JPMORGAN CHASE & CO.

Simplified Medical Plan Overview – effective January 1, 2020

Offered to U.S. benefits-eligible employees living in Arizona and Ohio

Effective January 1, 2020, U.S. benefits-eligible employees who live in Arizona and Ohio, will be offered a new medical plan design, called the JPMorgan Chase Simplified Medical Plan. The new Simplified Medical Plan has no in-network deductible or coinsurance. Instead, there are fixed fees – or 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.

The Simplified Medical Plan consists of two options: Simplified Option 1 and Simplified Option 2, administered by both Aetna and Cigna (UnitedHealthcare will no longer be offered). Both Aetna and Cigna have broad national networks of doctors and hospitals, and both cover medically necessary services and supplies. The key differences between these options are:

- **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.

CVS Caremark is the administrator of the Simplified Prescription Drug Plan, which is part of the Simplified Medical Plan, regardless of whether you select Aetna or Cigna or Simplified Option 1 or Simplified Option 2.

Our 2020 Health Care Companies – Aetna and Cigna

JPMorgan Chase partnered with Aetna and Cigna to administer Simplified Option 1 and Option 2 of our Medical Plan. You pay the same medical payroll contributions for Medical Plan benefits regardless of which company you choose. Both are large, established companies that offer broad nationwide provider networks. They also offer clinical programs, coaching and provide tools and resources to help you research and understand your health treatment alternatives.

You choose your health care company and your Simplified Medical Plan (Option 1 or Option 2) during Annual Benefits Enrollment.

UnitedHealthcare No Longer Offered

Support is available for those changing health care companies for 2020. Please review the 2020 Annual Enrollment Bulletin, as well as **My Health**, for details on resources available to you throughout the transition. Don't forget that the AccessHR Contact Center is also a resource to you throughout the year.

This overview provides details of the Simplified Medical Plan features and explains how other aspects of your health care benefits work, including prescription drug coverage, the Medical Reimbursement Account (MRA) and the associated Simplified Wellness Program. It also includes detailed information about the many wellness features, tools and resources that can help you manage your well-being. Our goal is to help you better understand your benefits so you can make good decisions and be an informed consumer of health care in 2020 and beyond.

Complete a Wellness Screening and Wellness Assessment for 2020 MRA Funds

Employees (and covered spouse/domestic partner) who complete **both a biometric Wellness Screening and online Wellness Assessment** between Jan. 1 – Nov. 22, 2019, will **earn $100** in their 2020 MRA (plus $50 for spouse/domestic partner), and **save $500** in 2020 medical payroll contributions (plus additional $500 for spouse/domestic partner). **See details starting on page 14.**

Coverage effective after September 1, 2019?

Employees and/or their covered spouse/domestic partner who become eligible for benefits coverage after September 1, 2019, have from their coverage effective date until the 2020 deadline (to be communicated during calendar year 2020) to complete a Wellness Screening and Wellness Assessment to earn 2020 Initial Wellness Rewards. If newly eligible for coverage after September 1, 2019, employees will automatically pay the reduced medical payroll contributions for 2020.

For details, go to Learn About Screenings and Assessments on **My Health**.

On a leave of absence? See more detail on page 15.

*The Simplified Medical Plan is part of the JPMC Medical Plan and is available only to those benefits eligible employees residing in Arizona and Ohio. The Simplified Medical Plan Overview is a Summary of Material Modification to the JPMC Medical Plan. For complete plan details, see the Summary Plan Descriptions (SPDs) found on **My Health** > Learn About the JPMC Benefits Program > Benefits Plan Details (Summary Plan Descriptions).*

How the Plan Works

The Simplified Medical Plan covers the same medical services as the JPMC consumer-driven health care (CDHP) Medical Plan – also known as the Core Medical Plan. For a detailed description of eligible and covered services under the Plan, please refer to the JPMC Medical Plan Summary Plan Description (accessible through **My Health** > Learn About the JPMC Benefits Program > Benefits Plan Details (Summary Plan Descriptions).

- 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 and no coinsurance.
  - 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. See the charts on pages 3-5.
    - 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** to search for PCPs/primary care physicians and mental health care providers.

Defined Terms

Copay –The fixed dollar amount you pay for certain covered services

Coinsurance – The way that you and the Medical Plan share a percentage of the costs for certain covered health care services. There is no coinsurance in the Simplified Medical Plan

Deductible – The amount you pay upfront each calendar year before the Plan generally begins to pay benefits for many expenses. There are no deductibles for in-network care in the Simplified Medical Plan.

- 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.
- **Out-of-network** information:
  - You generally 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 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 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 > 2020 Benefits Resources.
  - Prescription drug coverage is not available out-of-network.
- Prescription drug coverage copays are based on the drug category. Preventive generic drugs are covered at 100%, with no copay. (See page 11 for details.)
- 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 eligible 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. (More details about the MRA and what you can do to maximize funding for 2020 starts on page 14)

– Any balances remaining in your MRA that was attached to the Core Medical Plan as of December 31, 2019 will transition to your MRA account attached to the Simplified Medical Plan and can be used for eligible out-of-pocket medical and prescription drug expenses in the Simplified Medical Plan.

What Happens 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 currently live in Arizona or Ohio, but will be moving out of Arizona or Ohio to one of the other 48 states:

- If you move before December 31, 2019, you will remain in the Core Medical Plan; you will not transition to the Simplified Medical Plan on Jan 1, 2020 like other employees living in Arizona or Ohio
- If you move between January 1 and December 31, 2020, you will remain in the Simplified Medical Plan for all of 2020 (i.e., you will not switch between Simplified and Core Medical Plans). You will become eligible for the Core Medical Plan effective January 1, 2021.

Overview of Plan Information

The charts below and on the following pages present an overview of plan features for Simplified Medical Plan Option 1 and Simplified Medical Plan Option 2. For more detailed information, see the information following the chart or call your health care company (Aetna or Cigna).

Deductibles

There are no deductibles for in-network care, but there is a deductible for out-of-network care which varies based on coverage level.

ANNUAL DEDUCTIBLES				
COVERAGE LEVELS	OPTION 1		OPTION 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee (Also serves as "per person"[1] amount)	None	$2,000	None	$4,000
Employee + Spouse/Domestic Partner *or* Child(ren)	None	$3,000	None	$6,000
Employee + Spouse/Domestic Partner + Child(ren)	None	$4,000	None	$8,000

[1]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.

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Copayments (Copays)

In the new Simplified 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. See page 6 for a detailed description of the types of services that fall into each category below.

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.

Important! These copay amounts are maximum amounts – if the service or drug costs less than the copay, then you pay the lesser amount.

MEDICAL COPAYMENT AMOUNTS					
Medical Service	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
	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
Virtual doctor visit	$15	$15	$15	$15	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 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 - per ride	$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 more detail on page 10. [2] Psychologists are classified in outpatient therapy and psychiatrists are classified as specialists. [3] see types of Services on page 6 for limits. [4] Non-emergency care will cost $100 more for Option 1 and $150 more for Option 2. See page 8 for more details.

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Annual Out-Of-Pocket Maximums

These annual out-of-pocket maximums are across both medical and prescription drugs. Details on the Prescription Drug Plan starts on page 11.

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[1]: 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[1]: $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[1]: $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

[1] Total Annual Cash Compensation. See more detail on page 10.

NOTE: The Core Medical Plan had separate out-of-pocket maximums (and deductibles) for Medical and Prescription Drugs, but your new Simplified Medical Plan combines those two amounts. This makes it easier for you to track to a single number to determine your costs.

Per-Person Rule

For 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 services they use during the year until: (1) any one of them reaches $2,500 out-of-pocket and that individual will then have met their maximum (similar to Mary), or (2) all three of them combined spend $3,000 ($5,500 family out-of-pocket maximum less $2,500 spent by Mary).

Types of Services

The below chart is intended to describe the types of services that are covered within each Medical Services category defined in the Copay chart on page 4. 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, will be available on **My Health** in early 2020. 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). 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.
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. Virtual doctor visits are delivered through Aetna (via Teladoc) and Cigna (via MDLive). See Contact Information 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.
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 test and genetic testing (when approved as medically necessary).

Physical therapy (PT), speech therapy (ST), occupational therapy (OT) services	Physical, speech and occupational 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 and speech 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 and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance 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. 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.

[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). If you are visiting your allergist's office simply to receive an injection and do not have a corresponding visit with the allergist, the administration of the injection will be assigned a $15 copay.

[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 you're your health care company (Aetna or Cigna).

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 - per ride[7]	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.
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[8], 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) as long as: • You, the physician, or a member of your family calls your health care company within 48 hours after the emergency; and

[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] Cigna administers the ambulance benefit on a per day basis, not per ride

[8] Prescriptions given to you in the ER that you fill at a pharmacy are subject to the applicable prescription drug co-pays.

	• 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 $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.

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.

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 bariatric surgery 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.

Total Annual Cash Compensation (TACC)

Under the Medical Plan, Total Annual Cash Compensation (TACC) is used to determine your Medical Plan contribution pay tier, copays and the annual in-network out-of-pocket 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 features 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 **My Health** > Benefits Web Center
Please Note: Your TACC is measured as of August 1 and remains unchanged for purposes of determining Medical Plan features that apply to you for the next calendar year.

TIER	TOTAL ANNUAL CASH COMPENSATION	EMPLOYEE PAYS
1	Less than $45,000	Least
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	Most

Medical Payroll Contributions

You and JPMorgan Chase share in the cost of coverage under the Simplified Medical Plan. Your contributions toward the cost of coverage are deducted from your pay on a before-tax basis before federal (and, in most cases, state and local) income taxes are withheld. The amount you pay in 2020 depends on:

- The Medical Plan Option you choose (Option 1 vs. Option 2); note that the amount you pay in payroll contributions does not differ whether you choose Aetna or Cigna).
- Number and type of eligible dependents you cover,
- Level of your TACC in effect for the plan year,
- Where you live,
- If you and/or your covered spouse/domestic partner completed **both** a biometric Wellness Screening and online Wellness Assessment between January 1 and November 22, 2019, and/or
- If you and/or covered spouse/domestic partner use tobacco. The 2020 tobacco user surcharge will be $80 per month, or $960 annually, for each adult. If you identify both you and your covered spouse/domestic partner as tobacco users for 2020, the surcharge will be $160 per month or $1,920 annually.

Tobacco Cessation
Get the support you need to quit tobacco by enrolling in the Tobacco Cessation Program. You'll receive coaching over the phone and online support, a copy of a Quit Guide, and free quitting aids at no cost (e.g., patches, gum). You also avoid the 2020 tobacco user surcharge if you complete the Tobacco Cessation Program by Dec. 5, 2019.

Provided by: Quit for Life through Optum. Call 1-866-QUIT-4-LIFE (1-866-784-8454). You can also access the program through My Health > Wellness Activities & Services.

Dependent Coverage

Similar to the Core Medical Plan, in addition to covering yourself under the Simplified Medical Plan, you can also cover your eligible dependents, but generally only under the same option you choose for yourself. Your eligible dependents under the Simplified Medical Plan include:

- Your spouse/domestic partner (see the Domestic Partner Tip Sheet on **My Health** > Benefits Enrollment > 2020 Benefits Resources); 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 depends on you for financial support, is enrolled in that benefit and is deemed unable to support him/herself because of a mental or physical disability that began before age 26. 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.

Important! You are responsible for understanding the dependent eligibility rules applicable to each Plan and abiding by them. Please see full details on the Dependent Eligibility Tip Sheet or the Core Medical Plan Summary Plan Description (SPD) on **My Health** > Learn About the JPMC Benefits Program.

Transition of Dependents to a New Health Care Company

If you have already provided dependent eligibility support documentation and your dependents were authorized for 2019, you do **not** need to provide documentation again if you change health care companies for 2020.

If you are adding a dependent to your coverage for 2020, you'll need to provide that dependent's Social Security Number and provide required substantiation documents. Go to the **My Health** > Benefits Web Center and you'll be prompted for the Social Security Number when adding each dependent for coverage.

Prescription Drug Coverage

Your prescription drug coverage is part of the Simplified Medical Plan and is administered by CVS Caremark. There is no out-of-network coverage.

Free Preventive Generic Drugs

To encourage preventive care and the use of generic drugs, eligible preventive generic drugs are covered at 100% with no copays. 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 complete list of generic drugs covered at 100%, as determined by CVS Caremark. The list can be found on CVS Caremark's website, on the Covered Drug List (Formulary) section of the Plan & Benefits tab, through **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 long-term brand name 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.

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.

You can use your Medical Reimbursement Account (MRA) to help pay for eligible prescription drug expenses (copays). Costs for certain non-covered prescription drugs, such as non-sedating antihistamines (e.g., Clarinex; Allegra) may be reimbursed through the MRA.

Overview of Your Prescription Drug Coverage

Important! These copay amounts are maximum amounts – if the drug costs less than the copay, then you pay the lesser amount.

Prescription Drug Benefit Provisions	Simplified Option 1		Simplified Option 2	
	Traditional	Specialty	Traditional	Specialty
Preventive Generic Drugs	Free		Free	
Retail Pharmacy (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
Mail-Order Pharmacy or CVS Retail Pharmacy (Up to a 90-day supply)	Employee copayment: • 2 times Retail copay amount shown above		Employee copayment: • 2 times Retail copay amount shown above	
Out-of-Pocket Maximum (Combined with Medical Out-of-Pocket Maximum)	Please refer to Annual Out-of-Pocket Maximum chart on page 5		Please refer to Annual Out-of-Pocket Maximum chart on page 5	

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 alternative is available, you pay the entire cost difference plus the generic drug copay. **Please Note:** These cost differences will not be limited by copayment 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.

Three Ways to Fill Your Prescription Drugs

There are three ways to fill your prescription drugs, depending on whether you are purchasing short-term or long-term medications:

Short-Term Drugs

- **At an in-network retail pharmacy:** Short-term (acute) medications, such as antibiotics, generally have a limited number of refills. Always present your CVS Caremark ID card at the pharmacy. Network pharmacies are easy to find, with more than 68,000 nationwide.

Long-Term Drugs

- **Through the Maintenance Choice® Program:** This is best for long-term medications, such as those taken for chronic conditions like diabetes and high cholesterol, because you can get up to a 90-day supply. The cost through Maintenance Choice® is often lower than if you were to refill the prescription each month at a retail pharmacy. You can obtain your prescription drugs through either mail order or by picking them up at a CVS retail store at the same low price.
- **Through opting out of the Maintenance Choice® Program:** If you would prefer to obtain long-term medications in either a 30- or 90-day supply through any network pharmacy, you must first call CVS Caremark to opt out of the Maintenance Choice® Program. Please Note: Your costs for these medications may be greater than if you utilize the Maintenance Choice® Program.

Traditional (Non-Specialty) and Specialty Lists of Covered and Excluded Drugs

JPMorgan Chase uses 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. The following drug lists are available on CVS Caremark's website, on the Covered Drug List (Formulary) section of the Plan & Benefits tab, available through **My Health** > Medical, Rx, MRA & Spending Accounts > My Prescription Drugs:

- CVS Caremark® Standard drug list: a guide that includes covered generic and preferred brand name traditional drugs.
- CVS Caremark® Specialty drug list: a guide that includes covered generic and preferred brand name specialty drugs.
- CVS Caremark® Excluded drug list: a complete list of not covered traditional and specialty drugs along with preferred alternatives.

The CVS Caremark Standard and Specialty drug lists are not all-inclusive lists of covered drugs. Both drug lists include covered drugs grouped by drug category, alphabetically for quick reference, and also include a complete list of excluded/not covered drugs along with their preferred alternatives.

Please Note: CVS Caremark excluded drugs (Traditional and Specialty) are not covered. Additionally, non-sedating antihistamines (NSAs) like Clarinex® and Allegra®, are not covered under the Prescription Drug plan. If you take a non-covered drug, you will pay the full cost of the drug.

Go to the CVS Caremark website for information

Find the information you need on CVS Caremark's website, available through **My Health** > Medical, Rx, MRA & Spending Accounts > My Prescriptions Drugs, such as:

- An in-network retail pharmacy near you,
- "Important Messages" on the website for instructions on how to learn more about your 2020 Prescription Drug plan design and costs, including Specialty and Traditional (Non-specialty) drug lists,
- Cost differences between generic and brand name drugs, and
- List of preferred brand name drugs.

Simplified Wellness Program

Medical Reimbursement Account (MRA) and Medical Payroll Contribution Savings

A key part of our Medical Plan and wellness strategy is to engage employees in specific Wellness Activities by providing Medical Reimbursement Account (MRA) funds. JPMorgan Chase contributes money to your MRA to help you pay for eligible out-of-pocket medical and prescription drug copays. You cannot contribute your own money to the MRA. Your health care company – Aetna or Cigna – will administer your MRA.

The new Simplified Wellness Program is designed to create a more personalized approach to health improvement and foster sustained behavior changes focused on physical activity, health coaching and stress management - all critical components of total well-being. To earn funds, participants will need to engage in wellness activities on a regular basis (generally monthly).

How You Can Earn Funds for Your 2020 MRA

If you are enrolled in the Simplified Medical Plan, you can earn up to $740 in Wellness Rewards towards your Medical Reimbursement (MRA) account ($370 for a covered spouse/domestic partner), which includes completing your Initial Wellness Activities and Additional Wellness Activities.

INITIAL WELLNESS ACTIVITIES (BIOMETRIC WELLNESS SCREENING AND ONLINE WELLNESS ASSESSMENT)

When you, the employee, complete **both** a biometric Wellness Screening and online Wellness Assessment between **January 1 and November 22, 2019**, you will **earn $100** in your 2020 MRA, and **save $500** in 2020 medical payroll contributions. If your covered spouse/domestic partner completes both Initial Wellness Activities (i.e., Wellness Screening and Wellness Assessment) in the required timeframe, you will earn another $50 in your 2020 MRA and save an additional $500 on your 2020 medical payroll contributions. The medical payroll contributions shown when you enroll on the Benefits Web Center assumes you and your covered spouse/domestic partner have completed both Initial Wellness Activities between **Jan. 1 – Nov. 22, 2019**.

Transition of your MRA from the Core Medical Plan to the Simplified Medical Plan

Any balance remaining in your MRA as of Dec. 31, 2019 that was attached to the Core Medical Plan will transition to your MRA account attached to the 2020 Simplified Plan and can be used for eligible out-of-pocket medical and prescription drug expenses under the Simplified Medical Plan. Your MRA account will remain with your 2019 health care company through March 31, 2020 to allow for residual 2019 claims processing. Any residual MRA balance after processing eligible 2019 claims will transition to your 2020 health care company in April.

- If the Wellness Screening was completed at your doctor's office, make sure the *Wellness Screening Results Form* (found on **My Health** > Wellness Activities & Services > Wellness Screening and Assessment is submitted as soon as possible, but no later than December 6, 2019.
- If you believe you are entitled to the 2020 medical payroll contributions savings but those are not reflected in your pay, you must contact your Cigna and open a case no later than June 30, 2020.

Important: Starting in January 2020, your 2020 medical payroll contributions will initially reflect these savings. If you or your covered spouse/domestic partner chooses **not** to complete both activities between **Jan. 1 – Nov. 22, 2019**, your medical payroll contributions will increase in March 2020 for both you and your covered spouse/domestic partner. The full $500 (or $1,000) increase will be applied in equal installments to each pay from the first effective pay in March through December 2020.

Complete your Wellness Activities by November 22, 2019

The deadline to complete your biometric Wellness Screening and online Wellness Assessment is midnight, Eastern time on **November 22, 2019**. You will not save on 2020 medical payroll contributions or earn funds for Initial Wellness Activities if you complete after November 22, 2019.

- Don't forget that you can still earn rewards for 2019 Additional Wellness Activities (e.g., health coaching) you complete by Dec. 31, 2019. Check out the 2019 MRA Action Plan on **My Health** > Wellness Activities & Services

If you become eligible for benefits coverage — and/or you add your spouse/domestic partner for medical coverage — after September 1, 2019:
You'll have until the 2020 deadline (which will be communicated during the 2020 calendar year) to complete a biometric Wellness Screening and online Wellness Assessment to earn MRA dollars, and you won't pay more for 2019 or 2020 medical coverage.

If you are on an approved Leave of Absence
We encourage all employees and their covered spouses/domestic partners to participate in our Simplified Wellness Program. However, if an employee is on an approved Leave of Absence for at least 45 consecutive days between September 1 and November 22, 2019, and does not complete their biometric Wellness Screening and online Wellness Assessment during that period, then they will not lose the $500 in 2020 medical payroll contribution savings ($1,000 if covering a spouse/domestic partner). Other provisions of the Simplified Medical Plan and Simplified Wellness Program will continue to apply, including the opportunity to earn MRA funds by completing the Additional Wellness Activities under their assigned incentive path.

What's a biometric Wellness Screening and online Wellness Assessment?

A biometric Wellness Screening provides overall key indicators of your health. Screenings measure your blood pressure, blood sugar, cholesterol, triglycerides, and body mass index (BMI). There are four ways to get a Wellness Screening, including during your annual physical (three ways for your covered spouse/domestic partner).

The Wellness Assessment is an online survey that asks you questions about your biometric wellness screening results, diet, lifestyle, sleep patterns and health goals.

For details, see **My Health** > Learn About Screenings & Assessments. Together, your Wellness Screening and Wellness Assessment results provide you with helpful information about what you're doing well, recommendations for improving your health, and potential issues to discuss with your doctor.

JPMorgan Chase does not receive the data from your Wellness Screening and Wellness Assessment. That information goes directly to your health care company. See Privacy information on page 20 for more details.

ADDITIONAL WELLNESS ACTIVITIES

To earn more, you and your covered spouse/domestic partner will need to engage in Additional Wellness Activities on a regular basis (generally monthly). These Activities – based on biometric Wellness Screening results – are designed to create a more personalized approach to health improvement and foster sustained behavioral changes focused on your general needs.

NEW: You (and your covered spouse/domestic partner) must complete a Wellness Screening in order to participate in Additional Wellness Activities. You will be assigned to either Path A or Path B based on your Wellness Screening results (primarily Body Mass Index (BMI) and a number of health risk factors). You cannot self-select a path. If you completed your Wellness Screening by the deadline of November 22, 2019, you will be able to view your custom Additional Wellness Activities (Path A or Path B) on the Virgin Pulse website to track completion of these Additional Wellness Activities starting in 2020. Virgin Pulse is our new Additional Wellness Activities website (your funds will still be in a MRA account with your health care company).

NOTE: You (and your covered spouse/domestic partner) will not be eligible to earn Additional Wellness Rewards in 2020 until you complete a Wellness Screening. If you missed the 2019 deadline (November 22, 2019), you can still complete your Wellness Screening, however, you will not save on payroll contributions and you will not be eligible to earn the full year's total amount of rewards for Additional Wellness Activities.

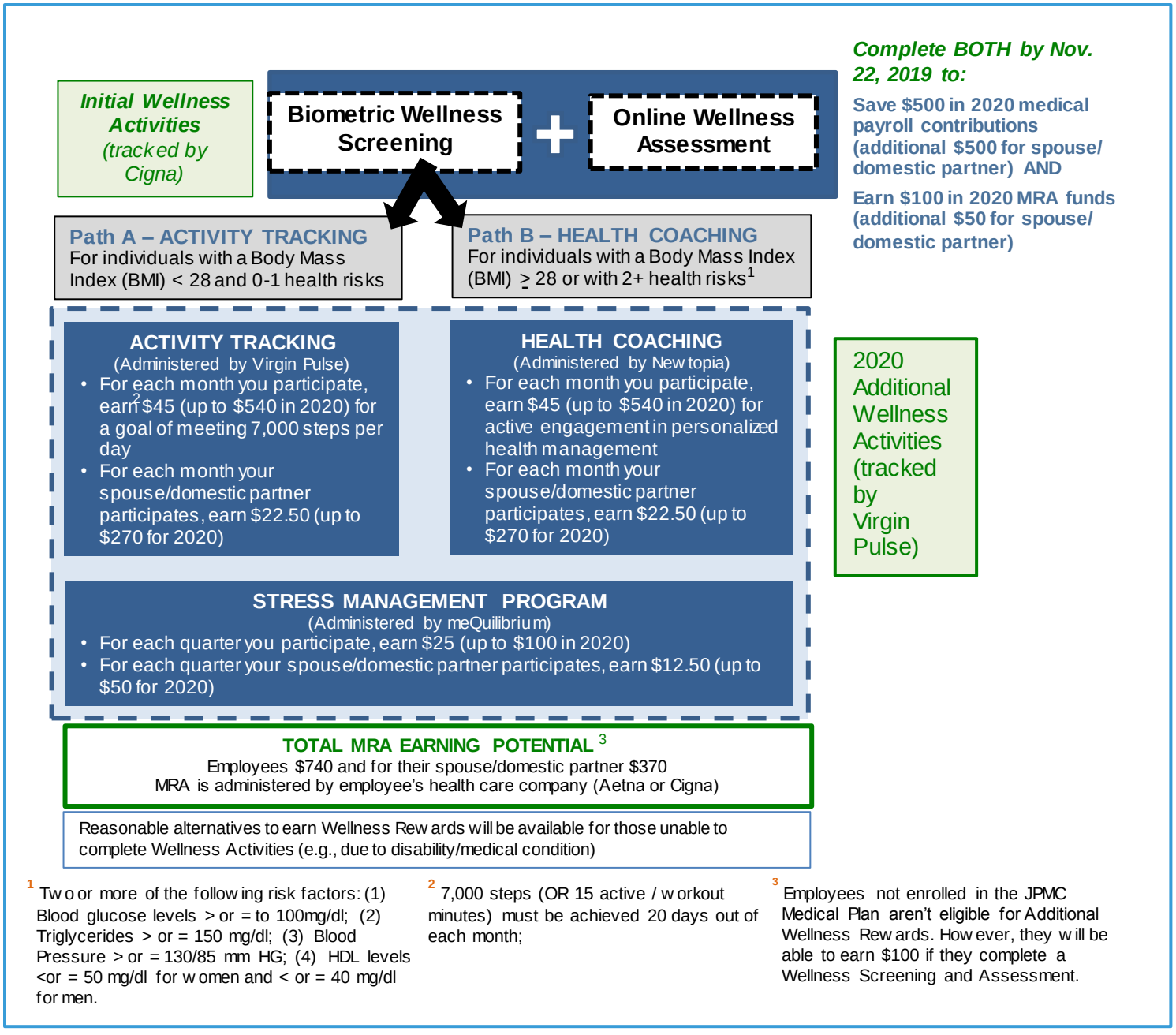
NEW: You can earn up to **$640** for Additional Wellness Activities in 2020 plus an additional $320 if your covered spouse/domestic partner regularly engages in these activities throughout the year for a total of $960.

The chart on page 16 presents an overview of the 2020 Simplified Wellness Activities for your 2020 Medical Reimbursement Account.

Go to your health care company, Aetna or Cigna, to view your MRA balance. You can use MRA funds to pay for eligible medical and prescription drug expenses you'll have in 2020 or in future years.

Your 2020 Simplified Wellness Program

Your path to wellness still starts with completing your biometric Wellness Screening and online Wellness Assessment. But now, the results of your screening will help to create a more personalized approach to improving well-being throughout the year. And, as always, you and your covered spouse/domestic partner will earn Wellness Rewards along the way! See how it works below.



[1] Two or more of the following risk factors: (1) Blood glucose levels > or = to 100mg/dl; (2) Triglycerides > or = 150 mg/dl; (3) Blood Pressure > or = 130/85 mm HG; (4) HDL levels <or = 50 mg/dl for women and < or = 40 mg/dl for men.

[2] 7,000 steps (OR 15 active / workout minutes) must be achieved 20 days out of each month;

[3] Employees not enrolled in the JPMC Medical Plan aren't eligible for Additional Wellness Rewards. However, they will be able to earn $100 if they complete a Wellness Screening and Assessment.

Wellness Rewards if You Don't Enroll in a JPMorgan Chase Medical Plan for 2020

You (the employee) will still be able to earn Wellness Rewards up to $100 in 2020, payable (and taxable) through payroll in January 2020 when you complete **both** a biometric Wellness Screening and an online Wellness Assessment between January 1 – November 22, 2019. ***If you did not enroll in JPMorgan Chase medical coverage, Cigna has been designated as your health care company to administer your Wellness Rewards.*** Wellness Rewards are not available to spouses/domestic partners of employees who do not enroll in the JPMorgan Chase Medical Plan.

Note: Wellness Rewards for employees not enrolled in the JPMorgan Chase Medical Plan are intended for those whose medical insurance does not provide similar cash incentives.

You can find more information on your Wellness Rewards program on **My Health** > **Not Enrolled in JPMC Medical?**

Health Care Spending Account (HCSA)

During Annual Benefits Enrollment, you can elect to contribute to a Health Care Spending Account (HCSA) up to the annual maximum for 2020 on a before-tax basis to pay for eligible out-of-pocket health care expenses. With respect to eligible medical and prescription drug expenses, your MRA funds are used first.

What is an HCSA?

Also known as a Flexible Spending Account, an HCSA is a tax-free way for you to pay for eligible out-of-pocket health care expenses. It means you'll save money on certain expenses that are not reimbursed by your medical (including your MRA), dental, or vision plans.

You may use your HCSA for these eligible expenses after your MRA funds are used:

- Medical and prescription drug copays; **and**
- Costs for non-sedating antihistamines (e.g., Clarinex; Allegra).

You may use your HCSA for these eligible expenses immediately as MRA funds cannot be used:

- Prescription drugs taken that are excluded from the CVS Caremark covered drug lists;
- Costs for over-the-counter medications for which you have a prescription and all forms of insulin (even if you do not have a prescription);
- Dental deductibles and coinsurance **not** covered under any Dental Plan you may be enrolled in; **and**
- Eyeglasses and contact lenses for amounts **not** covered under any Vision Plan you may be enrolled in.

Note: Certain expenses, such as those for cosmetic surgery or health care premiums, are not reimbursable under the HCSA.

The HCSA is generally subject to the "use it or lose it" rule. This means you lose funds that are left in your account at year end. However, any balance of up to $500 remaining in your Health Care Spending Account (HCSA) at the end of 2019 will be automatically carried over to your 2020 HCSA to use toward 2020 expenses. Any amount over $500 in your HCSA, after processing claims for the year, **will be forfeited**. Keep in mind that this rule will apply each year going forward. Your 2020 MRA funds and any MRA funds that carry over from 2019 must be used **first** to pay for eligible out-of-pocket medical and prescription drug expenses before you can use your HCSA funds. It's important to take this into consideration when planning your 2020 HCSA election.

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 eligible health care expenses.

Carry Over MRA Funds From Year to Year

Any unused MRA funds at year-end will automatically carry over to the next year to pay for eligible out-of-pocket medical and prescription drug expenses (copays and out-of-network deductibles). Be sure to factor in any unused MRA funds from the prior year when considering any Health Care Spending Account (HCSA) elections during Annual Enrollment each year as MRA funds are used first for eligible medical and prescription drug expenses. Unused MRA funds are forfeited upon termination unless you are eligible to enroll in retiree medical coverage or elect COBRA. More information can be found in the *As You Leave/As You Retire* guides on **me@jpmc**.

HCSA Claim Filing Deadline

The claim filing deadline for 2019 expenses is March 31, 2020. Be sure to file your claims before this deadline and continue to file those claims with your 2019 health care company.

Who Administers Your HCSA?

Your health care company (Aetna or Cigna) will be the administrator of your HCSA.

If you do not have medical coverage through JPMorgan Chase, Cigna will administer your HCSA. You have until March 31, 2020 to file your 2019 Health Care Spending Account claims with your 2019 health care company.

Comparing Your MRA and HCSA

MRA (a feature of your Medical Plan)	HCSA (an account you elect separately)
Your MRA is funded exclusively by JPMorgan Chase and consists of: • **Initial Wellness Funds:** For completing **both** the Wellness Screening and Wellness Assessment. • **Additional Wellness Funds:** For completing activities from the chart on page 16. Unused MRA funds carryover from year to year.	Your HCSA is funded by you via payroll deductions, on a before-tax basis, based on the election you make during enrollment. It is a 'use it or lose it' account. Unused amounts up to $500 will automatically carryover to the next year. **Unused amounts over $500 will be forfeited.**
The MRA can be used only for eligible out-of-pocket medical and prescription drug expenses, including medical and prescription drug copayments and out-of-network deductibles. MRA funds cannot be used for other expenses (e.g., dental and vision). See the MRA/HCSA tip sheet on **My Health** > Benefits Enrollment > 2020 Benefits Resources.	Your HCSA can be used to pay for the same out-of-pocket costs paid by your MRA, ***after*** you have used up your MRA funds; **AND** Other out-of-pocket health care costs, such as dental and vision, which cannot be paid out of your MRA. See the MRA/HCSA tip sheet on **My Health** > Benefits Enrollment > 2020 Benefits Resources.

Payment Method for your MRA/HCSA

When you enroll in the JPMorgan Chase Simplified Medical Plan, you will receive a Debit Card which will allow you to pay your portion of eligible expenses from your MRA and HCSA (if you elect to participate in the HCSA).

With the debit card, you have the flexibility to choose when you want to use your MRA and HCSA funds. You decide each time you get care or services whether you want to pay your portion of the expense using the debit card or using your personal funds

- **Medical Plan expenses:** You are encouraged not to pay your medical plan providers or facilities at point of service.
    - If the provider requires you to pay at point of service, you can pay using your debit card or using personal funds (and later submit for reimbursement from your MRA/HCSA).
    - If you do not pay at point of service, you will receive an invoice from the provider/facility once your health care company (Aetna or Cigna) processes the claim and determines the amount you owe. You can use your debit card when paying the hard copy invoice (via mail) or you can go online to pay your provider with your debit card either through your provider's site or your health care company's site (if supported by your health care company). Alternatively, you can pay the provider invoice from personal funds and then submit for reimbursement from your MRA/HCSA.
- **Prescription Drug expenses:** The pharmacy electronically connects to CVS Caremark to determine how much you owe for your prescription and will require you to pay your portion at the point of sale. If you use your debit card for your portion, your cost will pay from your MRA first, then your HCSA. Or, you can pay from your personal funds at point of sale and later

submit for reimbursement from your MRA or HCSA.

- **Dental and Vision expenses:** These can only be paid from your HCSA. You can choose to pay using your debit card, or to pay from your personal funds at point of service and later submit for reimbursement from your HCSA. (Remember: MRA funds cannot be used to pay for dental and vision expenses.)
- If you need to file for reimbursement, you can submit an online claim form for reimbursement from your MRA or HCSA or a paper claim form (via mail or fax). The paper claim 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.

Debit card only works at eligible merchants and providers, which generally includes doctor and dental offices, hospitals, pharmacies, etc. And, while most eligible expenses won't require substantiation, you should always keep your itemized receipts and be prepared to substantiate any debit card claims, as required by the IRS.

For more information on the Debit Card payment method, review the *Spending Your MRA and HCSA: Using Your Debit Card* Tip Sheet on My Health.

If You See an Out-of-Network Provider

We encourage you to stay in-network, but if you choose to visit an out-of-network provider, you should present your ID card, and ask if your provider will submit the claim for you. If your provider agrees to do so, your claim will be processed as explained in the **My Health** Tip Sheet, What you Need to Know and Do for Out-of-Network Care. 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 paper claim reimbursement form to your health care company. If you use an out-of-network provider, it is your responsibility to obtain preauthorization for certain treatment, service or procedure.

Note on Medical Necessity and Preauthorization Guidelines: If you use an **in-network** doctor, facility or other in-network service provider, they are responsible for checking with your health care company (Aetna or Cigna) to ensure that the treatment, service or procedure meets your health care company's and the Medical Plan's requirements and guidelines.

Take Advantage of Onsite JPMC Health & Wellness Centers and Employee Assistance Program

At the JPMC Health & Wellness Centers, you have access to basic medical services and educational resources -many at no charge to you. The Centers provide medical care, treatment, and resources when you need them at work to supplement the care and direction you get from your own doctor. Onsite nurses are available to act as advisors and help you connect with your health care company's coaching programs. Doctors are also available at most JPMC Health and Wellness Centers to provide additional onsite care when you need it. More informa Dtion is available on **My Health** > Wellness Activities & Services.

Use the Employee Assistance Program (EAP) and Work-Life services for free, confidential, short-term counseling and referrals to help you and your family handle stress, depression, relationship issues, addiction and eating disorders, and other emotional well-being concerns. You can receive up to five free EAP counseling sessions—even before you use your medical benefits. Call 1-877-576-2007 or go online:

- **From work: type go/eap into your intranet browser and select U.S. region.**
- **From home: eapandworklife.com**

Your Privacy is Important

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 anyon e, 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 JPMorgan Chase Simplified 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 Simplified 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 > Learn about the JPMC Benefits Program > Privacy Notice**.

Get Help with Ongoing Health Conditions

With the Simplified Medical Plan, your health care company will help you manage a health condition, including high blood pressure, high cholesterol, or diabetes, as well as providing health coaching programs to help you improve your health.

If your health care company (Aetna or Cigna) feels you could benefit by working with a health coach based on their review of your biometric Wellness Screening results, online Wellness Assessment responses, and/or claims data, your health care company representative (not JPMorgan Chase) will 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 biometric Wellness Screening or complete an online Wellness Assessment, you may still be contacted by your health care company. Keep in mind that you do not have to participate in these programs, but if you don't, you'll miss out on programs that can improve your health. So take the call!

Don't wait to receive a call to participate; you can call your health care company directly. (Please see contact information on page 22.)

Here is a look at the most common health topics addressed by the health coaches at Aetna and Cigna. But, you should feel free to contact them on any health topic.

✓ Asthma	✓ High Blood Pressure
✓ Congestive Heart Failure	✓ High Cholesterol
✓ COPD, Emphysema, or Chronic Bronchitis	✓ Maternity Support
✓ Coronary Artery Disease	✓ Physical Activity
✓ Depression or Anxiety	✓ Stress Management
✓ Diabetes/Pre-Diabetes	✓ Weight Management
✓ Healthy Eating	

Please refer to the Aetna and Cigna websites available through **My Health** for a more comprehensive list of the topics they address through their telephonic and online programs.

My Health

Health and wellness questions can arise at any time. With **My Health**, you have a centralized resource with 24/7 access to information related to your Medical Plan and health care company, your MRA, wellness activities, tip sheets on how the plan works, the Benefits Web Center for enrollment information, and much more for you and your covered spouse/domestic partner.

As an employee, **My Health** provides one-stop access to all of your medical plan, prescription plan, and MRA information on a personalized basis. Simply use your Single Sign-On password to access **My Health**. You can access **My Health** from work or through the internet:

- From work: **My Health** via me@jpmc or type "go/myhealth" into your intranet browser. For the best user experience, use Internet Explorer or Firefox browsers
- From internet: **myhealth.jpmorganchase.com**

Spouse/DP Access to My Health: The internet URL can be used by both employees and spouses/domestic partners anywhere. Spouses/ Domestic Partners can access **My Health** without a password, but their health care company's website will require their own username and password.

Expert Medical Advice

If enrolled in the JPMC Simplified Medical Plan, you and your covered family members have access to Expert Medical Advice through Grand Rounds. It's free and voluntary.

Leading expert physicians are available to review documentation on an initial diagnosis you've received, recommended treatment plan for a condition or diagnosis, complex medical condition, scheduled surgery/major procedure and medications you are taking.

They 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.

For more information, go to **My Health** > Medical Specialty Services

To access Expert Medical Advice, contact Grand Rounds:

- Online: www.grandrounds/jpmc
- Phone: 1-888-868-4693; 8 a.m. to 9 p.m., Eastern Time, Monday through Friday
- Mobile app: download from the iPhone or Android app store (search: Grand Rounds)
- JPMC Health & Wellness Center (employees only)

Questions?

Additional information to help you make informed health care choices at any time can be found on **My Health**.

You may also contact:

For questions about the Medical Plan (Coverage, Claims or Costs), MRA, or HCSA…	
Aetna	**1-800-468-1266**; 8 a.m. to 8 p.m. all time zones
Cigna • Along with your Medical Plan questions, Cigna can answer Wellness Screening and Assessment questions	**1-800-790-3086**; 24/7
For questions about prescription drug coverage…	
CVS Caremark	**1-866-209-6093**; 24/7 (1-800-863-5488 for TDD assistance)
For enrollment and general benefits questions…	
accessHR Benefits Contact Center	You can send a question to Ask HR through me@jpmc, or call **1-877-JPMChase (1-877-576-2427)** or 1-212-552-5100 if calling from outside the United States; 8 a.m. to 7 p.m. Eastern Time, Monday through Friday Quick Path: Enter your Standard ID or Social Security Number; press 2; enter your PIN; press 6.
For additional help with claims, navigating health care and/or the Health Care Exchanges …	
Health Advocate	**1-866-611-8298**; 8 a.m. to 9 p.m. Eastern Time, Monday through Friday
For Virtual Doctor Visits	
Virtual Doctor Visits	Go to **My Health** > Medical Specialty Services
For Expert Medical Advice…	
Grand Rounds	**1-888-868-4693**; 8 a.m. – 9 p.m., Eastern Time, Monday through Friday
Activity Tracking or reasonable alternatives	
Virgin Pulse	**1-833-568-3958** 8 a.m. – 9 p.m., Eastern Time, Monday through Friday