the Plans. To help you better understand the Plans, many of those important terms are defined here.

Actively-at-Work	Actively-at-Work means you are performing all the duties that pertain to your work on a regular basis at the place where they're normally performed or where they're required to be performed by JPMorgan Chase. A person who works at home must be able to report to a place of employment outside the home. You must be actively-at-work for your new or newly approved increase in coverage to take effect. The actively-at-work provision also applies if your coverage is subject to evidence of insurability. The insurance carriers for each of these Plans may have additional actively-at-work requirements that are specific to their Plan. For more information, please contact the insurance carriers directly.
After-Tax Contributions	After-tax contributions that are taken from your pay after federal and, in most cases, state and local income taxes have been withheld.
Annual Earnings	(For the Business Travel Accident Insurance Plan only) Annual earnings means your annual wage or salary from JPMorgan Chase as of the date of the accident, including the monthly average times 12 of any amounts paid during the preceding 36 months as hourly wages and/or commissions, but excluding any overtime earnings, bonuses, or other extra compensation arrangements.
Beneficiary	Your beneficiary is the person, people, estate, or entity you name to receive benefits from the insurance plan if you die.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Life and Accident Insurance Plans. The claims administrator for each benefit is noted at the beginning of the description of each Plan. JPMorgan Chase is not involved in deciding appeals for any benefits claim denied under the Life and Accident Insurance Plans. All fiduciary responsibility and decisions regarding a claim for a denied benefit under the Plans rest solely with the claims administrator.
Eligible Compensation	(For accidental death and dismemberment coverage) Generally, your Eligible Compensation is your annual base salary/regular pay plus applicable job differential pay (e.g., shift pay). It does not include any annual incentive, overtime, special recognition, or other incentive awards you might receive. In certain situations, your Eligible Compensation may include other cash earnings (e.g., commissions, draws, and overrides) paid under certain non-annual incentive plans that provide compensation in lieu of base salary. For the benefits plans described here, your Eligible Compensation is updated as changes occur throughout the year (including while you are on a leave of absence). **Please Note:** Various JPMorgan Chase plans have different definitions of Eligible Compensation. Separate definitions may apply to employees in certain sales positions who are paid on a draw-and-commission basis.
Eligible Dependents	Under the Life and Accident Insurance Plans, your eligible dependents can include your spouse or domestic partner and your children (including children of your domestic partner). Please see "Eligible Dependents" in the *Health Care Participation* section for more information.
Evidence of Insurability	(Does not apply to the Business Travel Accident Insurance Plan or AD&D Plan) Evidence of insurability (EOI) is information that must be provided to Metropolitan Life Insurance Company (MetLife), the claims administrator for the Supplemental Term Life Insurance Plan, before you can be approved for certain levels of coverage. Please see "Evidence of Insurability" on page 319 for more information.

Imputed Income	(Applies to the Basic Life Insurance Plan only) Imputed income is the value of company-provided basic life insurance above $50,000, which must be reported as income to the Internal Revenue Service (IRS). Imputed income becomes part of your taxable income reported on your W-2.
Loss	For details on what qualifies as a loss under each plan, see: ▪ For Accidental Death & Dismemberment, “How the Plan Pays Benefits” on page 321. ▪ For Business Travel Accident, “How BTA Insurance Pays Benefits” on page 326.
Qualified Change in Status	(For the Life and Accident Insurance Plans) 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. The benefits you elect will be effective the date of the event if you make the elections timely. Any changes you make during the year must be consistent with your QSC. Please see “Changing Your Coverage Midyear” on page 313 for more information.
Total Annual Cash Compensation	(For basic and supplemental term life insurance) 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.

Other Benefits

Effective 1/1/21

This section of the Guide covers the following benefits:

- *The Health and Wellness Centers Plan*
- *Fertility Benefits Program*
- *The Group Legal Services Plan*
- *The Group Personal Excess Liability Insurance Plan*
- *The Back-Up Child Care Plan*
- *The Expatriate Medical and Dental Plans*

The Health & Wellness Centers Plan

Questions?

If you still have questions after reviewing this Guide, contact your local Health & Wellness Center. For a list of centers and their contact details, please see the Health & Wellness Centers Directory on **My Health**. As a next step, consult the *Contacts* section.

Effective 1/1/21

The JPMorgan Chase Health & Wellness Centers Plan offers employees the convenience of onsite medical support when an unexpected illness arises. The Health & Wellness Centers also provide Wellness Screenings and other activities as part of the company's commitment to your health.

The JPMorgan Chase Health & Wellness Centers Plan is designed to supplement your routine health care by offering access to care if you have a medical emergency, injury, or the sudden onset of an illness. The Centers' medical staff can provide treatment as needed, discuss your medical issues, and provide guidance with respect to appropriate next steps. ***Please Note:*** *The Health & Wellness Centers are not intended to replace your primary care physician or directly manage your chronic health conditions.*

This section of the Guide will provide you with more information about the services offered through the JPMorgan Chase Health & Wellness Centers Plan, and how you can take advantage of this convenient benefit.

Be sure to see important additional information about the Plan, 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 Health & Wellness Centers Plan. Please retain this section for your records. Other sections may also constitute the complete SPD/plan document, including the *Plan Administration* section.

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

The JPMorgan Chase U.S. Benefits Program is available to most employees on 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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Health & Wellness Centers Highlights

Available Services	The JPMorgan Chase Health & Wellness Centers Plan offers the following services to U.S. benefits-eligible employees: ▪ Emergency evaluation; ▪ Medical services for acute/urgent and episodic conditions; ▪ Consultation for appropriate next steps in plan of care; ▪ Wellness Screenings and other onsite evaluations; ▪ Flu shots (in season); ▪ Travel Health information and vaccinations; and ▪ Information regarding health issues and health resources that are available to you.
Using Services	You do not need an appointment to visit a Health & Wellness Center, although you may call ahead to reserve one. You may also visit a Health & Wellness Center while traveling to or near a JPMorgan Chase location other than your usual place of work. See "Locations" below for information on how to access a directory of Health & Wellness Centers.
Locations	JPMorgan Chase has onsite Health & Wellness Centers throughout the United States. The Health & Wellness Centers Directory on **My Health** has a list of JPMorgan Chase Health & Wellness Centers locations, phone numbers, and hours.

Who's Eligible?

In general, you are eligible to take advantage of onsite Health & Wellness Centers if you are:

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

Who's Not Eligible?

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

Examples of such individuals include an:

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

Even if You Are Ineligible, or at a Different Work Location

The Health & Wellness Centers are available to provide assistance for treatment of an urgent health condition, illness, or injury that occurs during working hours, even if you are not otherwise eligible.

This includes while traveling to or near a JPMorgan Chase location other than your usual place of work.

No Enrollment Necessary

You do not have to elect or enroll for coverage in order to take advantage of the Health & Wellness Centers Plan — coverage begins on your first day of work. If you have a change in work status (e.g., adjustment to your regularly scheduled work hours that results in a change in eligibility), your coverage will take effect as of the date of the change in work status.

When Coverage Ends

Your eligibility to use the JPMorgan Chase Health & Wellness Centers ends on the last day of the month in which you are actively employed or become ineligible due to a work status change to less than 20 hours per week, unless you elect coverage under COBRA.

For details, see "Continuing Health Coverage Under COBRA" in the *Health Care Participation* section, particularly the subsection "What's Included with COBRA Medical Plan Coverage."

Available Services and Their Costs

The Health & Wellness Centers Plan provides for acute/urgent medical services and educational resources to be available at onsite centers. The Health & Wellness Centers offer medical care, treatment, and resources for medical emergencies, injuries, or the sudden onset of illnesses. Onsite nurses and, in many cases, physicians or nurse practitioners are available to act as advisors and help you connect with your health care company's coaching programs and other support. In certain larger locations, Employee Assistance Program counselors are also available onsite to help you deal with challenging situations.

A Supplement, Not a Replacement

The onsite Health & Wellness Centers are not intended to provide comprehensive medical care. You should still have a family practitioner whom you visit regularly for routine and longer-term health care needs.

Specific services available at onsite Health & Wellness Centers include:

- Emergency evaluation;
- Limited acute/urgent and episodic care;
- Practitioner evaluations and prescriptions, as appropriate and where available;
- Blood drawing for lab tests (the laboratory fee for the testing of the blood will be submitted to your medical plan by the external lab that tests the blood sample);
- Travel health information and vaccinations;
- Flu shots (in season);
- Wellness Screenings for blood pressure, blood sugar, cholesterol, triglycerides, and body mass index (BMI) numbers;
- Assistance with referrals to Physicians if requested; and
- Guidance regarding questions about your health.

There are many medical services that are not covered by the Health & Wellness Centers Plan. For example, treatment that is generally provided in a hospital emergency room is not covered by the Plan. To learn if a specific service is available, please contact your local Health & Wellness Center. Please see the *Contacts* section for contact information.

Cost

Most services provided by Health & Wellness Center staff are provided at no cost to you, including Wellness Screenings and certain lab tests performed onsite.

Fees for evaluation by specialists (e.g., orthopedists, sports medicine physicians), where available, will be discussed with you when you make an appointment and will be submitted to your medical plan by the specialist.

Costs for onsite physical therapy visits, where available, will be discussed with you when you schedule an appointment and will be submitted to your medical plan by the therapist.

Fees for laboratory testing of blood drawn by Health & Wellness Center staff will be submitted to your medical plan by the external lab that tests the blood sample.

If an onsite provider writes a prescription, the pharmacist will submit the claim to your prescription plan.

Using the Centers

You do not need an appointment to visit an onsite Health & Wellness Center, although you may call ahead to reserve one. You may use any onsite Health & Wellness Center, whether or not you work at that site.

JPMorgan Chase has onsite Health & Wellness Centers throughout the United States. 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** > Medical Specialty Services > JPMC Health & Wellness Centers > list of site locations and contact information

Claiming Benefits

Onsite services provided by Health & Wellness Center staff are usually provided at no cost to U.S. benefits eligible employees, so no claims for reimbursement need to be filed. Fees for evaluation by specialists (e.g., orthopedists, sports medicine physicians), where available, will be discussed with you when you make an appointment and will be billed to your medical plan by the specialist. Fees for laboratory testing of blood drawn by Health & Wellness Center staff will be submitted to your medical plan by the external lab that tests the blood sample. If an onsite provider writes a prescription, the pharmacist will submit the claim to your prescription plan.

The *Plan Administration* section contains more detailed information regarding claiming benefits related to the Health & Wellness Centers Plan. Please see the *Plan Administration* section for information regarding how to:

- File claims or appeals regarding benefits under the Health & Wellness Centers Plan; and
- Appeal a decision made by the Health & Wellness Centers with respect to eligibility for benefits.

Your Privacy

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**).

While the JPMorgan Chase Health & Wellness Centers are staffed with physicians and nurses who are employed/contracted by JPMorgan Chase, they are licensed 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 the 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.

Defined Terms

As you read this summary of the JPMorgan Chase Health & Wellness Centers Plan, you'll come across some important terms, which are defined below.

Acute/Urgent Care	Acute/urgent care is care provided as treatment for a brief or limited episode of illness or an accident or other trauma.
Body Mass Index	Body Mass Index (BMI) is a measure of body fat based on height and weight. BMI provides a reliable indicator of body fatness for most people. BMI is used to screen for weight categories that may lead to health problems.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise end. The *Health Care Participation* section provides details on COBRA coverage.
Episodic Care	Episodic care means services to treat a medical condition without establishing an ongoing relationship for treatment between the patient and the health care professional for the treatment.

The U.S. Fertility Benefits Program

Effective 1/1/21

JPMorgan Chase is committed to assisting employees in meeting their diverse family planning needs. Through the Family Building Assistance Policy, financial support is provided to eligible employees to help offset the high cost of adoption, surrogacy, and certain fertility treatments. The U.S. Fertility Benefits Program provides assistance with fertility treatments for individuals who do not have a medical diagnosis of infertility.

This summary will provide you with a better understanding of how the Fertility Benefits Program works, including how and when benefits are paid.

Questions?

For questions or concerns regarding the U.S. Fertility Benefits Program, please contact the Program's service provider:

WINFertility
(833) 439-1517

Representatives are available Monday through Friday, from 9 a.m. to 7:30 p.m. Eastern Time.

About This Summary Plan Description

This section is the summary plan description (SPD) and the plan document for the JPMorgan Chase U.S. Fertility Benefits Program, which is a benefit offered under the JPMorgan Chase U.S. Medical Plan. This summary plan description provides you with important information required by the Employee Retirement Income Security Act of 1974 (ERISA) about the Program.

While ERISA does not require JPMorgan Chase to provide you with benefits, it does mandate that JPMorgan Chase clearly communicate to you how the Program operates and what rights you have under the law regarding Program benefits. The U.S. Department of Labor requires JPMorgan Chase to routinely provide benefits plan summaries to Program participants. Please retain this section for your records.

Be sure to read the "Program Administration" section on page 354 for more important details about the Program and this summary plan description.

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 Care and Insurance 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 to a health care service provider the right to payment. Please contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) for more information.

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

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Fertility Benefits Highlights

parents@jpmc	**parents@jpmc** is your central online resource for information about expanding your family, parental leave and support for working parents. From **parents@jpmc** you can learn more about the fertility benefit available.
Eligibility	U.S. benefits-eligible employees who have completed the Introductory Period and their covered spouses/domestic partners are eligible for fertility benefits only if they meet the following requirements: ▪ The person receiving the fertility services is enrolled in the JPMorgan Chase U.S. Medical Plan ▪ The person receiving the fertility services and their partner (if applicable and clinically linked to the fertility treatment) have not received a medical diagnosis of infertility ▪ The person receiving the fertility services has enrolled with WINFertility, the administrator of fertility benefits ▪ The expenses are incurred while the person receiving the fertility services was enrolled in the Medical Plan Note: If a medical diagnosis of infertility is determined, the person receiving the fertility services may qualify for infertility benefits under the JPMorgan Chase U.S. Medical Plan in lieu of this fertility benefit. If, during the course or treatment, it is determined that there is a medical diagnosis of infertility, WINFertility will transfer you to your JPMorgan Chase U.S. Medical Plan health care company to utilize the infertility benefit.
You Must Enroll	To be eligible for benefits from the Program, you must enroll by calling WINFertility and complete a consultation with a WINFertility Nurse Care Manager. If you do not call and complete a consultation, you will not be eligible for benefits and you will not be eligible for reimbursement for fertility services incurred prior to enrollment.
Covered Services	Examples of fertility services that are covered include, but are not limited to, the following if performed on the individual enrolled in the U.S. Medical Plan: ▪ Intrauterine insemination (IUI); ▪ In vitro fertilization (IVF); ▪ Medications associated with an approved IUI or IVF cycle. For more details on the covered services and the exclusions, see “What the Plan Provides” on page 206 and “What’s Not Covered” on page 347.
WINFertility Network	WINFertility has a network of providers that feature credentialed reproductive endocrinologists and associated clinical staff, and has negotiated competitive pricing across this network. If you use an in-network WINFertility provider, you will have the associated costs automatically processed by WINFertility as the services are received, up to the lifetime maximum. This means you won’t have to pay out-of-pocket at the time of service and will not have to submit claims for reimbursement. Ancillary services prescribed by the WINFertility provider to outside labs, facilities, or providers may not be payable directly by WINFertility, but would be eligible for reimbursement. If you use an out-of-network provider, you will pay for those services out-of-pocket and then submit a request for reimbursement to WINFertility. Claims must be submitted within six months of when the expenses are incurred.
Lifetime Maximum Benefit	The Program provides benefits for covered services, up to a per-person lifetime maximum of $30,000 in benefits for medical and prescription drug costs.

Participating in the Program

Who's Eligible?

U.S. benefits-eligible employees who have completed the Introductory Period and their covered spouses/domestic partners are eligible for fertility benefits only if they meet the following requirements:

- The person receiving the fertility services is enrolled in the JPMorgan Chase U.S. Medical Plan,
- The person receiving the fertility services and their partner (if applicable and clinically linked to the fertility treatment) have not received a medical diagnosis of infertility,
- The person receiving the fertility services has enrolled with WINFertility, the administrator of fertility benefits, and
- The expenses are incurred while the person receiving the fertility services was enrolled in the Medical Plan.

Who's Not Eligible

You are not eligible for Fertility Program benefits if you do not meet the criteria under "Who's Eligible" or if there is a medical diagnosis of infertility. If there is a medical diagnosis of infertility, you may quality for infertility benefits under the JPMorgan Chase U.S. Medical Plan in lieu of this fertility benefit.

Your family members other than your spouse/domestic partner, such as your children, are not eligible for benefits under the Fertility Benefits Program, even if they are covered by the JPMorgan Chase U.S. Medical Plan.

The services incurred by egg and sperm donors that may be involved in the fertility treatment are not covered under this benefit.

Enrolling

To be eligible for benefits from the Fertility Benefits Program, you must enroll in the program by calling WINFertility and completing a consultation with a WINFertility Nurse Care Manager.

If you do not call and complete a consultation, you will not be eligible for benefits and you will not be reimbursed for fertility services incurred prior to enrollment.

When Coverage Begins

The Fertility Program's coverage begins immediately after you complete your consultation with a WINFertility Nurse Care Manager.

There is no retroactive coverage. For example, if you receive fertility services and then call WINFertility and have a consultation with a Nurse Care Manager *after* receiving those services, Fertility Benefits Program benefits will not be payable for any services received before your consultation.

Cost of Coverage

There is no additional payroll contribution cost for the Fertility Benefits Program benefits; your payroll contributions for the U.S. Medical Plan also covers the Fertility Benefits Program benefits. The Fertility Benefits Program benefits are in addition to the benefits you receive as a member of the U.S. Medical Plan.

When Coverage Ends

Your eligibility for the Fertility Benefits Program ends when your coverage under the JPMorgan Chase U.S. Medical Plan ends, unless you elect Medical Plan coverage under COBRA. For details, see “Continuing Health Coverage Under COBRA” on page 349.

Our Partner, WINFertility

JPMorgan Chase has partnered with WINFertility as the claims administrator for the Program. WINFertility is a fertility benefit management company that offers integrated fertility management services to participants in the JPMorgan Chase U.S. Medical Plan (e.g., clinical oversight, advocacy, and nurse care managers that provide support throughout the fertility journey).

Fertility-related medical and drug expenses incurred under the Fertility Benefits Program will be managed and processed by WINFertility, and not the carriers responsible for the U.S. Medical Plan (i.e., Aetna, Cigna or CVS Caremark).

WINFertility’s Network

WINFertility has a network of providers that feature credentialed reproductive endocrinologists and associated clinical staff, and has negotiated competitive pricing across this network.

If You Have Other Coverage

If your fertility care expenses are covered by another source (such as an insurance company) or under a plan maintained by your spouse/domestic partner’s employer or any government provided assistance, then those expenses will not be eligible for reimbursement under the JPMorgan Chase U.S. Fertility Benefits Program.

What’s Covered

The following services are covered up to a $30,000 total lifetime benefit maximum*:

- Artificial insemination / intrauterine insemination under medical supervision
- Advanced reproductive technologies:
  - In-Vitro Fertilization
  - Reciprocal IVF is covered if the patient receiving treatment is an eligible member and is enrolled in the program with WINFertility
  - Frozen Embryo Transfer
  - Cryopreservation for the following:
    - Blastocysts(s) and embryo(s) from covered IVF cycles. Covered blastocyst and embryo storage is limited to one year.
      - All frozen embryos stored after a completed cycle with ovarian stimulation must be utilized prior to coverage availability for another ovarian stimulation cycle. Embryo transfer guidelines per the American Society of Reproductive Medicine should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate
- Medically necessary diagnostic workup and radiology services

Confirm Coverage

The services listed here are not a complete list. To confirm that your treatment is covered under the plan, call WINFertility at (833) 439-1517, weekdays from 9 a.m. through 7:30 p.m. Eastern Time.

- Pathology and laboratory services, including:
  - Hormonal assays
  - Swimup semen analysis, as appropriate
  - Ultrasound exams
  - Ova identification
  - Fertilization and embryo culture
  - Embryo, gamete-zygote transfer
  - Preimplantation Genetic Diagnosis* and Preimplantation Genetic Screening
- Medications necessary for the procedures above, including parenteral injection and oral ovulation induction drugs.

* Preimplantation Genetic Diagnosis may be covered under your Medical Plan.

The Lifetime Maximum

Under the Program, the firm may pay for or reimburse qualified, non-duplicative expenses up to a lifetime maximum of $30,000 per eligible person receiving fertility services (i.e., the employee in the U.S. Medical Plan or their enrolled spouse/domestic partner) for fertility treatment.

Note that in cases where both individuals are employees of JPMorgan Chase and both are enrolled in the U.S. Medical Plan, the $30,000 lifetime maximum is for each employee.

The $30,000 lifetime maximum applies to all fertility-related expenses processed through the Fertility Benefits Program, including both in-network and out-of-network services. Expenses related to a person receiving healthcare services once pregnant, including the delivery, would be covered under the JPMorgan Chase U.S. Medical Plan.

If, during the course or treatment, it is determined that there is a medical diagnosis of infertility, WINFertility will assist you with transitioning to your JPMorgan Chase U.S. Medical Plan health care company to utilize the infertility benefit. The infertility benefit as a separate lifetime maximum and the expenses for treatment under the fertility benefit will not count towards the infertility maximum.

What's Not Covered

The following services are not covered:

- Donor expenses for donated oocytes or sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications)
- Surrogacy expenses
- Services requested which are not medically appropriate, as determined by WINFertility in its sole discretion
- Elective egg freezing
- Cryopreservation of sperm or oocytes prior to gender reassignment
- Embryo adoption
- Services not specifically listed as covered in this benefit
- At-home inseminations
- Fertility services for an eligible member who has a diagnosis of medical infertility

Claiming Benefits

The following explains when and how to file claims for fertility services. For more information on your rights with respect to claims, please see “Program Administration” on page 354.

How to File Claims

Rules regarding claims depend on whether you use a WINFertility in-network provider or an out-of-network provider, as shown below:

Provider	Claims Process
WINFertility In-Network Provider	If you use a WINFertility in-network provider, you will have the associated costs automatically processed by WINFertility as the services are received, up to the lifetime maximum. This means you won’t have out-of-pocket costs for services provided by the WINFertility provider and will not have to submit claims for reimbursement. Ancillary services prescribed by the WINFertility provider to outside labs, facilities, or providers may not be payable directly by WINFertility, but would be eligible for reimbursement.
Out-of-Network Provider	If you use an out-of-network provider, you will pay for those services out-of-pocket and then submit a request for reimbursement of eligible services to WINFertility, up to the lifetime maximum. Claims must be submitted within six months of when the eligible expenses are incurred. Please see “Where to Submit Claims” on page 211 for your claim administrator’s phone and address information.

Your request for reimbursement must include the following:

- A complete WINFertility Out-of-Network Reimbursement Form which can be found on parents@jpmc;
- An itemized statement or claim form indicating the description of services, dates incurred, amounts, and name of the patient/person receiving the fertility services;
- Proof of payment.

Separate claim forms must be submitted for each family member for whom a claim is made.

Where to Submit Claims

WINFertility is the Fertility Benefits Program’s claims administrator.

Documentation can be emailed to:

reimbursementclaims@winfertility.com

or mailed to:

WINFertility
Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831
Attn: Claims Department
(833) 439-1517

Representatives can be reached from 9 a.m. to 7:30 p.m., Eastern Time, Monday through Friday.

Appealing a Claim

If a claim for reimbursement under the Fertility Benefits Program is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in “Program Administration” on page 354.

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.

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 the HR Answers Benefits Contact Center.

What Happens If…

For many of the JPMorgan Chase Health Care and Insurance Plans for Active Employees benefits, certain life changes and events can give you special opportunities to change your decisions to participate or to decline coverage under certain benefits.

Because participation in the U.S. Fertility Benefits Program requires that you be enrolled for coverage in the JPMorgan Chase U.S. Medical Plan, please see the *What Happens If…*section of *Your JPMC Benefits Guide*, available at www.jpmcbenefitsguide.com and in print on request to the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576 2427), for details on when you can adjust your participation in the JPMorgan Chase U.S. Medical Plan. For more information, see the Benefits Status Change Guide on **My Health** > Learn About the JPMC Benefits Program.

Continuing Health Coverage Under COBRA

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

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

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

COBRA coverage applies to the Medical Plan as well as certain other health care plans.

If you elect COBRA Medical Plan coverage, the U.S. Fertility Benefits Program is included in that election. This section regarding COBRA may make references to dependent children. As a reminder, dependent children are not eligible for benefits under the Fertility Benefits Program.

More details about coverage under COBRA are available through the HR Answers Benefits Contact Center.

Qualified Beneficiary

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

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

Qualifying Events

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

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

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

Continuation Coverage for a Domestic Partner Dependent

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

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

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

Giving Notice of a COBRA Qualifying Event

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

However, if you divorce or your eligible dependent child loses dependent status under the terms of the plan, you or one of your covered dependents must contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) within 60 days of any such event. If notice is not received within that 60-day period, your dependents will not be entitled to elect COBRA continuation coverage. Notice must be provided to the COBRA Administrator and must include the following information: the name of the employee or qualified beneficiaries requesting coverage, the qualifying event and the date of the qualifying event. In addition, you may be asked to provide supporting documentation such as a divorce decree. Otherwise, your covered dependents will not be eligible to elect continued coverage under COBRA.

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

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

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

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

Updating Your Personal Contact Information

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

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

Choosing COBRA Coverage

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

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

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

You will receive COBRA materials approximately two weeks after the date they are notified of the qualifying event. These materials will describe the enrollment instructions and time frames for making your elections. You will have a period of 60 days from the date of your qualifying event to elect COBRA coverage. **Important Note:** You must make an election at the time COBRA coverage is offered—it is not automatically provided.

Premium Due Dates

If you elect to continue coverage under COBRA, you must pay the first two premiums (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums are due on the first calendar day of the month for that month's coverage, and must be paid within 30 days of each due date. If you elect to continue your coverage under COBRA but do not make timely payments (even if you do not receive a bill), your coverage will be terminated retroactively to the time frame applicable to your last payment and will not be reinstated. As it relates to the U.S. Fertility Benefits Program, the cost of this coverage is included in your U.S. Medical Plan premiums; there is not a separate premium for this program.

Coverage During the Continuation Period

With respect to Medical Plan and Dental Plan coverage, you and your covered dependents may choose to continue the coverage option that you had as an active employee or you may elect a different option at the time you initially enroll for COBRA coverage. (Because the Vision Plan has only one option, there is no opportunity to change that coverage if you continue it under COBRA.) If coverage is changed for active employees, the same changes will be provided to individuals with COBRA coverage. In addition, you and your covered dependents may change coverage during Annual Benefits Enrollment, if a qualified change in status occurs, or at other times, to the same extent that active employees may do so.

Please Note: Although JPMorgan Chase allows you to elect a different option at the time of your initial COBRA election, not all plans allow a change. Generally, all self-insured options allow a change at this time. It is the responsibility of the employee to contact the health care administrator of his or her Medical and Dental Plan option to verify if coverage is available.

COBRA Coverage Costs

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

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

Company-Subsidized COBRA Coverage

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

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

How Continued Coverage Could End

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

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

Additional Questions About COBRA Coverage

If you have additional questions about your COBRA coverage, please call the HR Answers Benefits Contact Center 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 U.S. holidays.

Program Administration

This section provides you with important information as required by the Employee Retirement Income Security Act of 1974 (ERISA) about the U.S. Fertility Benefits Program. 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.

About This Section

This section summarizes administrative and rights information for the U.S. Fertility Benefits Program. Please retain this section for your records.

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.

Questions?

For questions or concerns regarding the U.S. Fertility Benefits Program, please contact the Program's service provider, WINFertility, at (833) 439-1517. Representatives are available Monday through Friday, from 9 a.m. to 7:30 p.m. Eastern Time.

For questions about eligibility and plan operations, contact the HR Answers Benefits Contact Center, 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 U.S. holidays.

General Information

The following summarizes important administrative information about the U.S. Fertility Benefits Program.

Keep Your Information Current

Update your contact information (home address and phone numbers) on My Personal Profile. To access My Personal Profile while actively employed, go to https://mpp.jpmchase.net

Program Sponsor

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

(Certain participating companies have adopted the U.S. Fertility Benefits Program for their eligible employees. See "Participating Companies" on page 289 for a list of participating companies.)

Program Year

January 1 – December 31

Plan Administrator

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

Claims Administrator

WINFertility, at (833) 439-1517.

COBRA Administrator

COBRA questions should be directed to JPMorgan Chase HR Answers Benefits Contact Center.

COBRA payments should be directed to:

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

(877) 576-2427

Benefits Fiduciaries

Please see “About Plan Fiduciaries” on page 357 for information on benefits fiduciaries.

Agent for Service of Legal Process

Legal Papers Served:

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

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

Employer Identification Number

13-4994650

Plan Administrative Information

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
JPMorgan Chase Medical Plan (U.S. Fertility Benefits Program)/502	Not Applicable (no insurer)	WINFertility, Inc. Greenwich American Center One American Lane Terrace Level Greenwich, CT 06831 (833) 439-1517	Self-Insured/Trustee

Participating Companies

In some cases, affiliates or subsidiaries of JPMorgan Chase have decided to participate in the U.S. Fertility Benefits Program. These affiliates or subsidiaries are referred to here as "participating companies." The list may change from time to time, and any company may end its participation in a plan at any time.

- Bear Stearns Asset Management, Inc.
- Connexions Loyalty Acquisition, LLC
- eCast Settlement Corp
- FNBC Leasing Corporation
- Highbridge Capital Mgmt, LLC
- InstaMed Communications, LLC
- J.P. Morgan Alternative Asset Management, Inc.
- J.P. Morgan Chase Custody Services, Inc.
- J.P. Morgan Electronic Financial Services, Inc.
- J.P. Morgan Institutional Investments, Inc.
- J.P. Morgan Investment Holdings LLC
- J.P. Morgan Investment Management Inc.
- J.P. Morgan Securities, LLC
- J.P. Morgan Trust Company of Delaware
- JPMorgan Chase Bank, National Association
- JPMorgan Chase Holding LLC
- JPMorgan Distribution Services, Inc.
- Neovest, Inc.
- Paymentech, LLC
- Security Capital Research & Management, Incorporated
- WePay Inc.
- 55i, LLC

Your Rights Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) gives you certain rights and protections while you are a participant in the U.S. Fertility Benefits Program. 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.

Enforce Your Rights

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

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

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

Keep Your Contact Information Current

Active participants are required to update their personal contact information, including mailing address, to receive benefits-related information and correspondence. You can make changes online via My Personal Profile at mpp.jpmorganchase.com. You can also call the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427).

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 the U.S. Fertility Benefits Program, 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 summary.

Assistance with Your Questions

If you have any questions about the U.S. Fertility Benefits Program, you should contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427). 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 U.S. Fertility Benefits Program, WINFertility may have access to your individual health care and prescription claims data related to fertility services. WINFertility maintains the confidentiality of your information in accordance with privacy regulations such as HIPAA.

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 the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) 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, which includes the U.S. Fertility Benefits Program, 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 Program, such as whether you meet the requirements of employees/dependents/beneficiaries who are allowed to obtain benefits under the plans. In addition, if you have a type of claim that is not otherwise described in this summary, including claims related to general plan operations, lawfulness of plan provisions, or Section 510 of ERISA, you must file your claim in accordance with this section. For information on filing claims for benefits, please see “Claiming Benefits” beginning on page 361.

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 the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427).

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

For questions about eligibility to participate in the Program and to receive benefits or about general plan operations, please contact the HR Answers Benefits Contact Center.

If you are not satisfied with the response, you may file a written claim with the plan administrator at the address provided in “General Information” on page 354. The plan administrator will assign your claim for a determination. You must file your claim within 90 days of the event giving rise to your claim. 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, you must submit a written request for appeal of your claim to the 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 will decide appeals under the Program.

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 298, which sets forth the rules that will apply.

Claiming Benefits

This section explains the benefits claims and appeals process for the benefits of the U.S. Fertility Benefits Program. It includes detailed information about what happens at each step in the process and includes important timing requirements. This section also includes information about each plan’s “fiduciary” and contact information. See “About Plan Fiduciaries” on page 357 and “Contacting the Claims Administrator” on page 365. For claims relating to eligibility questions or claims, please see “Claims Related to Eligibility to Participate in the Plans and Plan Operations” on page 360.

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.

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 U.S. Fertility Benefits Program. 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.

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:

- 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.

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.

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 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.

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 the benefit was denied based on medical appropriateness, 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.

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 U.S. Fertility Benefits Program.

The plan administrators delegate all fiduciary responsibility and decisions about a claim for a denied benefit under the Fertility Benefits Program to WINFertility.

Under certain plans including the U.S. Fertility Benefits Program, final appeals for denied claims will be heard by a review panel that is independent of both the company and the claims administrators.

If your initial claim for benefits is denied, you — or your authorized representative — may file an appeal of the decision with the claims administrator or plan administrator within 180 days after receipt of the claim denial.

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.

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 or plan administrator is legally required to notify you in writing of this decision within a "reasonable" period of time according:

- 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)

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 the benefit was denied based on medical appropriateness, 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 U.S. Fertility Benefits Program requires 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 coverage will be heard by a review panel that is independent of both the company and the claims administrator.

The independent review panel hears only appeals that involve medical judgment or a rescission of coverage; the panel does not hear appeals about eligibility to participate in a plan or legal interpretation of a plan that does not involve medical judgment.

Filing a Court Action

If an appeal 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 must start the 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. You cannot file a suit unless you have completed two appeals, if required by the claims administrators.

Contacting the Claims Administrator

WINFertility

Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831

(833) 439-1517

If You Are Covered by More Than One Health Care Plan

The JPMorgan Chase U.S. Fertility Benefits Program has 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 JPMorgan Chase Program. 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.

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.

Right of Recovery

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

Subrogation of Benefits

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

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

If you receive a subrogation request and have questions, please contact your health care company.

Right of Reimbursement

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

- You must reimburse the JPMorgan Chase plans in first priority from any recovery from a third party for the full amount of the benefits the plan paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- Regardless of any allocation or designation of your recovery made in a settlement agreement or court order, the JPMorgan Chase plans shall have a right of full reimbursement, in first priority, from the recovery.

- You must hold in trust for the benefit of the JPMorgan Chase plans the gross proceeds of a recovery, to be paid to the plans immediately upon your receipt of the recovery. You must reimburse the plans, in first priority and without any set-off or reduction for attorney fees or other expenses. The "common fund" doctrine does not apply to any funds recovered by any attorney you retain, regardless of whether the funds recovered are used to repay benefits paid by the plans.
- If you fail to reimburse the JPMorgan Chase plans, the plans may deduct any unsatisfied portion of the amount of benefits the plans have paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plans.

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

Special Notice for Employees Who Have Been Rehired by JPMorgan Chase

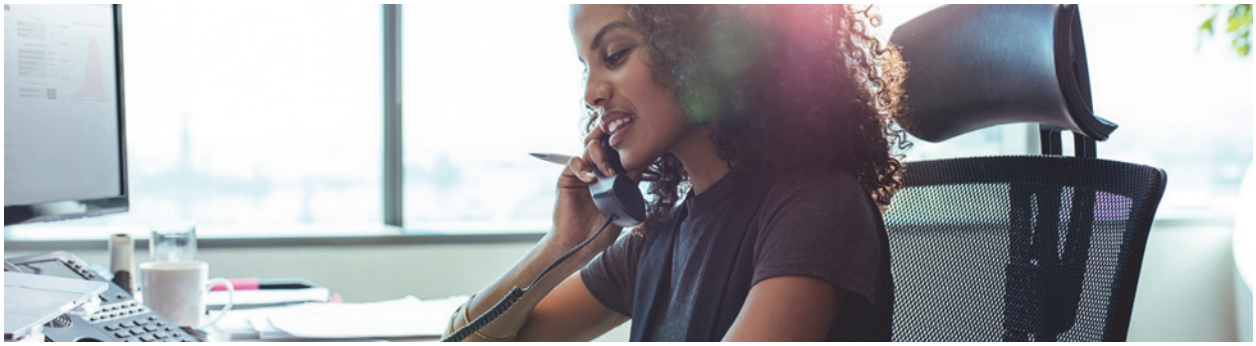
If your employment has been reinstated with JPMorgan Chase (that is, you have been rehired within 31 days of your employment termination date or your coverage termination date), you and your dependents will be assigned the same U.S. Medical Plan coverage (which includes Fertility Benefits Program coverage) 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.

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.

Defined Terms

As you read this summary of the JPMorgan Chase U.S. Fertility Benefits Program, you'll come across some important terms related to the Program. To help you better understand the Program, many of those important terms are defined here.

Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Program. For the Fertility Benefits Program benefits, the claims administrator is WINFertility.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue certain health plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. "Continuing Health Coverage Under COBRA" on page 282 provides details on COBRA coverage. You must elect JPMorgan Chase Medical Plan coverage under COBRA to continue the Fertility Benefit under COBRA. There is no additional charge for the Fertility Benefit under COBRA if Medical Plan coverage is elected.
Covered Services	Covered services are services and procedures that are generally reimbursable by the Program. While the Program provides coverage for numerous services and supplies, there are limitations on what's covered. While a service or supply may be necessary, it may not be covered under the Program. Please see the sections that explain what the Program covers and what is not covered for more details.
Introductory Period	All employees, including re-employed individuals, begin employment with a 90-day introductory period, regardless of the length of the break in employment for re-employed individuals. The introductory period does not apply if an employee transfers or is promoted into a new position or if the employee joins the firm through a merger or acquisition. During the 90-day introductory period of continuous service, employees demonstrate their performance capabilities and assess whether the position is suited to them. The manager also assesses whether the employee is appropriately qualified and suited for the position. The introductory period may also serve as a period of time to complete any training or licensing requirements for the position in which the employee was hired. At JPMorgan Chase's discretion, there may be times when the introductory period will be extended beyond 90 days. During an employee's introductory period (and throughout employment with JPMorgan Chase) an employee's employment may be terminated at any time without prior warning.
In-Network Provider/Out-of-Network Provider	"In-network" and "out-of-network" are terms referring to whether a provider is part of the WINFertility network (in-network provider) or is not part of the WINFertility network (out-of-network provider).



The Group Legal Services Plan

Effective 1/1/21

The JPMorgan Chase Group Legal Services Plan, offers you and your family access to an affordable network of attorneys in the United States. The Plan provides coverage for attorney fees for routine legal services related to personal or family legal issues. Most services authorized by the Plan are covered at 100% when you use network attorneys. A reimbursement schedule applies to fees charged by out-of-network attorneys.

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

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

Questions?

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

MetLife Legal Plans

(800) 821-6400

Representatives are available from 8 a.m. to 8 p.m. Eastern Time, Monday – Friday.

For additional resources, consult the *Contacts* section.

Additional Legal Support

In addition to the Group Legal Services described in this Summary Plan Description (SPD), you have access to certain free legal services through the Work Life Program. For more information on the legal services offered as part of the Work Life Program go to **me@jpmc** > Health, Life & Parenting > Employee Assistance and Work Life Program > U.S. or call (877) 576-2007.

About This Summary Plan Description

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

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

The JPMorgan Chase U.S. Benefits Program is available to most employees on 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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Legal Services Plan Highlights

Benefits of Participating	The Plan offers you and your family access to an affordable network of attorneys for routine legal services related to personal and family legal issue. Most services are covered at 100% when you use in-network attorneys. In-network services are available only in the continental United States, U.S. Virgin Islands, Puerto Rico and Hawaii. A reimbursement schedule applies to fees charged by out-of-network attorneys. Attorneys will only provide services for U.S.-related issues.
Covered Services	Covered services include all of the following: ▪ Advice and consultation; ▪ Consumer protection; ▪ Identity Theft; ▪ Defense of civil lawsuits; ▪ Document preparation and review; ▪ Family law; ▪ Immigration; ▪ Real estate matters; ▪ Traffic and criminal matters; and ▪ Wills and estate matters. Please see “What Is Covered” on page 379 for details of covered services.
Pre-Existing Legal Matters Excluded	Any legal matter for which an attorney-client relationship existed prior to you joining the Plan will be excluded, and no benefits will apply.
Who’s Covered?	If you enroll for coverage, the Plan provides coverage for you and all of your dependents who are eligible and qualify for the JPMorgan Chase Medical Plan coverage (your spouse or domestic partner and your children under age 26). For more details, see “Your Eligible Dependents” in the *Health Care Participation* section.
Costs	You pay the full cost of your coverage on an after-tax basis. There is a flat rate for coverage — your cost per pay period is the same regardless of how many dependents are covered with you. For more details, see “Cost of Coverage” on page 375.
Enrolling and Changing Coverage	**Enrolling:** You can only enroll for coverage during Annual Benefits Enrollment or when you first become eligible (generally, as a newly hired employee or due to a work status change). Because there is one contribution level for the Group Legal Services Plan coverage, your cost for coverage does not increase if you add dependents (e.g., if you marry, add a domestic partner, or have a baby, they will be considered covered as of the date of the event. **Changing Coverage:** You may not drop coverage during the plan year. You can only make changes to your coverage during Annual Benefits Enrollment (usually held in the fall of each year for the following year’s participation). Midyear changes due to a Qualified Status Change (QSC) are not permitted under this Plan. When you enroll, your participation is in effect through December 31 and you may not stop participating unless you are no longer eligible due to a work status change.
Claims Administrator	The Plan’s claims administrator is MetLife Legal Plans.

Participating in the Plan

Who's Eligible?

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

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

Who's Not Eligible?

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

Examples of such individuals include an:

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

When You Become Eligible

Employees are eligible to participate in the Group Legal Plan as follows:

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

Who's Covered?

If you, the JPMorgan Chase employee, enroll in the Plan, the Plan automatically covers you, your spouse/domestic partner, and all eligible children that are eligible and qualify for coverage under the JPMorgan Chase Medical Plan. For details about your eligible dependents, please see "Your Eligible Dependents" in the *Health Care Participation* section.

An Important Note About Your Coverage

If you and your spouse/domestic partner both work at JPMorgan Chase and if one of you enrolls in the Group Legal Services Plan, the other will automatically be covered. However, in cases involving a dispute between you and your spouse/domestic partner, only the employee enrolled in coverage (and paying for the coverage through payroll deductions) will be eligible for benefits. If you and your spouse/domestic partner enroll separately, you cannot be covered as dependents under one another's coverage.

Cost of Coverage

You pay the entire cost for coverage under the Plan with after-tax contributions. Your cost is the same regardless of how many dependents are covered under the Plan.

Your contributions toward the cost of coverage start when your coverage begins. (Please see “When Coverage Begins” on page 376 for more information.) Your contributions are automatically deducted from your pay.

If you have coverage but are away from work because of an unpaid sickness or leave of absence, you will pay for coverage on an after-tax basis through direct-billing with JPMorgan Chase’s administrator.

How to Enroll

You can only enroll for coverage when you first become eligible (generally, as a newly hired employee) or during Annual Benefits Enrollment. Unlike other JPMorgan Chase benefits, you cannot enroll, change, or cancel your coverage during the year, even if you have a Qualified Status Change (QSC). Participation in the Plan is optional. You must enroll to have coverage.

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

- Current, eligible employee, enrolling during Annual Benefits Enrollment;
- Newly hired employee; or
- Newly eligible employee (because of a change in work status).

Enrolling if You Are an Employee

You’ll receive information on Plan benefits as well as instructions on enrolling during Annual Benefits Enrollment. You make your elections through the Benefits Web Center on **My Health** or through HR Answers.

Elections you make during Annual Benefits Enrollment are effective the following January 1.

You need to consider your choice carefully, as you can’t change or cancel your choice during the year, even if you have a Qualified Status Change (QSC).

If you’re already participating in the Plan and do not cancel coverage during Annual Benefits Enrollment, you’ll continue with the same coverage you had before Annual Benefits Enrollment. However, you’ll be subject to any changes in the Plan and coverage costs effective with the new plan year.

Enrolling if You Are a Newly Hired Employee

If you’ve just joined JPMorgan Chase and are enrolling for the first time, you need to make your choices through the Benefits Web Center on **My Health** or through HR Answers.

You will need to enroll within 31 days of your date of hire if you are a full-time employee, and within 31 days prior to becoming eligible if you are a part-time employee, as explained below.

- **If you are a full-time employee,** you may receive information regarding benefits enrollment after accepting a position with JPMorgan Chase but before your hire date. Your coverage will begin on the first of the month following your hire date, as long as you enroll prior to your hire date or within 31 days after your hire date.
- **If you are a part-time employee,** you are eligible for coverage on the first of the month after 60 days from your date of hire. You will receive your enrollment materials within 31 days before becoming eligible for coverage. You need to enroll within 31 days before your eligibility date.

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

Enrolling if You Are a Newly Eligible Employee

If you're enrolling during the year because you're a newly eligible employee due to a work status change, you'll have 31 days from the date of the change in work status to make your new choices through the Benefits Web Center on **My Health** > Benefits Web Center or through HR Answers.

If You Do *Not* Enroll

If You Are an Enrolled Employee

If you're already participating in the Plan and do not cancel coverage during Annual Benefits Enrollment, you'll generally keep the same coverage you had before Annual Benefits Enrollment. However, you'll be subject to any changes in the Plan and coverage costs effective with the new plan year.

If You Are a Newly Hired or Newly Eligible Employee

If you're a newly hired or newly eligible employee and do not actively enroll before the end of the designated 31-day enrollment period, you won't be able to enroll in the Group Legal Services Plan until the next Annual Benefits Enrollment.

When Coverage Begins

If You Are an Employee

If you enroll during Annual Benefits Enrollment, your coverage will be effective January 1 and you will continue to participate for the full calendar year (January through December).

If You Are a Newly Hired or Newly Eligible Employee

If you enroll, coverage will be effective on the first of the month following your hire date if you are a full-time employee. If you are a part-time employee, coverage will be effective the first day of the month following 60 days from your date of hire.

You will continue to participate from the effective date through the end of the calendar year. If you go on a leave of absence and not receiving payroll deductions, your participation will continue as long as you continue to pay applicable premiums.

Your Membership Number

MetLife Legal Plans will send your membership number to you after you enroll. You will need the number to get services and file claims for benefits. Please retain this number.

No Midyear Changes

When you enroll, your participation is in effect through December 31 and you may not stop participating unless you are no longer eligible. Midyear changes are not permitted under this Plan, even if you have a Qualified Status Change (QSC) that allows you to change other JPMorgan Chase benefits.

You can only make changes to your coverage during Annual Benefits Enrollment (usually held in the fall of each year for the following year's participation).

If your work status changes and you are then scheduled to work fewer than 20 hours per week, your Group Legal Services Plan coverage will end on the date of the work status change.

When Coverage Ends

Generally, your coverage ends on your last day of active employment. Other reasons your coverage ends are when:

- You stop paying applicable premiums; or
- After you have been on an approved long-term disability leave and receiving LTD benefits under the LTD Plan for 24 months.
- You no longer meet the eligibility requirements of the Group Legal Services Plan (unless you are temporarily approved for additional leave under another JPMorgan Chase Policy, such as the Disability and Reasonable Accommodation Policy);
- The Group Legal Services Plan is discontinued;
- You pass away.

Coverage for your dependents ends the earlier of when your coverage ends or when your dependents no longer meet the eligibility requirements described in "Your Eligible Dependents" in the *Health Care Participation* section of this Guide. For your spouse/domestic partner, this means when you pass away, divorce, or end your relationship. For a child, this means when you pass away or the last day of the month in which he or she turns age 26.

- **Please Note:** You may continue coverage beyond age 26 for an unmarried child who is not capable of supporting himself or herself due to a mental or physical disability that began before the age limits described above and who is fully dependent on you for financial support.
- Coverage for a domestic partner ends when the domestic partner ceases to meet the eligibility requirements described in "Your Eligible Dependents" in the *Medical Plan* section of this Guide.

Continuing Coverage After It Ends

You have the option to continue group legal coverage by contacting MetLife Legal Plans at (800) 821-6400.

- You must contact MetLife within 31 days of the date your coverage ends.
- Currently, you can continue the Plan for an additional 12 months of coverage.
- If you continue coverage, you will pay premiums on a direct-bill basis to MetLife Legal Plans.

Services in Progress Continue

Even if you don't continue group legal coverage, any services in progress before your coverage end date will be provided.

How the Plan Works

The Plan provides coverage for attorney fees for routine, U.S.-related legal services related to personal or family legal issues.

The Plan offers access to a network of U.S. attorneys who provide a wide range of legal services. In-network services are available only in the United States, U.S. Virgin Islands, and Puerto Rico.

- Most services authorized by the Plan are covered at 100% when you use network attorneys.
- A reimbursement schedule applies to fees charged by out-of-network attorneys.

Finding Network Attorneys

You can call MetLife Legal Plans' Call Center to find a network attorney. A Client Service Representative will ask you to identify yourself as a JPMorgan Chase employee and will request your membership number, which is located in your welcome letter MetLife Legal Plans sends to you after you elect coverage.

Your spouse/domestic partner and any eligible child may use the Plan. Those family members will be required to provide your membership number when requested, to verify their eligibility.

The Plan Call Center

The Client Service Representative is responsible for all of the following:

- Verifying eligibility for services over the phone;
- Making an initial determination of whether and to what extent your case is covered (the Plan attorney will make the final determination of coverage);
- Providing a case number, which is similar to a claim number (each case is assigned a new case number);
- Providing the telephone number of the Plan attorney(s) most convenient to you; and
- Answering any questions you have about the Group Legal Services Plan.

Following your initial phone call, you may schedule an appointment with a Plan attorney. Evening and Saturday appointments are available, if requested.

Plan and Out-of-Network Attorneys

When you use a Plan (in-network) attorney, all attorney's fees for covered services are paid in full by the Plan (except for certain limits shown in "What Is Covered" on page 379).

If you choose to seek legal services from an out-of-network attorney, MetLife Legal Plans will reimburse you for out-of-network attorneys' fees in accordance with a set fee schedule. Please see "What Is Covered" on page 379.

For services to be covered, you or your eligible dependents must establish an attorney-client relationship while you are an enrolled member of the Group Legal Services Plan.

Your use of the Plan and the legal services provided by the Plan are totally confidential.

The Role of Plan Attorneys

The Plan attorney is required to maintain the strict confidentiality of a traditional attorney-client relationship. The attorney's relationship is exclusively with you. JPMorgan Chase will not receive information about your legal issues or the services you use under the Plan. In addition, no one will interfere with your Plan attorney's independent exercise of professional judgment when representing you.

The attorney will adhere to the rules of the Plan. MetLife Legal Plans, or the law firm providing services under the Plan, is responsible for all services provided by their attorneys.

JPMorgan Chase has no liability for the conduct of any Plan attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan. If you have a complaint about the legal services you have received or the conduct of an attorney, you can register a complaint by calling MetLife Legal Plans. Your complaint will be reviewed, and you will receive a response within two business days of your call.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous, or for the purpose of harassing another person.

What Is Covered

The following fee schedule describes the maximum amounts that the Group Legal Services Plan will reimburse you for covered legal services provided if you use an in-network or out-of-network attorney. Only one fee category per case-type applies to each matter — the fee category that best describes the services that were provided.

The Plan provides only for the personal legal matters listed below. Once you receive services from an out-of-network attorney, you cannot then use an in-network Plan attorney for the same matter.

If you or your attorney have any questions regarding coverage or exclusions, please visit the Plan website at www.legalplans.com or call (800) 821-6400 and ask to speak with MetLife's Payment Administrator before services are provided.

The list of covered services may change at any time.

Advice and Consultation

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Office Consultation and Telephone Advice	100%	$70 (If no further covered services are provided)

Consumer Protection

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Consumer Protection Matters Excludes disputes over real estate, construction or insurance. Disputed amount exceeds small claims limit and is evidenced by writing.		
Prior to Lawsuit Filing	100%	$500
After Lawsuit Filing	100%	$2,000, plus Trial Supplement*
Property Protection		
Prior to Lawsuit Filing	100%	$500
After Lawsuit Filing	100%	$2,000, plus Trial Supplement*
Small Claims		
Negotiation and Settlement	100%	$350
Filing Answer, Litigation Ending in Settlement or Judgment	100%	$1,050, plus Trial Supplement*

* Trial Supplement — In addition to the fees indicated, the Plan will pay one-half of the attorney's hourly rate for representation in trial beyond the third day of trial, for a maximum of $800 per day up to a $100,000 total trial supplement maximum.

Identity Theft

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Identity Theft	100%	
Correspondence/Notice to Creditors	100%	$250

Defense of Civil Lawsuits

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Administrative Hearing		
School Matters and Veterans Benefits Disputes	100%	$250
Civil Litigation Defense Excludes defense of matters arising from divorce, post-decree actions or other family law matters.		
Negotiation and Settlement	100%	$650
Filing Answer, Litigation Ending in Settlement or Judgment	100%	$1,800, PLUS TRIAL SUPPLEMENT*
Incompetency Defense		
Negotiation and Settlement	100%	$500
Contested Hearings Ending in Settlement or Judgment	100%	$1,800, PLUS TRIAL SUPPLEMENT*

* Trial Supplement — In addition to the fees indicated, the Plan will pay one-half of the attorney's hourly rate for representation in trial beyond the third day of trial, for a maximum of $800 per day up to a $100,000 total trial supplement maximum.

Document Preparation and Review

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Affidavits	100%	$75
Deeds	100%	$100
Demand Letters	100%	$75
Document Review	100%	$100
Elder Law Matters (Counseling and document review of only documents pertaining to the participant's parents as affecting the participant)	100%	$140
Mortgages	100%	$70
Promissory Notes	100%	$70

Family Law

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Adoption and Legitimization		
Uncontested	100%	$650
Contested	100%	$1,500, plus Trial Supplement*
Change or Establishment of Custody Order		
Uncontested	100%	$650
Contested	100%	$1,500
Divorce, Dissolution and Annulment (Available to Eligible Plan Member only)	100% (up to 20 hours/event)	$1,800
Enforcement or Modification of Support Order	100%	$750
Enforcement or Modification of Visitation Order (Defense Only)	100%	$750
Guardianship or Conservatorship		
Uncontested	100%	$650
Contested	100%	$1,500, plus Trial Supplement*
Juvenile Court Proceeding Parental Responsibilities in Juvenile Court	100%	$600, plus Trial Supplement*
Name Change	100%	$400
Prenuptial Agreement	100%	$750

* Trial Supplement — In addition to the fees indicated, the Plan will pay one-half of the attorney's hourly rate for representation in trial beyond the third day of trial, for a maximum of $800 per day up to a $100,000 total trial supplement maximum.

Immigration

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Immigration assistance Counseling on Preparing Forms and Hearing Preparation	100%	$500

Real Estate Matters

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Boundary or Title Disputes		
Prior to Lawsuit Filing	100%	$500
After Lawsuit Filing	100%	$1,500, plus Trial Supplement*

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Building/Permit Code Violations (Primary Residence)		
Negotiation and Settlement	100%	$500
Trial	100%	$1,000, plus Trial Supplement*
Eviction and Tenant Problems (Primary Residence - Tenant only)		
Prior to Lawsuit Filing	100%	$280
After Lawsuit Filing	100%	$840, plus Trial Supplement*
Natural Disaster Insurance Claims (Primary or Secondary Residence) Correspondence and Negotiations	100%	$500
Property Tax Assessment (Primary Residence)		
Correspondence and Negotiations	100%	$500
Hearing	100%	$620, plus Trial Supplement*
Sale, Purchase or Refinance of Primary, Secondary, Vacation and Investment Home (Applies only to attorney who represents the Plan member, not the attorney representing the lending institution.)	100%	$500
Zoning and Variances (Primary Residence)		
Negotiation and Settlement	100%	$500
Trial	100%	$800, plus Trial Supplement*

* Trial Supplement — In addition to the fees indicated, the Plan will pay one-half of the attorney's hourly rate for representation in trial beyond the third day of trial, for a maximum of $800 per day up to a $100,000 total trial supplement maximum.

Traffic and Criminal Matters

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Driving Privileges/Restoration of Suspended License Before Trial	100%	$385
Traffic Ticket Defense (No DUI)		
• Before Trial	100%	$250
• Representation at Trial	100%	$500, plus Trial Supplement*

* Trial Supplement — In addition to the fees indicated, the Plan will pay one-half of the attorney's hourly rate for representation in trial beyond the third day of trial, for a maximum of $800 per day up to a $100,000 total trial supplement maximum.

Wills and Estate Matters

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Living Wills		
Individual	100%	$75
Member and Spouse	100%	$80
Powers of Attorney		
Individual	100%	$65
Member and Spouse	100%	$75
Probate Proceedings		
Estate Administration and Closing	Up to the first $500	$500
Affidavit/Simple Procedure/Tax Only	100%	$500
Standard Probate/Court Supervised Probate	100%	$500
Trusts		
Individual	100%	$325
Member and Spouse	100%	$450
Wills and Codicils		
Codicil — Individual	100%	$150
Codicil — Member and Spouse	100%	$200
Standard Will — Individual	100%	$150
Standard Will — Member and Spouse	100%	$200

If there is any question about whether a service would be included or excluded, or the extent of coverage of a service, it is important to call MetLife Legal and receive confirmation as to whether and for how much a service is covered.

What Is Not Covered

The Plan does not cover the following:

- Employment-related matters, including company or statutory benefits;
- Matters involving JPMorgan Chase & Co., MetLife® and affiliates, and Plan attorneys;
- Matters in which there is a conflict of interest between employee and spouse/domestic partner or children, in which case services are excluded for the spouse/domestic partner and children;
- Appeals and class actions;
- Farm and business matters, including rental issues when the participant is the landlord;
- Patent, trademark, and copyright matters;
- Costs or fines;
- Frivolous or unethical matters; and
- Matters for which an attorney-client relationship exists prior to the participant becoming eligible for Plan benefits.

This list may change at any time.

Pre-Existing Legal Matters

Any legal matter for which an attorney-client relationship existed prior to your becoming eligible for services under the Group Legal Services Plan will be excluded and no benefits will apply.

Items Not Listed and Not Excluded
If there is any question about whether a service would be included or excluded, or the extent of coverage, it is important to call MetLife Legal and receive confirmation as to whether a service is covered.

Claiming Benefits

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

How to File Claims

Rules regarding claims depend on whether you receive your services in- or out-of-network, as shown below:

Source of Benefits	Claims Process
In-Network Benefits	You do not need to file a claim form.
Out-of-Network Benefits	Contact MetLife Legal Plans, the claims administrator, to obtain an out-of-network claim form and case number. (See contact information below under “Where to Submit Claims” on page 384.)

To have your claim considered for benefits, you need to file your claim by December 31 of the year following the year in which services were provided. If you fail to meet this deadline, your claim will be denied. Be sure to attach itemized bills or receipts to your claim form, and keep copies for your records. Separate claim forms must be submitted for each covered family member for whom a claim is made. Your claim will be processed within 15 business days of receipt by the claims administrator.

Where to Submit Claims

The claims administrator’s is MetLife Legal Plans, Inc.:

MetLife Legal Plans, Inc.
1111 Superior Avenue
Cleveland, OH 44114

(800) 821-6400

8 a.m. to 8 p.m. Eastern Time

Appealing Claims

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

Defined Terms

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

After-Tax Contributions	After-tax contributions are contributions that are taken from your pay after federal (and in most cases, state and local income taxes) have been withheld.
In-Network/Out-of-Network	Terms referring to whether a covered service is performed by a provider who is part of the network associated with the Group Legal Services Plan or by a provider who is not part of the network. When a service is performed through a network provider, benefits are paid at a higher level than they are when a service is performed through an out-of-network provider.

The Group Personal Excess Liability Insurance Plan

Effective 1/1/21

The JPMorgan Chase Group Personal Excess Liability Insurance Plan is not a plan governed by the Employee Retirement Income Security Act, and is therefore not governed by the rules and procedures of ERISA. This document is a description of the Group Personal Excess Liability Insurance Plan for informational purposes only. The Plan provides additional liability protection for up to $10 million in coverage for damages and costs you or a covered family member might have to pay, beyond the limits of liability provided by your primary auto, homeowners, renters, recreational vehicle, motorcycle and watercraft insurance policies. Examples of situations this coverage could potentially address are:

- *Serious auto and boat accidents;*
- *Youthful driver claims;*
- *Swimming pool accidents;*
- *"Slip and fall" accidents on your property;*
- *Snowmobile claims;*
- *Service on a homeowner's condominium or cooperative association, if not for profit; and*
- *Service as a director or officer for a non-profit organization for which you do not receive any pay.*

This section of the Guide will provide you with a better understanding of how coverage under the Group Personal Excess Liability Insurance Plan works, including how and when benefits are paid.

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

About This Summary

This section is a summary of the JPMorgan Chase Group Personal Excess Liability Insurance Plan. This summary does not include all of the details contained in the applicable insurance contracts, if any. If there is a discrepancy between the applicable insurance contracts and this summary, the insurance contracts 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 the Personal Excess Liability Insurance Plan, contact the claims administrator:

Arthur J. Gallagher
Risk Management Services

(866) 631-4630

Representatives are available from 9 a.m. to 5 p.m. Eastern time, Monday – Friday.

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. Because most benefits under the Group Personal Excess Liability Insurance Plan are provided by insurance, the terms of the policy or insurance certificate will control eligibility for benefits. If there is a discrepancy between this description and the policy or certificate, the policy or certificate 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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Personal Excess Liability Highlights

Benefits of Participating	The Group Personal Excess Liability Insurance Plan provides additional liability protection for damages and costs arising from bodily injury or personal injury to others, or for damage to the property of others. This insurance covers what you or a covered family member may be liable for beyond the limits of liability provided by your primary auto, homeowners, renters, recreational vehicle, motorcycle or watercraft insurance policies.
Your Choices	You can choose from among the following options: ▪ $2 million in coverage ▪ $5 million in coverage ▪ $10 million in coverage
Additional Features	Additional features include: ▪ Uninsured/Underinsured Motorist Protection — $2 million in coverage ▪ Identity Fraud — $25,000 in coverage ▪ Kidnap Expense — $100,000 in coverage ▪ Reputational Injury — $25,000 in coverage
Who's Covered?	If you enroll for coverage, the Plan provides coverage for you and all of the dependents who are eligible and qualify for the JPMorgan Chase Medical Plan (your spouse or domestic partner and your children under age 26). For more details, see "Your Eligible Dependents" in the *Health Care Participation* section.
Costs	You pay the full cost of any group personal excess liability insurance you choose on an after-tax basis. There is a flat rate for coverage based on the coverage level you elect — your cost per pay period is the same regardless of how many dependents you cover.
Enrolling and Changing Coverage	**Enrolling:** You can only enroll for coverage during Annual Benefits Enrollment or when you first become eligible (generally, as a newly hired employee or due to a work status change). **Changing Coverage:** You cannot drop coverage during the plan year. You can only make changes to your coverage during Annual Benefits Enrollment (usually held in the fall of each year for the following year's participation). Midyear changes due to a Qualified Status Change (QSC) are not permitted under this Plan. When you enroll, your participation is in effect through December 31 and you may not stop participating unless you are no longer eligible due to a work status change.
Required Underlying Insurance	The Plan is designed to provide protection in case of liabilities beyond the limits of liability provided by your primary auto, homeowners, renters, recreational vehicle, motorcycle or watercraft insurance policies. This primary coverage is called the underlying coverage. You are required to have primary insurance in place that meets the specifications noted in "Required Underlying Insurance" on page 394.
Claims Administrator	The claims administrator is Arthur J. Gallagher Risk Management Services. Plan benefits are provided through insurance offered by The Chubb Insurance Company.

Participating in the Plan

Who's Eligible?

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

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

Who's Not Eligible?

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

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

When You Become Eligible

Employees are eligible to participate in the Group Legal Plan as follows:

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

Who's Covered?

If you, the JPMorgan Chase employee, enroll in the Plan, the Plan automatically covers you, your spouse/domestic partner, and all eligible children that are eligible and qualify for coverage under the Medical Plan. For details about your eligible dependents, please see "Your Eligible Dependents" in the *Health Care Participation* section.

Please Note: Even if underlying personal liability (homeowners) and automobile personal liability coverage is not in the employee's name, group personal excess coverage will be extended to a spouse or a domestic partner since he or she is considered a family member.

Additional Covered Persons

If you enroll, in addition to you and the dependents noted above, under "Who's Covered," include:

- Your family members (a family member is your spouse or domestic partner or other relative who lives with you, or any other person under age 26 who lives with you and who is in your care or your relative's care);
- Any person using a vehicle or watercraft covered under this Plan with permission from you or a family member with respect to their legal responsibility arising out of its use;
- Any other person who is a covered person under your required primary underlying insurance;

- Any person or organization with respect to their legal responsibility for covered acts or omissions of you or a family member; or
- Any combination of the above.

Cost of Coverage

You pay the entire cost of coverage under the Plan with after-tax contributions. Your per-pay-period cost depends on your pay schedule frequency and the coverage level you choose.

There is a flat rate for coverage under this Plan, based on the level of coverage you choose. You can choose from among the following coverage levels:

- $2 million;
- $5 million; or
- $10 million.
- Your cost per-pay-period is the same regardless of how many dependents are covered.

How to Enroll

You can only enroll for coverage when you first become eligible (generally, as a newly hired employee) or during Annual Benefits Enrollment. Unlike other JPMorgan Chase benefits, you cannot enroll, change, or cancel your coverage during the year, even if you have a Qualified Status Change (QSC). Participation in the Plan is optional. You must enroll to have coverage.

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

- Current, eligible employee, enrolling during Annual Benefits Enrollment;
- Newly hired employee; or
- Newly eligible employee (because of a change in work status).

Enrolling if You Are an Employee

You'll receive information on Plan benefits as well as instructions on enrolling during Annual Benefits Enrollment. You make your elections through the Benefits Web Center on **My Health** or through HR Answers.

Elections you make during Annual Benefits Enrollment are effective the following January 1.

You need to consider your choice carefully and enroll for the coverage that best meets your needs. You can't change or cancel your choice during the year, even if you have a Qualified Status Change (QSC).

If you're already participating in the Plan and do not cancel coverage during Annual Benefits Enrollment, you'll continue with the same coverage you had before Annual Benefits Enrollment. However, you'll be subject to any changes in the Plan and coverage costs effective with the new plan year.

Enrolling if You Are a Newly Hired Employee

If you've just joined JPMorgan Chase and are enrolling for the first time, you need to make your choices through the Benefits Web Center on **My Health** or through HR Answers.

You will need to enroll within 31 days of your date of hire if you are a full-time employee, and within 31 days prior to becoming eligible if you are a part-time employee, as explained below.

- **If you are a full-time employee (regularly scheduled to work 40 hours per week),** you may receive information regarding benefits enrollment after accepting a position with JPMorgan Chase but before your hire date. Your coverage will begin on the first of the month following your hire date, as long as you enroll prior to your hire date or within 31 days after your hire date.

- **If you are a part-time employee (regularly scheduled to work at least 20 but less than 40 hours per week),** you are eligible for coverage on the first of the month after 60 days from your date of hire. You will receive your enrollment materials within 31 days before becoming eligible for coverage. You need to enroll within 31 days before your eligibility date.

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

Enrolling if You Are a Newly Eligible Employee

If you're enrolling during the year because you're a newly eligible employee due to a work status change, you'll have 31 days from the date of the change in work status to make your new choices through the Benefits Web Center on **My Health** > Benefits Enrollment or through HR Answers.

If You Do *Not* Enroll

If You Are an Employee

If you're already participating in the Plan and do not cancel coverage during Annual Benefits Enrollment, you'll generally keep the same coverage you had before Annual Benefits Enrollment. However, you'll be subject to any changes in the Plan and coverage costs effective with the new plan year.

If You Are a Newly Hired or Newly Eligible Employee

If you're a newly hired or newly eligible employee and do not actively enroll before the end of the designated 31-day enrollment period, you won't be able to enroll in the Group Personal Excess Liability Insurance until the next Annual Benefits Enrollment.

When Coverage Begins

If You Are an Employee

If you enroll during Annual Benefits Enrollment, your coverage will be effective January 1 and you will continue to participate for the full calendar year (January through December). If you go on a leave of absence and are not receiving payroll deductions, your participation will continue as long as you continue to pay applicable premiums.

If You Are a Newly Hired or Newly Eligible Employee

If you enroll, coverage will be effective on the first of the month following your hire date if you are a full-time employee. If you are a part-time employee, coverage will be effective the first day of the month following 60 days from your date of hire.

You will continue to participate from the effective date through the end of the calendar year. If you go on a leave of absence and are not receiving payroll deductions, your participation will continue as long as you continue to pay applicable premiums.

Your Insurance Certificate
Following your coverage effective date, you will receive an individual certificate of insurance directly from Arthur J. Gallagher Risk Management Services. This will be your proof of coverage under the Group Personal Excess Liability Insurance Plan. Please retain this certificate for your records.

No Midyear Changes

When you enroll, your participation is in effect through December 31 and you may not stop participating unless you are no longer eligible due to a termination or work status change. If your work status changes and you are then scheduled to work fewer than 20 hours per week, your Plan coverage will end on the date of the work status change.

Midyear changes are not permitted under this Plan, even if you have a Qualified Status Change (QSC) that allows you to change other JPMorgan Chase benefits.

You can only make changes to your coverage during Annual Benefits Enrollment (usually held in the fall of each year for the following year's participation).

When Coverage Ends

Group legal coverage ends on your last day of active employment. Your coverage can also end when:

- You stop paying applicable premiums or in any other way become ineligible to participate in the plan; or
- After you have been receiving long-term disability benefits for 24 months.

Continuing Coverage After It Ends

You cannot convert or port your coverage, but you are eligible to continue your current coverage through the end of the calendar year in which you leave, provided that you pay the balance of the policy in full directly to Arthur J. Gallagher Risk Management Services.

If your coverage ends because you leave JPMorgan Chase, Arthur J. Gallagher & Co., the plan administrator, will contact you with instructions for continuing your coverage and paying the balance. If your payment is not received within 31 days, your policy will be canceled effective as of your termination date. You may not continue to participate in the program after the end of the policy year in which you were an active employee.

How the Plan Works

The JPMorgan Chase Group Personal Excess Liability Insurance Plan provides additional liability protection for damages and costs for which you or a covered family member are liable, beyond the limits of liability provided by your primary auto, homeowners, renters, recreational vehicle, motorcycle, and watercraft insurance policies. If you enroll, you can choose from three levels of coverage:

- $2 million in coverage
- $5 million in coverage
- $10 million in coverage

Coverage under this type of plan is always in excess of any other collectible insurance and is also known as an "umbrella policy." The Plan generally covers damages a covered person is legally obligated to pay for personal injury or property damage, in excess of damages covered by the underlying insurance. The Plan also covers some liability exposures that may be excluded by your underlying policies. These exposures have no required underlying limits and are covered from the first dollar of loss, unless the Plan states otherwise.

For example, in the case of a car accident, your primary auto insurance policy would provide the first level of coverage and the JPMorgan Chase Group Personal Excess Liability Insurance Plan would be available once the primary limits are exhausted. However, if you already have a personal excess liability policy, that policy would act as the second level of coverage and then the JPMorgan Chase Group Personal Excess Liability Insurance Plan would be the final level of coverage after all other policy limits are reached.

The Chubb Insurance Company will pay on the participant's behalf up to that amount for covered damages from any one occurrence, regardless of how many claims, homes, vehicles, watercraft, or people are involved in the occurrence. Any costs The Chubb Insurance Company pays for legal expenses are in addition to the amount of coverage.

In case of an accident or occurrence, you must notify Arthur J. Gallagher Risk Management Services as soon as reasonably possible.

Required Underlying Insurance

It is a condition of the Group Personal Excess Liability Plan that you and your family members maintain in full effect primary underlying liability insurance of the types and in at least the amounts shown below. **If you carry less than the minimum required limits, you will be responsible for any "gaps in coverage" between what is required and the amount of the primary coverage.** Unless there is underlying coverage as stipulated below, rented, borrowed, or furnished vehicles and watercraft are not covered for more than 60 days.

The following chart shows the minimum underlying primary liability policy limits that are required for coverage under the Plan. **It is recommended that you contact your current insurance carrier or agent to ensure that you meet the limits before enrolling in this Plan.**

Coverage	Underlying Limits (Per Person/Per Accident)
Personal Liability/ Property Damage	• $300,000
Personal Automobile Liability (Registered Vehicle)	• $250,000/$500,000 of bodily injury and $100,000 of property damage; **OR** • $300,000/$300,000 of bodily injury and $100,000 of property damage; **OR** • $300,000 single limit each occurrence
Personal Automobile Liability (Unregistered Vehicle)	• $300,000 bodily injury and property damage each occurrence
Registered Vehicles (less than four wheels) and Motor Homes	• $250,000/$500,000 of bodily injury and $100,000 of property damage; **OR** • $300,000/$300,000 of bodily injury and $100,000 of property damage; **OR** • $300,000 single limit each occurrence
Uninsured Motorist/ Underinsured Motorist Protection	• $250,000/$500,000 of bodily injury and $100,000 of property damage; **OR** • $300,000/$300,000 of bodily injury and $100,000 of property damage; **OR** • $300,000 single limit each occurrence
Watercraft	
Less than 26 ft. and 50 engine-rated HP or less	• $300,000 each occurrence
26 ft. or longer, or more than 50 engine-rated HP	• $500,000 each occurrence

Please Note: If you carry limits that are higher than the minimums required under the Plan, you can either reduce your underlying limits to the required minimums or keep the higher limits. If you choose to leave your underlying limits higher than the minimum amounts required, you will have a higher level of coverage.

If you fail to maintain the required underlying limits for your primary insurance, and there is an occurrence that would have been covered by such insurance, you will be responsible for the amount of damages up to the applicable minimum required underlying limits of your required primary insurance.

The Plan will only pay amounts in excess of your required underlying limits.

Additional Features

Additional features of the Plan include:

Coverage	Coverage Amount
Uninsured/Underinsured Motorist Protection	$2,000,000
Defense Coverages	See details under “Defense Coverages” on page 328
Shadow Defense Coverages	$10,000
Identity Fraud	$25,000
Kidnap Expense	$100,000
Reputational Injury	$25,000

Uninsured/Underinsured Motorist Protection

This protection covers bodily injury and property damage, in excess of the underlying insurance or required primary underlying insurance, whichever is greater, that you are legally entitled to receive from the owner or operator of an uninsured motorized/underinsured motorized land vehicle. You will be covered for up to $2 million, regardless of the number of vehicles covered by the required primary underlying insurance and regardless of the number of claims, vehicles, or people involved in any one occurrence.

If there is a disagreement around the legal entitlement or the amount covered, either you or The Chubb Insurance Company can make a written demand for arbitration. Local rules of law as to procedure and evidence will apply.

Defense Coverages

This coverage offers defense against any suit brought against you to recover damages for personal injury or property damage that is either covered or not covered by an underlying insurance. The Chubb Insurance Company will begin defense, at its own expense, once the underlying coverage has been exhausted.

The Chubb Insurance Company will provide defense at its own expense, even if the suit is groundless, false or fraudulent, using counsel of its choice. The Chubb Insurance Company may investigate, negotiate, and settle any such claim or suit at its discretion.

Expenses to be paid include:

- All expenses incurred by the insurance company;
- All costs taxed against you;
- All earnings lost by you at the insurance company’s request, up to $25,000;
- Other reasonable expenses incurred by you at the insurance company’s request; and
- The cost of bail bonds required of you because of a covered loss.

Shadow Defense Coverage

If you or a family member is being defended by The Chubb Insurance Company in a suit, the insurance company will pay up to $10,000 for you to have a law firm of your choice review and monitor the defense being provided. You must obtain prior approval from the insurance company before incurring any fees or expenses in order for them to be paid. Any recommendation made by your attorney will not be binding on the insurance company.

Identity Fraud

Expenses for identity fraud occurrences will be paid by the insurance company up to $25,000 for each occurrence. Identity fraud is defined by the Plan as the act of knowingly transferring or using, without lawful authority, your or a family member's means of identity, which constitutes a violation of federal law or a crime under any applicable state or local law.

Identity fraud expenses include:

- The cost for notarizing affidavits or similar documents to law enforcement agencies, financial institutions or similar credit grantors, and credit agencies;
- The cost for sending certified mail to law enforcement agencies, financial institutions or similar credit grantors, and credit agencies;
- Loan application fees to reapply for loan(s) due to rejection of original application because of incorrect credit information;
- Reasonable attorney fees incurred with prior notice and approval by insurance company for:
  - the defense of you or a family member against any suit(s) by businesses or their collection agencies;
  - the removal of any criminal or civil judgments wrongly entered against you or a family member;
  - any challenge to the information in your or a family member's consumer credit report; and
- Reasonable fees incurred by an identity fraud mitigation entity with prior notice and approval by the insurance company to:
  - provide services for the activities described above;
  - restore accounts or credit standing with financial institutions or similar credit grantors and credit agencies; and
  - monitor for up to one year the effectiveness of the fraud mitigation and detect additional identity fraud activity after the first identity fraud occurrence.

Kidnap Expenses

You will be covered for up to $100,000 in kidnap expenses incurred by you or a family member as a result of a kidnap and ransom occurrence. The occurrence ***must*** include a demand for ransom payment, which would be paid by you or a family member in exchange for the release of the kidnapped person(s). Also, up to $25,000 will be paid to any person for information not otherwise available that would lead to the arrest and conviction of any person(s) who kidnaps you, a family member, or covered relative. (You, a family member, or a covered relative who witnessed the occurrence will not be eligible to receive a reward payment.)

Kidnap expenses include other reasonable costs described in the insurance certificate.

Reputational Injury

This coverage will pay the reasonable and necessary fees or expenses that you or a family member may incur for services by a reputation management firm to minimize potential injury to your or a family member's reputation as a result of personal injury or property damage caused by an occurrence. The maximum amount of coverage is $25,000 for any one occurrence regardless of the number of claims or people involved. In order to have expenses paid:

- The reputational injury must be reported as soon as reasonably possible, but no later than 30 days after the occurrence, and
- You must obtain approval of the reputation management firm from the insurance company before incurring any fees or expenses, unless stated otherwise or an exclusion applies. There is no deductible for this coverage.

What's Not Covered

These are some exclusions that apply to your Group Personal Excess Liability Insurance Coverage, unless stated otherwise. The following list is a partial list of exclusions under the Plan. The Plan will not pay benefits for the following:

- Damages arising out of the ownership, maintenance, use, loading, unloading, or towing of any aircraft, except aircraft with crew chartered by you;
- Property damages to aircraft rented to, owned by, or in the care, custody, or control of a covered person;
- Damages arising out of the ownership, maintenance, use, loading, unloading, or towing of any hovercraft;
- Property damages to hovercraft rented to, owned by, or in the care, custody, or control of a covered person;
- Damages arising out of the ownership, maintenance or use of any motorized land vehicle:
  - during any instruction, practice, preparation for, or participation in, any competitive, prearranged or organized racing, speed contest, rally, gymkhana, sports event, stunting activity, or timed event of any kind; or
  - on a racetrack, test track, or other course of any kind.
- Damages arising out of the ownership, maintenance or use of any watercraft or aircraft during any instruction, practice, preparation for, or participation in, any competitive, prearranged or organized racing, speed contest, rally, sports event, stunting activity, or timed event of any kind. This exclusion does not apply to you or a family member for sailboat racing, even if the sailboat is equipped with an auxiliary motor.
- Damages arising out of the ownership, maintenance, or use of a motorized land vehicle by any person who is employed or otherwise engaged in the business of selling, repairing, servicing, storing, parking, testing, or delivering motorized land vehicles. This exclusion does not apply to you, a family member, or your employee or an employee of a family member for damages arising out of the ownership, maintenance, or use of a motorized land vehicle owned by, rented to, or furnished to you or a family member.
- Damages arising out of the ownership, maintenance, or use of a watercraft by any person who is engaged by or employed by, or is operating a marina, boat repair yard, shipyard, yacht club, boat sales agency, boat service station, or other similar organization. This exclusion does not apply to damages arising out of the ownership, maintenance, or use of a watercraft by you, a family member, or your or a family member's captain or full-time paid crew member maintaining or using this watercraft with permission from you or a family member.

- Damages owed to any person or organization, other than you or a family member or your or a family member's employees, with respect to the loading or unloading of motorized land vehicles or watercraft.
- Damages a covered person is legally:
  - required to provide; or
  - voluntarily provided under any:
    - workers' compensation;
    - disability benefits;
    - unemployment compensation; or
    - other similar laws.

The Plan does provide coverage in excess over any other insurance for damages you or a family member are legally required to pay for bodily injury to a domestic employee of a residence covered under the required primary underlying insurance which are not compensable under workers' compensation, unless another exclusion applies.

- Damages for any covered person's actions or failure to act as an officer or member of a board of directors of any corporation or organization. However, the Plan does cover such damages if you are or a family member is an officer or member of a board of directors of a:
  - homeowner, condominium, or cooperative association; or
  - not−for−profit corporation or organization for which he or she is not compensated;

  unless another exclusion applies.
- Damages owed to any person for property damage to property owned by any covered person.
- Damages owed to any person for property damage to property rented to, occupied by, used by, or in the care of any covered person, to the extent that the covered person is required by contract to provide insurance. But the Plan does cover such damages for loss caused by fire, smoke, or explosion unless another exclusion applies.
- Damages arising out of a wrongful employment act. A wrongful employment act means any employment discrimination, sexual harassment, or wrongful termination of any residential staff actually or allegedly committed or attempted by a covered person while acting in the capacity as an employer, that violates applicable employment law of any federal, state, or local statute, regulation, ordinance, or common law of the United States of America, its territories or possessions, or Puerto Rico.
- Damages arising out of discrimination due to age, race, color, sex, creed, national origin, or any other discrimination.
- Damages arising out of a willful, malicious, fraudulent, or dishonest act or any act intended by any covered person to cause personal injury or property damage, even if the injury or damage is of a different degree or type than actually intended or expected. But the Plan does cover such damages if the act was intended to protect people or property unless another exclusion applies. An intentional act is one whose consequences could have been foreseen by a reasonable person.
- Damages arising out of any actual, alleged, or threatened:
  - sexual molestation;
  - sexual misconduct or harassment; or
  - abuse.
- Damages owed to any person who uses a motorized land vehicle or watercraft without permission from you or a family member;

- Any damages arising out of a covered person's business pursuits, investment or other for−profit activities, for the account of a covered person or others, or business property except on a follow form basis. But the Plan does cover damages arising out of volunteer work for an organized charitable, religious, or community group, an incidental business away from home, incidental business at home, incidental business property, incidental farming, or residence premises conditional business liability unless another exclusion applies. The Plan also covers damages arising out of your or a family member's ownership, maintenance, or use of a private passenger motor vehicle in business activities other than selling, repairing, servicing, storing, parking, testing, or delivering motorized land vehicles.

The list above is a partial list of exclusions under the Plan.

Filing a Claim

If you have specific coverage questions or need to file a claim for benefits, you should contact the claims administrator, Arthur J. Gallagher Risk Management Services, at (866) 631-4630, Monday – Friday, from 9 a.m. to 5 p.m. Eastern Time, except certain holidays.

It is your responsibility to notify the claims administrator as soon as possible after an occurrence or wrongful act that may result in a claim.

Defined Terms

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

Bodily Injury	Bodily injury means physical bodily harm, including sickness or disease that results from it, and required care, loss of services and resulting death.
Covered Person	A covered person includes: ▪ You or a family member; ▪ Any person using a vehicle or watercraft covered under the Plan with permission from you or a family member with respect to their legal responsibility arising out of its use; ▪ Any other person who is a covered person under your required primary underlying insurance; ▪ Any person or organization with respect to their legal responsibility for covered acts or omissions of you or a family member; or ▪ Any combination of the above.
Damages	Damages means the sum that is paid or is payable to satisfy a claim settled by The Chubb Insurance Company or resolved by judicial procedure or by a compromise agreed to in writing.
Follow Form	Follow Form means that The Chubb Insurance Company covers damages to the extent they are both covered under the required primary underlying insurance and not excluded under the Plan. The amount of coverage, defense coverages, cancellation and "other insurance" provisions of the Plan supersede and replace the similar provisions contained in such other policies. When the Group Personal Excess Liability Plan is called upon to pay losses in excess of required primary underlying policies exhausted by payment of claims, The Chubb Insurance Company will not provide broader coverage than provided by such policies. When no primary underlying coverage exists, the extent of coverage provided on a follow form basis will be determined as if the required primary underlying insurance had been purchased from the Chubb Insurance Company.
Occurrence	An occurrence is an accident or offense to which this insurance applies and which begins within the Plan period. Continuous or repeated exposure to substantially the same general conditions, unless excluded, is considered to be one occurrence.

Personal Injury	A personal injury includes the following injuries, and resulting death: ▪ Bodily injury; ▪ Shock, mental anguish, or mental injury; ▪ False arrest, false imprisonment, or wrongful detention; ▪ Wrongful entry or eviction; ▪ Malicious prosecution or humiliation; and ▪ Libel, slander, defamation of character, or invasion of privacy.
Property Damage	Property damage means physical injury to or destruction of tangible property and the resulting loss of its use. Tangible property includes the cost of recreating or replacing stocks, bonds, deeds, mortgages, bank deposits, and similar instruments, but does not include the value represented by such instruments. Tangible property does not include the cost of recreating or replacing any software, data or other information that is in electronic form.
Registered Vehicle	A registered vehicle is any motorized land vehicle not described in “unregistered vehicle.”
Sponsoring Organization	The sponsoring organization is the entity, corporation, partnership, or sole proprietorship sponsoring and defining the criteria for qualifications as an insured.
Underlying Insurance	Underlying insurance includes all liability coverage that applies to the covered damages, except for other insurance purchased in excess of the Group Personal Excess Liability Plan.
Unregistered Vehicle	An unregistered vehicle includes the following: ▪ Any motorized land vehicle not designed for or required to be registered for use on public roads; ▪ Any motorized land vehicle in dead storage at your residence; ▪ Any motorized land vehicle used solely on and to service your residence premises; ▪ Any motorized land vehicle used to assist the disabled that is not designed for or required to be registered for use on public roads; and ▪ Golf carts.

Back-Up Child Care

Effective 1/1/21

The JPMorgan Back-Up Child Care Plan helps when your regular child care solution is unavailable. The Plan currently offers 14 dedicated JPMorgan Chase back-up child care centers, managed by Bright Horizons Family Solutions, as well as providing access to Bright Horizons full-service and back-up centers throughout the U.S.

Back-up care is available for children who are 6 weeks to 12 years old, for whom you are the legal guardian. You can use care for your stepchildren and the children of your domestic partner, provided that these children live with you. Care for grandchildren, nieces and nephews is only available if you can provide court-issued documentation that you are their legal guardian.

Questions?

If you still have questions after reviewing this Guide, contact your local dedicated back-up child care center. You can also call Bright Horizons at (888) 701-2235. For more information about the Plan, see **me@ jpmc** > Health, Life & Parenting > parents@ jpmc, where you can find more details and a link to the Parent Handbook.

You are eligible for up to 20 days of back-up care per child per year. Back-up care is only available on days when you are working at JPMorgan Chase.

To use the back-up care, you must register in advance, and then make reservations when care is needed, up to 35 days in advance. Space is limited, so be sure to make your reservation as soon as you know you will need back-up care. You can make reservations online, at https://backup.brighthorizons .com/jpmc.

In addition to providing back-up care, the 14 dedicated centers offer special programs, the 8-Week Advantage program, the Patriotic Leave program, the Relocation Program and the Summer Advantage program.

This section of the Guide will provide you with more information about the services offered through the JPMorgan Chase Back-Up Child Care Plan, and how you can take advantage of this convenient benefit.

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

About this Summary Plan Description

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

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

The JPMorgan Chase U.S. Benefits Program is generally 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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Back-Up Child Care Highlights

14 Dedicated JPMorgan Chase Centers	JPMorgan Chase has 14 dedicated back-up child care centers, in Delaware, Florida, Louisiana, New Jersey, New York, Ohio, and Texas. In addition to providing back-up child care, the 14 dedicated centers also offer special programs, summarized below and described in detail under "Special Programs" on page 406. For a temporary period of time (e.g., through December 31, 2021), JPMorgan Chase has added full service care options along with the back-up care options currently offered at the 14 dedicated child care centers. Full-service care will be offered on a limited basis for infants through 12 years of age. For more details, please visit brighthorizons.com/JPMCFullService.
Additional Back-Up Care Centers	If you aren't located near one of the 14 dedicated centers, you still have access to back-up child care at the approximately 400 Bright Horizons full-service and back-up child care centers throughout the U.S. In addition, you temporarily have expanded access to thousands of vetted non-Bright Horizons partner centers. These centers are available through the Back-Up Care Advantage (BUCA) Program. These centers do not offer the special programs available at the dedicated centers.
In-Home Care	If you do not have access to the 14 JPMorgan Chase dedicated centers, you temporarily have access to in-home care (where Bright Horizons sends a caregiver to your home), dependent on availability. There is a minimum of four hours and maximum of 10 hours of care per day. These uses count as part of your annual back-up care day allotment.
Eligible Children	Back-up child care is available for children between 6 weeks and 12 years old, including: ▪ Your natural children; ▪ Your stepchildren (children of your current spouse); ▪ Children of your domestic partner; ▪ 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. For more details about your children's eligibility, see "Eligible Children" on page 404.
Up to 20 Days of Care per Child per Year	You are eligible for up to 20 days of care per child per year. The 20-day annual limit applies even if both you and your spouse work at JPMorgan Chase. Note: In 2021, employees receive an additional 10 days of back-up care, for a total of 30 days. Care is only available for days when you are working at JPMorgan Chase. However, if you are not working because you are on an approved military leave, back-up care is available.
Register in Advance	Before you can use back-up child care, and even before you can make a reservation for back-up child care, you must first register each child for whom you might request care. You'll register online, and through the registration process, you will provide materials such as a care profile, an informed consent form, and allergy and medication details. To register for back-up care, visit https://backup.brighthorizons.com/jpmc. To enroll in full service care, please visit brighthorizons.com/JPMCFullService. In addition to registering, we also strongly recommend that you and your child visit the center you would use, before you need to use it for care.
Special Needs	JPMorgan Chase will make every reasonable effort to accommodate children with special needs — even it that requires special programming or staff training. Please contact your center in advance to discuss your child's needs.

Your Cost for Back-Up Care	For each day of care, you pay a copayment. The copayments are based on your Total Annual Cash Compensation (TACC). To check your TACC, visit **My Health >** Benefits Web Center > Your Profile > Personal Information. If your TACC is: ▪ Less than $60,000, your copayment is $10 per child per day, with a family maximum of $25 per day ▪ $60,000 or more but less than $150,000, your copayment is $20 per child per day, with a family maximum of $50 per day ▪ $150,000 or more, your copayment is $40 per child per day, with a family maximum of $100 per day
Your Cost for In-Home Care	For each hour of in-home care, you pay a copayment. The copayments are based on your Total Annual Cash Compensation (TACC). To check your TACC, visit **My Health >** Benefits Web Center > Your Profile > Personal Information. If your TACC is: ▪ Less than $60,000, your copayment is $6 per hour, minimum of 4 hours ▪ $60,000 or more but less than $150,000, your copayment is $8, minimum of 4 hours ▪ $150,000 or more, your copayment is $10 per hour, minimum of 4 hours
Your Cost for Full Service Care	The full service care tuition rates are subsidized by JPMorgan Chase and tiered based on Total Annual Cash Compensation. Please visit brighthorizons.com/JPMCFullService to find the applicable tuition rates for your market (if applicable).
To Make a Reservation for Child Care	You can make a reservation for back-up care up to 35 days in advance of the day you need care. You can also make reservations on the day care is needed. Keep in mind that centers experience high-demand periods that are usually consistent with public and private school closings. Centers make every effort to confirm your reservation. Reservations will be considered on a “first come, first served” basis and can only be made for children registered with the center. To make a reservation, visit https://backup.brighthorizons.com/jpmc. There is no specified timeframe to enroll in full service care. Please visit brighthorizons.com/JPMCFullService.
Special Programs	The 14 dedicated JPMorgan Chase centers offer several special programs, in addition to the 20 days of back-up care. For more details, see “Special Programs” on page 339.

Who’s Eligible?

You are eligible for the Back-Up or Full Service Child Care Plan if you are actively employed by JPMorgan Chase & Co., or one of its subsidiaries that has adopted the Plan. The Back-Up or Full Service Child Care Plan is available to all benefits eligible active employees (full-time or part-time).

Who’s Not Eligible?

You are not eligible if you are:

- An otherwise eligible employee who is on a leave of absence, except if the leave is for military service; or
- A contingent worker.

Eligible Children

The Back-up or Full Service Child Care Plan is available for children between 6 weeks and 12 years old (that is, children are eligible until they reach their 13th birthday), including:

- Your natural children;
- Your stepchildren (children of your current spouse);

- Children of your domestic partner;
- 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.

Special Needs

JPMorgan Chase will make every reasonable effort to accommodate children with special needs — even if that requires special programming or staff training. Please contact your center in advance to discuss your child's needs.

Advance Registration Required

You do not have to elect or enroll for coverage in order to take advantage of the Back-Up or Full Service Child Care Plan. But you do have to register each child for whom you might request care. You will register online, and through the registration process you will provide materials such as a care profile, an informed consent form, and allergy and medication details.

To register for back-up care, visit https://backup.brighthorizons.com/jpmc.

To enroll in full service care, please visit brighthorizons.com/JPMCFullService.

In addition to registering, we also strongly recommend that you and your child visit the center you would use, before you need to use it for back-up or full service care.

What the Centers Provide

The JPMorgan Chase Back-Up Child Care Plan primarily provides child care for times when your regular child care arrangements are unavailable, or when school is closed for school-age children. The Plan allows you to use up to 20 days of care, per child, per year. Note: In 2021, employees receive an additional 10 days of back-up care, for a total of 30 days. Care is provided through two types of child care centers:

- The 14 dedicated JPMorgan Chase child care centers, and
- Approximately 400 Bright Horizons child care centers throughout the U.S. as well as temporary access to thousands of vetted non-Bright Horizons partner centers.

To find a center for back-up care, visit: https://me.jpmchase.net/mejpmc/content/hr/health-life/child-care/our-back-up-child-care-options.aspx.

For a temporary period of time (e.g., through December 31, 2021), JPMorgan Chase has added full service care options along with the back-up care options currently offered at the 14 dedicated child care centers. Full-service care will be offered on a limited basis for infants through 12 years of age.

To find a center for full service care, visit: brighthorizons.com/JPMCFullService.

About the Dedicated Centers

The JPMorgan Chase Back-Up and Full Service Child Care Centers are managed by Bright Horizons. These centers are exclusively for the children of JPMorgan Chase employees and are generally located at the same site as or very near to the JPMorgan Chase workplace. Support can be provided to help school-age children navigate virtual school learning and homework (half days are available for back-up care).

The centers offer a high-quality program for learning, through Bright Horizons' *World at Their Fingertips*® curriculum, and feature state-of-the-art child care facilities, with spaces designed specifically to match the development of each age group. The staff are well-trained, experienced caregivers and educators trained in health, safety, and security procedures, and all eligible JPMorgan Chase centers are accredited (or in the process of accreditation) by the National Association for the Education of Young Children (NAEYC). For more details, see the *Parent Handbook* available at **me@jpmc** > Health, Life & Parenting > parents@jpmc.

About the Bright Horizons Centers

If you are not able to use one of the 14 dedicated centers, you still have access to approximately 400 Bright Horizons child care centers throughout the U.S. as well as temporary access to thousands of vetted non-Bright Horizons partner centers. These centers follow the same program and have the same standards and accreditation as the dedicated centers. The only difference is that they are not exclusively used by JPMorgan Chase employees and they do not offer the special programs that the dedicated centers do, described under "Special Programs" on page 406.

Special Programs

The JPMorgan Chase Network of 14 dedicated back-up child care centers offer the following special programs designed to help you with care for your children in special situations. These programs are in addition to the 20 days of back-up care available per child per year. Note: In 2021, employees receive an additional 10 days of back-up care, for a total of 30 days.

If you are interested in any of these programs, please contact the center directly for more information and to reserve care. Special Programs are only offered at the 14 dedicated JPMorgan Chase network of Back-up Child Care Centers.

All back-up child care days used including special program days require a copayment. Review "Using Full Service Care" on page 407 for more information on copayments, penalties, and limits on tax-free child care benefits (imputed income).

8-week Advantage Program

To help new parents adjust when returning to work after having or adopting a child, we offer eight consecutive weeks of child care. As there is limited space in this program, you should contact the center director as soon as you know you are expecting a new child to discuss how to register and make reservations. This program must be used within six months of returning from leave. The eight weeks of this program must be used consecutively; weeks cannot be split up. A week of usage will be counted whether your child is in attendance at the center one day or five days that week.

Summer Advantage Program

During pre-determined weeks throughout each summer, the summer advantage program provides 20 additional days of back-up child care in our toddler, preschool, and school-age classrooms.

Patriotic Leave Program

When one or both parents have been deployed into active military duty, we offer 20 additional days of back-up child care. To be eligible for the program, you must show your military deployment documents, or the deployment documents of your spouse or domestic partner, to the center director.

Relocation Program

When you are relocating from one work site to another, we offer 20 additional days of back-up care to assist in the transition of household, job, and child care arrangements at your new work location. You must be relocating, or have recently relocated, to a new job site and must have a new, permanent household relocation and a permanent change in child care arrangements.

Travel Program

If you are traveling on business, 20 additional days of back-up care will be made available at the onsite JPMC child care center in the location to which you are traveling for each child. The center used must be at the location to which you are traveling.

Using Back-Up Care

Registration

Before you can use any of the JPMorgan Chase Back-Up Child Care Plan services, your child must be registered. You'll register online, and through the registration process you will provide materials such as a care profile, an informed consent form, and allergy and medication details. To register, visit https://backup.brighthorizons.com/jpmc.

While we're committed to assisting all families, a back-up child care center may not be an appropriate setting for all children. Eligibility will be determined by the center's ability to provide quality care for each child.

In addition to registering, we also strongly recommend that you and your child visit the center you would use, before you need to use it for back-up care.

Reserving Back-Up Child Care

You can make a reservation for back-up care up to 35 days in advance of the day you need care. You can also make reservations on the day care is needed. Keep in mind that centers experience high-demand periods that are usually consistent with public and private school closings. Centers make every effort to confirm your reservation. Reservations will be considered on a "first come, first served" basis and can only be made for children registered with the center. To make a reservation, visit https://backup.brighthorizons.com/jpmc.

At the Child Care Center

After you have made a reservation, make appropriate plans to drop your child off. Please see the Parent Handbook at **me@jpmc** > Health, Life & Parenting > parents@jpmc for tips on what to expect and what to do to make the day a great experience for your child and you.

Cancelling Reservations

If your plans change, and you will not be dropping your child off on a day you have a reservation, you must cancel your reservation no later than 5 p.m. local time on the day before your reservation.

To cancel, visit https://backup.brighthorizons.com/jpmc.

If you do not cancel by 5 p.m. the day before, you will be charged the copayment that would have applied, and your pool of 20 days per year for that child will be reduced by one day. Please see "Penalty Fees" on page 408.

Using Full Service Care

For a temporary period of time (e.g., through December 31, 2021), JPMorgan Chase has added full service care options along with the back-up care options currently offered at the 14 dedicated child care centers. Full-service care will be offered on a limited basis for infants through 12 years of age.

To find a center and for information about full service care, visit: brighthorizons.com/JPMCFullService.

What Care Costs

Copayments for Back-Up Care

For each day of back-up care or for each day of one of the special programs described under “Special Programs” on page 406, you will pay a copayment.

The copayments are based on your Total Annual Cash Compensation (TACC). To check your TACC, visit **My Health >** Benefits Web Center > Your Profile > Personal Information. If your TACC is:

- Less than $60,000, your copayment is $10 per child per day, with a family maximum of $25 per day
- $60,000 or more but less than $150,000, your copayment is $20 per child per day, with a family maximum of $50 per day
- $150,000 or more, your copayment is $40 per child per day, with a family maximum of $100 per day

Employees must provide a pay source in their Bright Horizons care profile. Co-pays will be charged on the day care is used.

Copayments for In-Home Care

For each hour of in-home care, you pay a copayment. The copayments are based on your Total Annual Cash Compensation (TACC). To check your TACC, visit **My Health >** Benefits Web Center > Your Profile > Personal Information. If your TACC is:

- Less than $60,000, your copayment is $6 per hour, minimum of 4 hours
- $60,000 or more but less than $150,000, your copayment is $8, minimum of 4 hours
- $150,000 or more, your copayment is $10 per hour, minimum of 4 hours

Tuition for Full Service Care

The full service care tuition rates are subsidized by JPMorgan Chase and tiered based on Total Annual Cash Compensation. Please visit brighthorizons.com/JPMCFullService to find the applicable tuition rates for your market (if applicable).

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.

Penalty Fees

Late Cancellations

If you make a reservation for back-up care or for one of the special programs and you will not be bringing your child in, you must cancel your reservation no later than 5 p.m. local time on the day before your reservation. Please see “Cancelling Reservations” on page 407.

If you do not cancel by 5 p.m. the day before, you will be charged the copayment that would have applied, and your pool of 20 days per year for that child will be reduced by one day.

No-Shows

If you make a reservation, do not cancel the reservation, and then do not drop your child off for care, you will be charged the copayment that would have applied, and your pool of 20 days per year for that child will be reduced by one day.

Taxes and Imputed Income

The Internal Revenue Service (IRS) limits employer-provided, tax-free child care benefits to $10,500 per family per year ($2,400 for highly compensated employees*).

Benefits from both the JPMorgan Chase Back-Up Child Care Plan and the JPMorgan Chase Dependent Care Spending Account are subject to these limits. For 2020, JPMorgan Chase values a day of back-up child care at $60.

Please note that due to the COVID emergency, the existing and new child care programs will not result in imputed income to you during the time that there is declared pandemic by the U.S. government (beginning March 13, 2020). During this time, your use of these programs will not increase your federal income or employment taxes. When the U.S. government no longer declares a pandemic (which is not known at this time), the use of the child support programs will result in imputed income.

*For 2021, you are considered a “highly compensated employee” if your 2020 W-2 compensation was $130,000 or more.

What Happens If You Exceed the Limit?

The IRS does not limit the benefits you can receive. Instead, the IRS limits how much of those benefits you can receive tax-free. If the value of your tax-free benefits exceeds the limit ($10,500 per family per year, or $2,400 if you are considered to be highly compensated (W-2 compensation $130,000 or more in 2020)), you will owe taxes on the value of the benefits over the limit.

For example, if you receive $11,500 in employer-provided child care benefits and your annual limit is $10,500, you would be $1,000 over the annual limit. The $1,000 is what you would owe taxes on, and this amount is called "child care imputed income."

For a more detailed example, say you received 20 days of back-up child care during the year, and that your TACC makes your copayment $10 for each day:

- The fair market value (FMV) of the 20 days of care would be $60 times 20, for a total FMV of $1,200.
- Your copayments for 20 days would total $200.
- Your copayments would be subtracted from the total FMV, so the resulting FMV of this employer-provided benefit would be $1,000.
- The $1,000 FMV would be added to the amount you have contributed to the Dependent Care Spending Account.
- If the sum of the FMV and your contributions to the Dependent Care Spending Account exceeds the annual limit, the excess would be considered child care imputed income, and you would owe taxes on that amount.

JPMorgan Chase will report the total value of your child-care benefits on Box 10 of your W-2 tax form.

Think About Other Employer Benefits

Keep in mind that the IRS limit is on benefits received by your family. If you are receiving any child-care benefits from another employer, you need to consider those benefits along with the JPMorgan Chase benefits when you make your tax plans.

Expatriate Medical and Dental Plans

Effective 1/1/21

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.

Table of Contents

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 work:** https://me.jpmchase.net > Career > Global Mobility > **Expatriate Health Benefits Resources** ▪ **From home:** https://me.jpmorganchase.com > 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 416 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 416.

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 work: me@jpmc** > Career > Global Mobility > **Expatriate Health Benefits Resources**
- **From home:** https://me.jpmorganchase.com > 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 work: me@jpmc** > Career > Global Mobility > **Expatriate Health Benefits Resources** > Benefits Web Center
- **From home:** https://me.jpmorganchase.com > 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 421 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 work: me@jpmc** > Career > Global Mobility > **Expatriate Health Benefits Resources** > Benefits Web Center

- **From home:** https://me.jpmorganchase.com > Career > Global Mobility > **Expatriate Health Benefits Resources** > Benefits Web Center

Please see “Changing Your Coverage Midyear” on page 421 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 421 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 421 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 420 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 426 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 433 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 456 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 424 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 456.)

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 456.)

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.
- 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.

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.

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 456.)

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%	

Country[1]	Cigna*Links*® Partner	Discounted Fees	In-Network Coinsurance[2]	Comment
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
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 427 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.

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.

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.

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 438 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 459). 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 415 and “Changing Your Coverage Midyear” on page 421 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 410.

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 433.

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 459);
- 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 448 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 450. 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 456).

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 459 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 451 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 459 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 450 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 452; 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 429 or "How the Expatriate Dental Plan Pays Benefits" beginning on page 449.

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 429 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 452 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 421.
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**.

Plan Administration

Effective 1/1/21

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

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

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

About This Section

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

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

Questions?

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

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

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

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General Information

The following summarizes important administrative information about the JPMorgan Chase Health Care and Insurance Plans for Active Employees governed by ERISA. **Please Note**: Each plan can be identified by a specific plan number, which is on file with the U.S. Department of Labor. Please see "Plan Administrative Information" on page 355 for a listing of official plan names and numbers.

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 356 for a list of participating companies.)

Plan Year

January 1 – December 31

Plan Administrator

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

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

For the Business Travel Accident Insurance Plan:

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

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

JPMorgan Chase Employee Relations Executive
JPMorgan Chase & Co.
28 Liberty Street
22nd Floor
Mail Code: NY1-A302
New York, NY 10005-1401

Claims Administrator

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

COBRA Administrator

COBRA questions should be directed to JPMorgan Chase HR Answers.

COBRA payments should be directed to:

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

(877) 576-2427

Benefits Fiduciaries

Please see “About Plan Fiduciaries” on page 357 for information on benefits fiduciaries.

Agent for Service of Legal Process

Legal Papers Served:

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

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

Employer Identification Number

13-4994650

Plan Administrative Information

The following chart shows the information that varies by plan. All of the following plans are governed by ERISA. (The Dependent Care Spending Account, Transportation Spending Accounts, and the Group Personal Excess Liability Insurance Plan are not governed by ERISA and are not listed here. For more information, see “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 489.)

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

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Dental Plan/502	See "Contacting the Claims Administrator" on page 365 for names and addresses for the Preferred Dentist Program (PDP) Option, the Dental Maintenance Organization (DMO) Option, the Dental Health Maintenance Organization (DHMO) Option, and the Expatriate Dental Option.	See "Contacting the Claims Administrator" on page 365 for names, addresses, and telephone numbers for the PDP Option, the DMO Option, the DHMO Option, and the Expatriate Dental Option.	Self-Insured/Trustee: PDP Option and Expatriate Dental Option Fully Insured: DMO Option and DHMO Option
The JPMorgan Chase Vision Plan/502 (Group 1018009)	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111	Fully Insured
The JPMorgan Chase Basic Life Insurance Plan/502*	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured
The JPMorgan Chase Supplemental Term Life Insurance Plan/502*	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured
The JPMorgan Chase Accidental Death and Dismemberment (AD&D) Insurance Plan/502	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured
The JPMorgan Chase Long-Term Disability Plan's Group (LTD)/502	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176	Fully Insured
The JPMorgan Chase Long-Term Disability Plan's Individual Disability Insurance (IDI)/502	Unum 1 Fountain Square Chattanooga, TN 37402	Unum The Benefits Center P.O. Box 100262 Columbia, SC 29202-3262	Fully-Insured

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Group Legal Services Plan/502	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114	Fully Insured
The JPMorgan Chase Employee Assistance Program (EAP)/502	Administrator: Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152	Administrator: Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152	Fully-Insured (CA & NV—clinical component only) Pre-Paid Service (all other)
The JPMorgan Chase Back-up Child Care Plan/502	N/A	Bright Horizons Family Solutions 200 Talcott Avenue, South Watertown, MA 02472	Self-Insured
The JPMorgan Chase Business Travel Accident (BTA) Insurance Plan/506	AIG — National Union Fire Insurance Company of Pittsburgh, PA 17200 West 119 St. Shawnee Mission, KS 66225	AIG — National Union Fire Insurance Company of Pittsburgh, PA 17200 West 119 St. Shawnee Mission, KS 66225	Fully Insured
The JPMorgan Chase Health Care Spending Account Plan/510	N/A	See “Contacting the Claims Administrator” on page 365 for names, addresses, and telephone numbers for the Health Care Spending Account Plan	Salary Reduction/ Paid from the general assets of the employer
The JPMorgan Chase Short-Term Disability Plan/548	N/A	Sedgwick Claims Management Services JPMorgan Chase Leave of Absence Service Center P.O. Box 14648 Lexington, KY 40512-4648	Self-Insured

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Health & Wellness Centers Plan/559	N/A	JPMorgan Chase Medical Director JPMorgan Chase & Co. 270 Park Avenue, 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.
- Connexions Loyalty Acquisition, LLC
- eCast Settlement Corp
- FNBC Leasing Corporation
- Highbridge Capital Mgmt, LLC
- InstaMed Communications, LLC
- J.P. Morgan Alternative Asset Management, Inc.
- J.P. Morgan Chase Custody Services, Inc.
- J.P. Morgan Electronic Financial Services, Inc.
- J.P. Morgan Institutional Investments, Inc.
- J.P. Morgan Investment Holdings LLC
- J.P. Morgan Investment Management Inc.
- J.P. Morgan Securities, LLC
- J.P. Morgan Trust Company of Delaware
- JPMorgan Chase Bank, National Association
- JPMorgan Chase Holding LLC
- JPMorgan Distribution Services, Inc.
- Neovest, Inc.
- Paymentech, LLC
- Security Capital Research & Management, Incorporated
- WePay Inc.
- 55i, LLC

Your Rights Under ERISA

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

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.

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.

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.

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.

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 members and beneficiaries.

Prudent Actions by Plan Fiduciaries

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

Health Care and Insurance Plans for Active Employees

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

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

Assistance with Your Questions

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

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

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

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

Privacy Information

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

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

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

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

Privacy Notice

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

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

What Is Protected Health Information?

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

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

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

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

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

- Not use or further disclose protected health information other than as permitted or required by law;
- Not use or disclose protected health information that is genetic information for underwriting purposes;
- Ensure that any agents (such as an outside claims administrator) to whom the Medical Plan gives protected health information agree to the same restrictions and conditions that apply to the Medical Plan with respect to this information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of JPMorgan Chase;
- Notify you if a breach of your protected health information is discovered;
- Report to the JPMorgan Chase HIPAA Privacy Officer any use or disclosure of the information that is inconsistent with the designated protected health information uses or disclosures;
- Obtain your authorization for any use or disclosure of protected health information for marketing, or that is a sale of the protected health information as defined under applicable law;
- Make available protected health information in accordance with individuals' rights to review such personal information;
- Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules;
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules;
- Make the Medical Plan's internal practices, books, and records relating to the use and disclosure of protected health information received from the claims administrators available to the Secretary of Health and Human Services for purposes of determining the Medical Plan's compliance with HIPAA;
- Return or destroy all protected health information received in any form from the claims administrators. The Medical Plan will not retain copies of protected health information once it is no longer needed for the purpose of a disclosure. An exception may apply if the return or destruction of protected health information is not feasible. However, the Medical Plan must limit further uses and disclosures of this information to those purposes that make the return or destruction of the information infeasible; and
- Request your authorization to use or disclose psychotherapy notes except as permitted by law, which would include for the purposes of carrying out the following treatment, payment or health care operations:
  - Use by the originator of psychotherapy notes for treatment;
  - Use or disclosure by the Medical Plan for its own training program; or
  - Use or disclosure by the Medical Plan to defend itself in a legal action or other proceeding brought by you.

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

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

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

This section provides information about the claims and appeals process for questions relating to eligibility to participate in the plans, such as whether you meet the requirements of employees/dependents/beneficiaries who are allowed to obtain benefits under the plans, and whether you are eligible for Medical Reimbursement Account (MRA) funds. In addition, if, with respect to the plans subject to ERISA, you have a type of claim that is not otherwise described in this Guide, including claims related to general plan operations or Section 510 of ERISA, you must file your claim in accordance with this section. For information on filing claims for benefits, please see “Claiming Benefits” beginning on page 361.

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

Help Pursuing Claims for Eligibility

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

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

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

For the plans that are subject to ERISA, if you are not satisfied with the response, you may file a written claim with the appropriate plan administrator at the address provided in “General Information” on page 354. The plan administrator will assign your claim for a determination. You must file your claim within 90 days after the day you knew, or reasonably should have known, that you have a dispute with the plan regarding the matter that you wish to have revised or addressed. You will receive a written decision within 90 days of receipt of your claim. Under certain circumstances, this 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your request. In this situation, you will receive written notice of the extension and the reasons for it, as well as the date by which a decision is expected to be made, before the end of the initial 90-day period. If the extension is required because of your failure to submit information necessary to decide the claim, the period for making the determination will begin as of the date you submit the additional information, assuming it is provided in a timely fashion.

If Your Claim Is Denied

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

To appeal a denial of the type of claims described in this section for any of the Health Care and Insurance Plans for Active Employees, you must submit a written request for appeal of your claim to the appropriate plan administrator within 60 days after receiving the notice of denial. In connection with your appeal, you may submit written comments, documents, records, or other information relevant to your claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to your claim. The plan administrator for the Business Travel Accident Insurance Plan will decide your appeal under that plan. The plan administrator for the Short Term Disability Plan will decide appeals under that plan. The Health Care and Insurance Plans Appeals Committee is delegated responsibility for deciding appeals under all other Health Care and Insurance Plans for Active Employees. For appeals regarding general plan operations that are not otherwise described in this plan description, including claims related to general plan operations or Section 510 of ERISA, the appeal will be decided by the Plan Administrator or its delegate.

In most cases, a decision will be made within 60 days after you file your appeal. But if special circumstances require an extension of time for processing, and you are notified that there will be a delay and the reasons for needing more time, there will be an extension of up to 60 days for deciding your appeal. If an extension is necessary because you did not submit enough information to decide your appeal, the timing for making a decision about your appeal is stopped from the date the plan administrator sends you an extension notification until the date that you respond to the request for additional information, assuming your response comes within a reasonable time frame.

Once a decision is reached, you will be notified in writing of the outcome. If an adverse benefit determination is made on review, the notice will include the specific reasons for the decision, with references to specific plan provisions on which it is based.

If you would like to file a court action after your appeal, please see “Filing a Court Action” on page 365, which sets forth the rules that will apply.

Claiming Benefits: Plans Subject to ERISA

This section explains the benefits claims and appeals process for the benefits of the JPMorgan Chase Health Care and Insurance Plans for Active Employees that are subject to the Employee Retirement Income Security Act of 1974 (ERISA). It includes detailed information about what happens at each step in the process and includes important timing requirements. This section also includes information about each plan’s “fiduciary” and contact information. See “About Plan Fiduciaries” on page 357 and “Contacting the Claims Administrator” on page 365. For claims relating to eligibility questions or plan operations, please see “Claims Related to Eligibility to Participate in the Plans and Plan Operations” on page 477.

Please Note: Any claims or appeals that are related to a disability will be handled in accordance with the Department of Labor regulations found in Code 29 Section 2560. This section of the Code provides certain procedural protections and safeguards for disability benefit claims. For example, the regulations require that disability claimants receive a clear explanation of why their claim was denied and of their rights to appeal a claim denial. It also allows claimants to review and respond during the course of an appeal to any new or additional evidence that the Plan relied on in connections with the claim.

An Important Reminder

The Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan are not subject to the provisions of ERISA described in this section. For information about those plans, please see “Contacting the Claims Administrators: Plans Not Subject to ERISA” beginning on page 489.

Help Pursuing Claims
You may authorize someone else to pursue claim information on your behalf. If you do so, you must notify the claims administrator in writing of your choice of an authorized representative. For the Medical, Dental, and Vision Plans, your claims administrator will provide you with a HIPAA (Health Insurance Portability and Accountability Act of 1996) consent form that you must use to specify the extent to which your personal representative is authorized to act on your behalf. This form must be on file with your claims administrator prior to any action by your personal representative.

Steps in the Benefits Claims and Appeals Process

Step 1: Filing Your Initial Claim for Benefits

In general, when you file a claim for benefits, it is paid according to the provisions of the specific benefits plan. There are different timing requirements for different plans, as outlined in the following table. For all initial benefits claims, please contact the appropriate claims administrator for the plan. See “Contacting the Claims Administrator” on page 365.

Plan/Option	Appropriate Claims Administrator	Timing for Filing Your Initial Claim
Medical Plan*, including the Medical Reimbursement Account	Claims administrator for your Medical Plan option	No later than December 31 of the year after the year in which services were provided. Please contact your claims administrator for more information.
Prescription Drug Plan	CVS Caremark	
Dental Plan*	Claims administrator for your Dental Plan option	
Vision Plan*	FAA/EyeMed Vision Care	
Fertility Benefits Program	WINFertility	Your initial claims must be filed no later than six months of when the expenses are incurred. Generally, in-network claims filing is performed by the physician or care provider.
Health Care Spending Account	Claims administrator for your Health Care Spending Account	March 31 of the year following the year for which the expense is incurred.
Life Insurance Plan	Metropolitan Life Insurance Company (MetLife)**	There is no time limit to file a claim after a covered individual passes away.
AD&D Insurance Plan	Metropolitan Life Insurance Company (MetLife)**	Notification of a loss must be made 20 days from the date of loss. Proof must be provided to MetLife within 90 days following the date of an employee’s loss.
Business Travel Accident Insurance Plan	AIG-National Union Fire Insurance Company of Pittsburgh, PA	Within 20 days after an employee’s loss, or as soon as reasonably possible thereafter.
Group Long-Term Disability	The Prudential Insurance Company of America	Within 272 days (nine months) following the start of the disability***.

Plan/Option	Appropriate Claims Administrator	Timing for Filing Your Initial Claim
Individual Disability Insurance	Unum	Within 30 days following the start of the disability.
Short-Term Disability Plan	Sedgwick	Within 30 days of first day of absence from work.
Group Legal Services Plan****	MetLife Legal Plans, Inc.	No later than December 31 of the year following the year in which services were provided.
Employee Assistance Program	Cigna Behavioral Health, Inc. Insured (CA & NV residents): Cigna Health and Life Insurance Company	Within 90 days from date of service.
Health & Wellness Centers Plan	JPMorgan Chase Medical Director JPMorgan Chase & Co. 270 Park Avenue, 11th Floor Mail Code: NY1-K318 New York, NY 10017-2014?	No later than December 31 of the year following the year in which services were provided.
Back-up Child Care Plan	Bright Horizons Family Solutions 200 Talcott Avenue, South Watertown, MA 02472	Within 60 days from the date of service.

* Generally, in-network claims filing is performed by the physician or care provider.

** Notification of a death must be reported to JPMorgan Chase HR Answers; Bereavement Services within HR Answers will notify MetLife of the death on your behalf, allowing you to initiate the claims process. Please note that MetLife has sole responsibility and discretion to resolve any issues regarding beneficiary designations.

*** In certain circumstances, the time limit to file a claim may be up to 637 days (one year and nine months) following the start of the disability. The time limit may be even longer if the employee lacks legal capacity to file a claim earlier.

**** Generally, in-network services are filed by the Group Legal plan attorney.

Life Insurance Claims & Appeals

Life insurance claims and appeals are divided between two parties.

- The plan administrator handles all eligibility and other administrative decisions concerning your life insurance benefits.
- MetLife is primarily responsible for determining your beneficiaries. If you submit a claim/appeal regarding a beneficiary designation to the plan administrator, it will be re-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.

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.
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 or a rescission of coverage; the panel does not hear appeals about eligibility to participate in a plan or legal interpretation of a plan that does not involve medical judgment.

You are not required to file an appeal with the independent review panel before filing a court action. This level of appeal is voluntary.

Filing a Court Action

If an appeal under a plan subject to ERISA is denied (in whole or in part), you may file suit in a U.S. federal court. If you are successful, the court may order the defending person or organization to pay your related legal fees. If you lose, the court may order you to pay these fees (for example, if the court finds your claim frivolous). You may contact the U.S. Department of Labor or your state insurance regulatory agency for information about other available options.

If you bring a civil action under ERISA, you first must follow the procedures described above regarding filing a claim and up to two levels of internal appeals with the claims administrator. You must start the court action by the earlier of: (i) one year after the date of the denial of your final appeal; or (ii) three years after the date when your initial claim should have been filed, regardless of any state 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.

Contacting the Claims Administrators: Plans Subject to ERISA

This section provides specific contact information for each benefit plan covered by ERISA.

For contact information for the plans that are not subject to ERISA (which include the Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan), please see “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 489

Generally for all health care and insurance plans, questions related to general plan administration and eligibility to participate in the plans can be addressed by HR Answers. (See the *Contacts* section.)

For questions related to plan interpretation, filing initial claim, benefit provision under the plan, payment of benefits, or denial of benefits, please refer to the appropriate claims administrator for each benefit plan, as listed below.

Medical Plan Claims Administrators	
Medical Plan	
Aetna	Aetna P.O. Box 14079 Lexington, KY 40512-4079 (800) 468-1266
Cigna	Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 790-3086
Prescription Drug Plan*	CVS Caremark Attention: Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196 866-209-6093

Medical Plan Claims Administrators	
WINFertility	WINFertility, Inc. Greenwich American Center One American Lane Terrace Level Greenwich, CT 06831 (833) 439-1517
Expatriate Medical Option*	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050 (800) 390-7183 (302) 797-3644 (if calling from outside the U.S.)

* Options marked with an asterisk are self-insured. All other options are fully insured.

Dental Plan Claims Administrators	
Preferred Dentist Program (PDP)*	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 (888) 673-9582
Dental Maintenance Organization (DMO) Option	Aetna, Inc. P.O. Box 14094 Lexington, KY 40512 (800) 843-3661
Dental Health Maintenance Organization (DHMO) Option	Cigna Dental Health P.O. Box 188045 Chattanooga, TN 37422-8045 (800) 790-3086
Expatriate Dental Option*	Cigna International JPMorgan Chase Dedicated Service Center P.O. Box 15050 Wilmington, DE 19850-5050 (800) 390-7183 (302) 797-3644 (if calling from outside the U.S.)

* Options marked with an asterisk are self-insured. All other options are fully insured.

Other Health Care and Insurance Plans Subject to ERISA	
Plan	**Contact**
Vision Plan	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111 (833) 279-4363

Other Health Care and Insurance Plans Subject to ERISA	
Plan	**Contact**
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
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 (800) MET-LIFE ((800) 638-5433)
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

Other Health Care and Insurance Plans Subject to ERISA	
Plan	**Contact**
Group Legal Services Plan	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114 (800) 821-6400
Employee Assistance Program	Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152 (877) 576-2007

* Options marked with an asterisk are self-insured. All other options are fully insured.

Contacting the Claims Administrators: Plans Not Subject to ERISA

Plans that are not subject to ERISA include the Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan.

Although these plans are not subject to the claims process described under “Claiming Benefits” on page 361, you can always contact the claims administrator listed for each plan with questions about the eligibility of an expense for reimbursement, payment of benefits, or denial of plan benefits. For claims relating to questions of eligibility for benefits under the plans and how the plans operate, please see “Claims Related to Eligibility to Participate in the Plans and Plan Operations” on page 477.

For questions related to plan interpretation, filing initial claim, benefit provisions under the plan, payment of benefits, or denial of benefits, please refer to the appropriate claims administrator for the benefit plan, as listed below.

Plan	Contact
Dependent Care Spending Accounts	Refer to the same provider that you selected for your Medical Plan coverage. If you do not enroll in the Medical Plan coverage, contact Cigna. Cigna P.O. Box 188061 Chattanooga, TN 37422-8061 (800) 790-3086 Payflex, an Aetna company Payflex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 (888) 678-8242
Transportation Spending Accounts	Health Equity P.O. Box 14053 Lexington, KY 40511 (877) 924-3967

Plan	Contact
Group Personal Excess Liability Insurance Plan	Arthur J. Gallagher & Co. 250 Park Avenue, 5th Floor New York, NY 10177 (866) 631-4630

If You Are Covered by More Than One Health Care Plan

The JPMorgan Chase medical and dental plans (including the plans for expatriates) all have provisions to ensure that payments from all of your group health care plans don't exceed the amount the JPMorgan Chase plans would pay if they were your only coverage.

The rules described here apply to the JPMorgan Chase plans. The following rules do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

The JPMorgan Chase health care plans do not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. The non-duplication provisions of the JPMorgan Chase health care plans will ensure that, in total, you receive benefits up to what you would have received with the JPMorgan Chase plans as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount.

A summary of coordination rules (that is, how JPMorgan Chase coordinates coverage with another group plan to ensure non-duplication of benefits) follows. If you have questions, please contact your health care company for help. (Please see contact information in the *Contacts* section.)

Here's an example of how the JPMorgan Chase health care plans coordinate benefits with other group health care plans:

- Assume your spouse/domestic partner has a necessary covered procedure with a reasonable and customary (R&C) charge of $100 after meeting any deductible.
- If your spouse/domestic partner's plan (which we'll assume is primary) pays 70% for that procedure, your spouse/domestic partner will receive a $70 benefit (70% of $100).
- Also assume that your JPMorgan Chase health care plan (which we'll assume is your spouse/domestic partner's secondary coverage and that the deductible has already been satisfied)—would pay 80% for this necessary procedure. In this case, your spouse/domestic partner normally would receive an $80 benefit (80% of $100) from the JPMorgan Chase plan.
- Since your spouse/domestic partner already received $70 from his or her primary plan, he or she would receive the balance ($10) from the JPMorgan Chase plan.
- If, however, your JPMorgan Chase plan considered the R&C charge to be $80, no additional benefit would be payable, as the JPMorgan Chase plan would pay 80% of $80, or $64. As that amount would have already been paid by your spouse/domestic partner's plan, no additional benefit would be payable from the JPMorgan Chase plan.

Determining Primary Coverage

To determine which health care plan pays first as the primary plan, here are some general guidelines:

- If you are enrolled in the JPMorgan Chase plan and another plan and your other health care plan doesn't have a coordination of benefits provision, that plan will be considered primary, and it will pay first for you and your covered dependents.
- If your covered dependent has a claim, the plan covering your dependent as an employee or retiree will be considered primary to this plan.
- If your claim is for a covered child who is enrolled in coverage under both parents' plans, the plan covering the parent who has the earlier birthday in a calendar year (based on the month and date of birthday only, not the year) will be considered primary. In the event of divorce or legal separation, and in the absence of a qualified medical child support order, the plan covering the parent with court-decreed financial responsibility will be considered primary for the covered child. If there is no court decree, the plan of the parent who has custody of the covered child will be considered primary for the covered child. (Please see "Qualified Medical Child Support Orders" in the *Health Care Participation* section.)
- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

After it is determined which plan is primary, you'll need to submit your initial claim to that plan.

After the primary plan pays benefits (up to the limits of its coverage), you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You'll need to include a copy of the written Explanation of Benefits from your primary plan.

Coordination with Medicare

Medicare is a national health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). It generally provides coverage for Americans ages 65 and older. It also provides coverage to younger people with a qualifying disability. As long as you remain an active employee with JPMorgan Chase, your JPMorgan Chase coverage will be primary, and any Medicare coverage for you will be secondary. Additionally, any covered dependents who become eligible for Medicare, while you remain an active employee, will also have JPMorgan Chase coverage as primary.

- While you remain an active JPMorgan Chase employee, the JPMorgan Chase health care plans will be primary for you and your covered dependents unless those dependents have primary coverage elsewhere. If your covered dependents have primary coverage elsewhere, those claims will be considered by that primary coverage first, JPMC coverage will be secondary and Medicare will consider claims for those health care expenses tertiary (third) Even if you work past age 65 and you and/or a covered spouse/domestic partner enroll in Medicare, the JPMorgan Chase plans will consider claims for your health care expenses before Medicare while you are an active employee.
- When you are no longer an active JPMC employee or are receiving LTD benefits, Medicare coverage will be primary for the Medicare enrolled individual. JPMC coverage will be terminated upon Medicare eligibility and coverage in Medicare plans is available from Via Benefits. Please see "You Work Past Age 65" in the *What Happens If ...* section.

Right of Recovery

If the JPMorgan Chase plan provides benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the JPMorgan Chase plans have the right to recover these payments from you or from the person or company who is determined to be legally responsible. Assignment of your claim to a third party does not exempt you from your responsibility for repaying the plan. You must notify the JPMorgan Chase plan promptly of any circumstance in which a third party may be responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plan making payments on your behalf.

Subrogation of Benefits

The purpose of the JPMorgan Chase health care plans is to provide benefits for eligible health care expenses that are not the responsibility of any third party. The JPMorgan Chase plans have the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plans making payments on your behalf or on behalf of a covered dependent. This is known as subrogation of benefits. The following rules apply to the plan's subrogation of benefits rights:

- The JPMorgan Chase plans have first priority from any amounts recovered from a third party for the full amount of benefits the plans have paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the JPMorgan Chase plans use this right when requested.
- If you fail to help the JPMorgan Chase plans use this right when requested, the plans may deduct the amount the plans paid from any future benefits payable under the plans.
- The JPMorgan Chase plans have the right to take whatever legal action they deem appropriate against any third party to recover the benefits paid under the plans.
- If the amount you receive as a recovery from a third party is insufficient to satisfy the JPMorgan Chase plans' subrogation claim in full, the plans' subrogation claim shall be first satisfied before any part of a recovery is applied to your claim against the third party.
- The JPMorgan Chase plans are not responsible for any attorney fees, attorney liens, or other expenses you may incur without the plans' prior written consent. The "common fund" doctrine does not apply to any amount recovered by any attorney you retain regardless of whether the funds recovered are used to repay benefits paid by the plans.

If you receive a subrogation request and have questions, please contact your health care company (see contact information in the *Contacts* section).

Right of Reimbursement

In addition to their subrogation rights, the JPMorgan Chase health care plans are entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for health care expenses that have been paid by the plans. The following rules apply to the plans' right of reimbursement:

- You must reimburse the JPMorgan Chase plans in first priority from any recovery from a third party for the full amount of the benefits the plan paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- Regardless of any allocation or designation of your recovery made in a settlement agreement or court order, the JPMorgan Chase plans shall have a right of full reimbursement, in first priority, from the recovery.
- You must hold in trust for the benefit of the JPMorgan Chase plans the gross proceeds of a recovery, to be paid to the plans immediately upon your receipt of the recovery. You must reimburse the plans, in first priority and without any set-off or reduction for attorney fees or other expenses. The "common fund" doctrine does not apply to any funds recovered by any attorney you retain, regardless of whether the funds recovered are used to repay benefits paid by the plans.
- If you fail to reimburse the JPMorgan Chase plans, the plans may deduct any unsatisfied portion of the amount of benefits the plans have paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plans.

If you fail to disclose the amount of your recovery from a third party to the JPMorgan Chase plans, the plans shall be entitled to deduct the full amount of the benefits the plans paid on your behalf from any future benefits payable under the plans.

Special Notice for Employees Who Have Been Rehired by JPMorgan Chase

If your employment has been reinstated with JPMorgan Chase (that is, you have been rehired within 31 days of your employment termination date or your coverage termination date), your coverage for certain benefits under the JPMorgan Chase U.S. Benefits Program may be affected, as highlighted in the following chart:

Medical (including Medical Reimbursement Account and Prescription Drug Plan), Dental, Fertility Benefits Program, and Vision Plans	You and your dependents will be assigned the same coverage you had before your coverage termination date. **Please Note**: If you are a retired employee when rehired, you must take active employee coverage and discontinue any retiree coverage you may have elected.
Health Care Spending Account	Your previously elected annual contribution amount will be reinstated and prorated accordingly for the balance of the plan year. **Please Note**: Expenses incurred during your break in service are not eligible for reimbursement, unless you elected to make after-tax contributions under COBRA.
Dependent Care Spending Account	Your previously elected annual contribution amount will be reinstated and prorated accordingly for the balance of the plan year. **Please Note**: Expenses incurred during your break in service are not eligible for reimbursement.
Transportation Spending Accounts (Transit/Parking)	There are no reinstatement provisions for these accounts. You will need to make a new enrollment election upon your date of hire.
Life Insurance Plan	You and your dependents will be assigned the same coverage amount in effect before your termination date.
Accidental Death and Dismemberment (AD&D) Insurance Plan	You and your dependents will be assigned the same coverage amount in effect before your termination date.
Group Personal Excess Liability Insurance Plan	You will be assigned the same coverage in effect before your termination date.
Group Legal Services Plan	You will be assigned the same coverage in effect before your termination date.

Please Note: If you are rehired after 31 days of your termination date, you will need to make new benefits elections for all plans for which you would like to participate.

Contacts

Effective 1/1/21

My Health, My Rewards and HR Answers for More Information

My Health	In addition to the provider resources noted below, **My Health** provides one-stop access to all your Medical Plan, prescription drug, Medical Reimbursement Account, Spending Accounts, JPMorgan Chase Health & Wellness Centers, wellness programs, and access to the Benefits Web Center where you can access information about the Dental and Vision Plans as well as Life and AD&D Insurance, Group Legal and Personal Excess Liability Insurance. Simply use your Single Sign-On password to access other sites from **My Health.** ▪ From work: My Health from the intranet. ▪ From home: https://myhealth.jpmorganchase.com. **Please Note:** Your covered spouse/domestic partner can access **My Health** without a password, but their health care company's site will require a username and password.
My Rewards	In addition to the provider resources noted below, **My Rewards** provides one-stop access to retirement and savings information. Simply use your Single Sign-On password to access other sites from **My Rewards**. ▪ From work: **My Rewards** from the intranet. ▪ From home: https://myrewards.jpmorganchase.com/.
HR Answers	Like **My Health** and **My Rewards**, HR Answers provides access to benefits information. ▪ 877-JPMChase ((877) 576-2427) ▪ *Quick Path:* Enter your Standard ID or Social Security number; press 1; enter your PIN; press 1. If calling from outside the United States: ▪ (212) 552-5100 (GDP# 352-5100) Service Representatives are available Monday – Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays. For assistance with the Retirement Plan, representatives are available until 8:30 p.m.

Issue/Benefit	Contact Information
Medical (Not Including Prescription Drugs)	Aetna (800) 468-1266 8 a.m. to 8 p.m., all time zones, Monday – Friday **My Health** or www.aetna.com Cigna (800) 790-3086 24/7 **My Health** or www.mycigna.com
Prescription Drugs	CVS Caremark (866) 209-6093 24/7 www.caremark.com
Employee Assistance Program (EAP)	Cigna (EAP) and LifeCare (Work-Life) (877) 576-2007 www.eapandworklife.com
Tobacco Cessation Program	(866) QUIT-4-LIFE ((866) 784-8454) myquitforlife.com/jpmorganchase.com
Expert Medical Advice	Grand Rounds (888) 868-4693 8 a.m. to 9 p.m. Eastern time, Monday – Friday www.grandrounds.com/jpmc
Health Care Spending Account **Dependent Care Spending Account**	Your Medical Plan carrier — Aetna or Cigna — is the administrator of your Health Care and Dependent Care Spending Accounts. If you are not enrolled in the Medical Plan, Cigna is your administrator of these accounts. **Aetna (PayFlex is an Aetna company)** PayFlex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 Phone: (800) 468-1266 **Cigna** (800) 790-3086 24/7 www.mycigna.com You can check your spending account balances through **My Health**.

Issue/Benefit	Contact Information
Dental	**Aetna, Inc. Dental Maintenance Organization (DMO) Option: Aetna** (800) 843-3661 8 a.m. to 6 p.m. Eastern time, Monday – Friday www.aetna.com **Cigna Dental Health Maintenance Organization (DHMO) Option: Cigna Dental Health** (800) 790-3086 24/7 http://mycigna.com/ **MetLife Preferred Dentist Program (PDP) Option: MetLife Dental** (888) 673-9582 8 a.m. to 11 p.m. Eastern time, Monday – Friday https://mybenefits.metlife.com
Vision	EyeMed Vision Care (833) 279-4363 7:30 a.m. to 11 p.m. Eastern time, Monday – Saturday 11 a.m. to 8 p.m. Eastern time, Sunday **My Health >** Benefits Web Center
Transportation Spending Accounts (including for questions about eligibility and enrollment)	Health Equity (877) 924-3967 8 a.m. to 8 p.m., all time zones, Monday – Friday www.healthequity.com You can check your Transportation Spending Accounts balances on from the Transportation Spending Accounts Web Center via **My Rewards**. (myrewards.jpmorganchase.com)
Group Long –Term Disability	The Prudential Insurance Company of America (877) 361-4778 Monday – Friday from 8 a.m. to 11 p.m. Eastern time
Individual Disability Insurance	Covala Group (800) 235-3551 Monday – Friday from 8:30 a.m. to 5:30 p.m. Eastern time
Short-Term Disability Plan	Sedgwick Claims Management Services, Inc. (888) 931-3100 Service Representatives are available 24/7, Sunday through Saturday. You can also obtain answers to your questions 24 hours a day, seven days a week online at claimlookup.com/jpmc.
Life and Accidental Death & Dismemberment Insurance	Metropolitan Life Insurance Company (MetLife) (800) MET-LIFE ((800) 638-5433) 8 a.m. to 8 p.m. Eastern time, Monday – Friday **My Health >** Benefits Web Center
SurvivorSupport® Financial Counseling Services	The Ayco Company (800) 235-3417 8 a.m. to 5 p.m. Eastern time, Monday – Friday

Issue/Benefit	Contact Information
ID Theft Assistance Program, Travel Assistance, and Emergency Evacuation Services	AXA Assistance (800) 454-3679 (outside the U.S., call collect at (312) 935-3783) 24/7
Funeral Concierge Services	Dignity Memorial (866) 853-0954
Business Travel Accident Insurance	AIG-National Union Fire Insurance Company of Pittsburgh, PA (800) 551-0824 or (302) 661-4176 8 a.m. to 5 p.m. Central time, Monday – Friday
401(k) Savings Plan	**My Rewards >** My Web Centers > 401(k) Savings Plan 401(k) Savings Plan Call Center (866) JPMC401k ((866) 576-2401) TTY number (800) 345-1833 Outside the U.S.: (303) 737-7249 Speak to a Representative 8 a.m. to 10 p.m. Eastern Time, Monday – Friday (except NYSE holidays)
Retirement (Pension) Plan	**My Rewards >** My Web Centers > Pension Plan HR Answers (877) JPMChase ((877) 576-2427) Outside the U.S.: (212) 552-5100 Speak to a Representative 8 a.m. to 8:30 p.m. Eastern Time, Monday – Friday (except certain U.S. holidays)
Health & Wellness Centers	The Health & Wellness Centers Directory on **My Health** has a list of JPMorgan Chase Health & Wellness Centers locations, phone numbers, and hours. Go to **My Health** > Wellness Activities & Services.
Group Legal Plan	MetLife Legal Plans, Inc. (800) 821-6400 8 a.m. to 8 p.m. Eastern time, Monday – Friday
Personal Excess Liability Insurance	Arthur J. Gallagher Risk Management Services (866) 631-4630 9 a.m. to 5 p.m. Eastern time, Monday – Friday
Back-up Child Care Plan	Bright Horizons (877) BH-CARES ((877) 242-2737) https://backup.brighthorizons.com/jpmc (for reservations) **me@jpmc** > Health, Life & Parenting > parents@jpmc (for information about the Plan)
Expatriate Medical and Dental Plans	Cigna Global Health Benefits (800) 390-7183 (outside the U.S., call collect at (302) 797-3644 24/7 www.CignaEnvoy.com