The Centivo Select Plan Summary

Offered to benefits-eligible employees in most Dallas-Fort Worth, Texas area zip codes

Effective Jan. 1, 2025

This 2025 Centivo Select Plan Summary modifies the Your JPMC Benefits Guide ("Guide") and is intended to be a summary of material modifications (SMM) with respect the JPMorgan Chase Medical Plan. It supplements, clarifies, and amends the applicable sections of the Guide and should be referred to as part of the Guide and applicable Medical Plan component SPD. You are encouraged to save or print this document and retain it for your records. If there is any discrepancy between this information and the applicable governing documents, the governing documents will control.

How the Centivo Select Plan works

- **Primary Care Provider (PCP) selection is required**. In the Centivo Select Plan (the "Plan" or "Medical Plan"), you must select a PCP for yourself and for each covered family member.
  - You can select the same doctor for everyone in your plan or different doctors for each person. If you do not select a PCP, a virtual primary care doctor will be automatically assigned. You may change your designated PCP at any time.
  - You must visit your designated PCP's office for primary care services, otherwise a $30 penalty charge will apply to that office visit. Any visit at your designated PCP's office (including with Physician's Assistants and Nurse Practitioners within the practice) will count as a visit with your designated PCP.
- **Primary care referral to specialist is required:** If you have a specialist office visit or surgery without getting a referral from your designated primary care provider, there is a penalty charge equal to the copay amount listed.
  - No referral is needed for OB/GYN; mental health; urgent or emergency care; physical, occupational or speech therapy; chiropractic care; acupuncture; lab work; x-rays and other covered tests.
- **Network centered around the Baylor Scott & White health system.** The Centivo Select Plan offers medical coverage through a curated network of providers including the Baylor Scott & White health system and other providers, including Catalyst Health Group, Children's Health, Cook Children's, Methodist Health System and Scottish Rite.
- **Generally no out-of-network coverage**, except urgent care when traveling and emergency room visits.
  - Urgent care is covered as in-network when traveling outside the Centivo service area. Emergency room visits are always covered as in-network.
  - **Note:** Before selecting the Centivo Select Plan, you should review the provider directory available on jpmc.centivo.com. If you're not able to find providers that meet your needs, you should not select this plan.
- **Low, predictable costs:** The Plan provides a curated, award-winning network of healthcare providers at an overall lower cost to you. Key features:
  - $0 copay for visits with your primary care doctor (including pediatricians), OB/GYN and mental health providers
  - Fixed dollar copays for all other care
  - No deductible

Defined terms:

- **Copay** – Fixed dollar amount you pay for certain covered services.
- **Deductible** – Amount you pay upfront each calendar year before the plan generally begins to pay benefits for many expenses. The Centivo Select Plan has no deductible.

- **Prescription Drug Coverage** is administered by CVS Caremark. For a list of covered drugs, visit www.caremark.com/jpmc. A few highlights on your portion of the cost for prescription drugs:
  - No deductible for prescription drugs and fixed-dollar copayments for all drugs,
  - Covered preventive brand and generic drugs (like insulin and blood thinners) are free,
  - Generic drug copay of $5 for a month supply and low copays for preferred brand drugs, and
  - A separate annual out-of-pocket maximum for your spend on prescription drugs.

  Note: Certain prescription drugs received during the course of medical care (e.g. infusions during an office visit or at an outpatient facility) will continue to be covered under medical benefits. Please see pages 6-8 for additional detail.

- **A Medical Reimbursement Account (MRA)** is included with the Centivo Select Plan. Through a debit card, you can use your MRA funds to help pay for eligible out-of-pocket medical expenses and prescription drug copays. The MRA is funded by JPMorganChase when you take action and complete designated Wellness Incentive Activities. Employees cannot contribute funds to a MRA. Any 2024 MRA unused balances will roll over to your 2025 MRA and can be used for eligible out-of-pocket medical and prescription drug expenses . More details start on page 15.

Centivo Select Plan Costs

Important! These copay amounts are maximum amounts. If the negotiated cost of the services is less than the copay, then you will pay the lesser amount.

Network	Centivo
Out-of-network coverage?	No, except urgent care when traveling and emergency room*
Primary care doctor selection required?	Yes**
Primary care referrals to specialist required?	Yes**
(a) Copays for Medical services	
Preventive Care	$0
Primary Care Office Visit (PCP, Pediatrician)	$0
OB/GYN Office Visit	
Telehealth	
Mental Health Office Visits	
Specialist Office Visit	$30
Physical Therapy, Speech Therapy, Occupational Therapy	$20
Chiropractic Visit	$20
Basic Labs	$10

Urgent Care	$50
Ambulance	$250
Emergency Room	$300
Inpatient Hospital Admission	$500 per day
Outpatient Procedure / Surgery	$300
Standard Radiology	$50
Advanced Imaging (CT/MRI)	$150
Durable Medical Equipment	$100
(b) Medical deductible	**None**
(c) Out-of-pocket maximum (your "safety net," the most you'll pay in a year for medical services)	
Employee Only Coverage (see Per-Person Rule below)	$1,000
Employee + Spouse/Domestic Partner or Employee + Child(ren)	$2,000
Employee + Family (Employee + Spouse/Domestic Partner + Child(ren))	$2,800

* In the Centivo Select Plan, urgent care is covered as in-network when traveling outside the Centivo service area. Emergency room visits are always covered as in-network.

** In the Centivo Select Plan: You must visit your designated primary care provider's office for primary care services, otherwise a $30 penalty charge will apply to that office visit. Any visit at your designated PCP's office (including with Physician's Assistants and Nurse Practitioners within the practice) will count as a visit with your designated PCP. There is also a penalty charge, equal to the copay amount listed, if you have a specialist office visit or surgery without getting a referral from your designated primary care provider. No referral is needed for OB/GYN; mental health; urgent or emergency care; physical, occupational or speech therapy; chiropractic care; acupuncture; lab work; x-rays and other covered tests. Penalty amounts do not accrue towards the out-of-pocket maximums.

Per-Person Rule

Regarding 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.

Example: John is enrolled in Centivo Select Plan 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 with a total charge of $12,000 before medical insurance benefits are calculated. The out-of-pocket expenses related to Mary will be

$1,000 ($500 per day copay, up to a maximum of $1,000). Now that Mary has paid $1,000 and met the individual out-of-pocket maximum, all other eligible in-network expenses for Mary for the remainder of the year will be covered at 100% by the Plan. John and his children will continue to pay copayments for in-network services they use during the year until: (1) any one of them reaches $1,000 out-of-pocket and that individual will then have met their maximum (similar to Mary), and/or (2) all three of them combined spend $2,800 in medical copayments under the Plan. At this point, all medical care costs for all family members will be covered at 100% by the Plan for the remainder of the year.

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 Centivo Select Plan Costs chart starting on page 3. This list is not exhaustive. For more detailed questions on services, please contact Centivo at 833-543-4676.

Medical Service	Description of Services
Preventive Care	Preventive care services are covered at 100% ($0 copay) in-network by the Medical Plan and include: ▪ Routine physical exams ▪ Well-child/adult care office visits ▪ Immunizations ▪ Mammograms and PAP tests ▪ Prostate exams and colonoscopy exams Certain age and frequency limits may apply. Preventive care services are 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. JPMorganChase does not make this determination. Additionally, based on the medical findings resulting from preventive care, services may no longer be considered preventive and thus subject to member cost share.
Primary Care Office Visit (PCP, Pediatrician)	Visits with the following types of clinicians: Primary Care Physician (PCP, including Centivo's virtual PCP), Pediatricians, Family Practitioners, General Practitioners, Internal Medicine, Nurse Practitioner, and Physician Assistants (within a PCP's office). **Note:** In the Centivo Select Plan, OB/GYN and convenience care clinic visits (e.g., CVS Minute Clinic) are not considered primary care office visits. Services included in the Primary Care Office Visit copay: "incidental" labs, such as a swab for strep throat, urine analysis for a urinary tract infection (UTI), etc.; injections; procedures; lab work where the specimen is drawn during the office visit (even if it is sent to an external lab); standard radiology (e.g., x-rays); and diagnostic testing. Advanced imaging (e.g. CAT scans) performed during a PCP visit will be assessed a separate copay.
OB/GYN Office Visit	Visits with the following types of clinicians: OB/GYNs, GYNs, and Certified Nurse Midwife, as well as Physician Assistants and Nurse Practitioners within the OB/GYN practice. Services included in the OB/GYN Office Visit copay: Generally follows the same bundling guidelines as Primary Care Office Visit (see above).
Telehealth	Also known as telemedicine or virtual doctor visit. Virtual doctor visits for care needed when your PCP isn't available are delivered through MDLive. 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.

Mental Health Office Visit	Outpatient therapy for mental health, substance use therapy includes office visits with: Psychologists, Psychiatrists, Clinical Social Workers, Drug and Alcohol Counselors, Licensed Professional Counselors, Marriage/Family Therapists, Behavioral Health Nurse Practitioners, and Psychiatric Nurses. Any lab work where the specimen is drawn during the office visit (even if it is sent to an external lab) and standard radiology (e.g. x-rays) are included in the Mental Health Office Visit encounter. Advanced imaging (e.g. CAT scans) performed during a visit will be assessed a separate copay.
Specialist Office Visit[1]	Office visit with a specialist, such as: Acupuncturist, allergist[2], 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.) Minor surgery procedures performed at your specialist's office will be included under 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. Any lab work where the specimen is drawn during the office visit (even if it is sent to an external lab) and standard radiology (e.g., x-rays) are included in the Specialist Office Visit copay. Advanced imaging (e.g. CAT scans) and genetic testing performed at a specialist office visit will be assessed a separate copay. Dialysis performed during a specialist office visit is included in the Specialist Office Visit copay. Continuous ambulatory peritoneal dialysis (CAPD) or peritoneal dialysis based in the home setting falls under Durable Medical Equipment. Infusions[3] performed during a specialist office visit is included in the Specialist Office visit copay. If the medications (infusions or injections) are filled through CVS Specialty Pharmacy, the costs of the medications may be subject to a separate copay through the Prescription Drug Plan. Call CVS at 1-866-209-6093 to find out if medications you may be taking fall under this specialty medication ordering program.
Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT)	Physical, speech and occupational therapy rendered by a licensed therapist, have a limit of 60 visits per each therapy type, per calendar year when the underlying condition/diagnosis is medical in nature. For instance, the plan provides 60 PT visits in total, 60 ST visits in total, etc. For individuals with a mental health diagnosis[4], associated medical treatments for physical, occupational and speech therapy will not be subject to an annual visit limitation. ABA therapy is included in this PT/ST/OT category.
Chiropractic Visit	Centivo coverage is limited to 20 visits per year, no referral required for active treatment of illness, injury or disease.

[1] Certain mental health / substance use services, including Inpatient partial hospitalization, transcranial magnetic stimulation (TMS), electroconvulsive therapy, and Intensive-out-patient (IOP) will be subject to copays based on the place of service where treatment was received, please contact Centivo for more details.

[2] 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 could be less than your specialty copay and you would only be responsible for the lesser amount in this situation.

[3] 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 Centivo.

[4] 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 and may therefore be subject to a different cost share. 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.

Basic Labs	Lab work involves specimen-based tests using blood, urine, or tissue. This includes tests such as complete blood count (CBC), basal metabolism, lipid panel, liver panel, hemoglobin A1C, pathology, urine analysis, etc. Generally, you will be assessed a single copay per blood draw even if multiple tests are performed on that single blood draw. Copays will only apply if you go to a freestanding draw or collection site (i.e., outside your provider's office). Genetic testing will be assessed a $150 copay (when approved as medically necessary).
Urgent Care	Visits to an urgent care facility. Please use the directory found in the Centivo member portal (my.centivo.com), jpmc.centivo.com or by contacting Centivo at 833-543-4676 for information on in-network urgent care centers while at home, or while traveling.
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. Copay is assessed on a per ride basis.
Emergency Room	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[5], etc. If you are seen in an in-network or out-of-network Emergency Room and subsequently admitted to the hospital, the ER copay will be waived and only the Inpatient Hospital Admission copay applies (and if the hospital is out-of-network, it will be covered as in-network). If you are billed by the Emergency Room or the out-of-network facility for an amount greater than your copay, please contact Centivo at 833-543-4676.
Inpatient Hospital Admission	All services performed during your inpatient hospital stay will be included in the per day copayment under the Centivo Select Plan. Generally, a patient is considered in-patient 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., brace, splint, boot, crutches), that will be included in the Inpatient Hospital Admission copay. Larger Durable Medical Equipment (DME) items (e.g., wheelchair) may be billed by an external vendor and subject to the DME copay.
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, oral surgery related to temporomandibular joint syndrome (TMJ)[6] 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).

[5] Prescriptions given to you in the ER that you fill at a pharmacy are subject to the applicable prescription drug copays.

[6] Temporomandibular joint syndrome (TMJ) medical treatment (including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery) are limited to $1,000 per year (appliances are not covered).

	Lab work, standard radiology (e.g. x-rays) and advanced imaging (e.g. CAT scans) performed at an outpatient facility in conjunction with a scheduled procedure will be covered under the Outpatient Procedure / Surgery copay. Dialysis performed in an outpatient setting is covered at 100%. Continuous ambulatory peritoneal dialysis (CAPD) or peritoneal dialysis based in the home setting falls under Durable Medical Equipment. Infusions performed at an outpatient facility visit[7] are assessed the Outpatient Procedure/Surgery copay. If the medications (infusions or injections) are filled through CVS Specialty Pharmacy, the costs of the medications may be subject to a separate copay through the Prescription Drug Plan. Call CVS at 1-866-209-6093 to find out if medications you may be taking fall under this specialty medication ordering program.
Standard Radiology	Standard, or basic, radiology includes radioisotopes, scans, sonograms, pre-admission x-ray, ultrasound, 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 performed in a PCP, OB/GYN, Mental Health, Specialist, Inpatient Hospital, or ER setting will be bundled with their applicable copays, if performed on the same date of service. Standard radiology performed at an independent office or freestanding outpatient facility will be assessed the Standard Radiology copay. Basic diagnostic testing will be assessed the Standard Radiology copay; this could include hearing test, heart monitor, pre-admission tests.
Advanced Imaging (CT/MRI)	Advanced imaging includes CAT Scan, MRI, and PET scans. The applicable copay includes the costs associated with the image itself as well as cost associated with the radiologist's reading of the image and is applied per scan. Advanced imaging performed in a PCP, OB/GYN, Mental Health, Specialist, or freestanding outpatient facility setting will be subject to a separate Advanced Imaging copay. Advanced imaging performed as part of an inpatient hospital stay or emergency room (ER) visit will be included in the Inpatient Hospital Admission or Emergency Room copay.
Durable Medical Equipment	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; surgical dressings; splints; trusses; orthopedic braces; hearing aids[8]; 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); 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, home based dialysis machines and monthly supplies, CPAP machines and monthly supplies, woundVac machines, and other items necessary to the treatment of an illness or injury that are not excluded under the Plan. For more details on covered DMEs, please contact Centivo at 833-543-4676. Prior authorization or pre-certification may be required for coverage of medical equipment and supplies over $2,500 in cost (CPAP machines excluded). Centivo may authorize purchase of an item if more cost-effective than rental.

Note on Medical Necessity and Preauthorization Guidelines: Your doctor, facility and/or other in-network service provider are responsible for checking with Centivo to ensure that the treatment, service or procedure meets medical necessity definitions and the Medical Plan's covered benefit definitions.

[7] Outpatient copay will apply for infusions that occur in the outpatient facility, including if your specialist bills the infusion visit you had with him/her under an outpatient facility code rather than a specialist office visit. 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 Centivo.

[8] Hearing aids are limited to $3,000 plan benefit every 36 months, hearing aids may be obtained outside of the Centivo network, and members may submit a claim form with Centivo for reimbursement up to the maximum benefit.

Note on Appeals: If you have filed a claim for benefits and your claim is denied, you have the right to appeal the decision. For information on appeals, please contact Centivo at 833-543-4676.

Maternity Benefits

The Medical Plan provides maternity benefits. Below are cost shares for common services under the Centivo Select Plan:

- If performed outside the OB/GYN practice, lab work has a $10 copay and radiology (e.g., ultrasounds, amniocentesis, fetal stress tests) has a $50 copay.
- Genetic testing for mother and/or baby will be assessed a $150 copay.
- Inpatient hospital stay for delivery will be assessed a copay of $500 per day, up to a maximum of $1,000.
- If the baby is discharged from the hospital at the same time as the mother, there is no additional cost share. If the baby is discharged after the mother, a separate $500 per day copay and separate out-of-pocket maximum will apply for the baby's hospital care.

Family Building Benefits

The Medical Plan provides Family building benefits which include Fertility treatments such as:

- In vitro fertilization (IVF) and intrauterine insemination (IUI), whether or not you have a medical diagnosis of infertility
- Elective fertility preservation (egg and sperm freezing with 12 months of storage)
- Associated prescription medications

Family Building Benefits can provide up to $35,000 for medical procedures and $15,000 for prescription drugs (These are lifetime limits, meaning once this limit is reached, no additional benefits will be available under the Plan). To unlock access to the full Family Building Benefits medical lifetime limit of $35,000, you must enroll with WINFertility and complete a nurse consultation. If these steps are not completed with WINFertility, a reduced medical lifetime limit of $10,000 applies (rather than $35,000). To get started, call WINFertility at 833-439-1517. Representatives are available Monday – Friday, 9 a.m. – 9 p.m. (ET).

Please Note: These are lifetime limits and will carry over under the Medical Plan, and across healthcare companies (e.g., any amounts from enrollment in a previous JPMC Medical Plan will carry-over when you enroll in the Centivo Select Plan).

Amounts paid by the Plan (not your out-of-pocket expenses) apply to the Lifetime Family Building benefit limit. Under the Plan, cost share 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 procedures, genetic testing, or imaging performed in an outpatient facility will be assigned an outpatient procedure / surgery copay.

LGBTQ+ Benefits

The Medical Plan covers several procedures related to gender affirmation services, including tracheal shave, facial feminization/masculinization, voice therapy and voice modification surgery. Employees and their covered dependents enrolled in the Medical Plan also have access to the LGBTQ+ Health Concierge Service (see pages 19-20), delivered through Included Health, who can help navigate gender affirming care and understand plan benefits and coverage.

Organ Transplants and Bariatric Surgery

You or your provider must contact Centivo in advance of an organ transplant or bariatric surgery to receive instruction on any required precertification. Contact Centivo to understand the cost share that will apply.

Out-of-Network Medical Coverage

Out-of-network care is generally not covered under the Centivo Select Plan, except urgent care when traveling and emergency room visits no matter where you are. If you do visit an out-of-network provider (e.g., urgent care when traveling), you should present your Centivo ID card, and ask if your provider will submit the claim for you. 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 Centivo. You can find this form on your Centivo portal at your my.centivo.com, or you can request it by calling Centivo Member Care at 833-543-4676.

Transition of Care

If you're currently pregnant (and will be in your second or third trimester on January 1, 2025) or actively being treated for a medical condition by a provider who isn't in the Centivo Network, you may be eligible to continue care with your current provider at the in-network rate until your current treatment is completed.

- To get details on the Transition of Care process, please contact Centivo Member Care at 833-543-4676.
- After discussing with Member Care, if you believe your current medical treatments qualify you for transition of care, you must submit your formal request to Centivo and a determination must be made prior to receiving additional care. It is recommended that you start this process in early December but no later than 30 days of being effective with the Plan.

Total Annual Cash Compensation (TACC)

Under the Medical Plan, Total Annual Cash Compensation (TACC) is used to determine your medical plan pay tier, which impacts your Medical Plan payroll contributions. Those who have higher levels of compensation pay more for coverage, while lower-paid employees pay less.

TIER	TOTAL ANNUAL CASH COMPENSATION
1	Less than $60,000
2	$60,000 - $79,999
3	$80,000 - $99,999
4	$100,000 - $149,999
5	$150,000 - $249,999
6	$250,000 - $349,999
7	$350,000 and above

Total Annual Cash Compensation (TACC) is defined as 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 that are paid to or deferred by you for the previous 12-month period ending each July 31 (for example, annual incentive compensation, commissions, draws, overrides and special recognition payments or incentives). 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 for the remainder of year and through the end of the following year will be equal to base salary plus job differentials as of the employee's hire date. You can find your TACC on the Benefits Web Center under My Profile > Personal Information > Personal Details.

Medical Payroll Contributions

You and JPMorganChase share in the cost of coverage under the 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 2025 depends on:

- The Medical Plan Option you choose (Option 1 vs. Option 2 vs. Centivo Select Plan)
- 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 November 18, 2023 – November 22, 2024 (11:59pm ET), and/or
- If you and/or covered spouse/domestic partner use tobacco. The 2025 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 2025, the surcharge will be $160 per month or $1,920 annually.

If your TACC increased and caused you to move from one pay tier to another (e.g., from under $150,000 to $150,000 or more), you may see a larger than expected increase in your employee payroll contributions.

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 2025 tobacco user surcharge if you complete the 4 interactions for Tobacco Cessation Program by Dec. 6, 2024.

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

In addition to covering yourself under the 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 Medical Plan include:

- Your spouse/domestic partner (see the Covering a Domestic Partner document on **My Health** > Benefits Enrollment > 2025 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 Centivo 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 the Plan and abiding by them. Please see full details on the Dependent Eligibility Requirements document or the Medical Plan Summary Plan Description (SPD) on **My Health**.

If you are adding a dependent to your coverage for 2025, you'll need to provide that dependent's Social Security Number and provide required substantiation documents. Go to **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 Medical Plan (i.e. no separate election required for prescription drug coverage) and is administered by CVS Caremark. There is no out-of-network coverage.

Your prescription drug coverage depends on the type of drug your doctor prescribes and where you fill your prescription.

- **Generic**: Generics have equivalent ingredients to brand name drugs, but can cost significantly less.
- **Preferred Brand Name**: 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:** 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.
- **Specialty:** Drugs that are generally used to treat complex medical conditions such as rheumatoid arthritis, multiple sclerosis and psoriasis. These 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.

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.

In-Network Prescription Drug Copays[9]		
Preventive (generic and brand drugs)[10]		$0
Retail Pharmacy (non-preventive, up to a 30-day supply)	Generic	$5
	Preferred Brand	$50
	Non-Preferred Brand	$150
	Specialty	$200
Mail-Order Pharmacy or Maintenance Choice (non-preventive, up to a 90-day supply)		2x copays above
Deductible		Not applicable
Out Of Pocket Maximum (your "safety net," the most you will pay in a year for prescription drugs)[11]		
Employee Only Coverage		$1,250
Employee + Spouse/Domestic Partner or EE + Child(ren)		$2,000
Employee + Family (Employee + Spouse/DP + Child(ren))		$2,600

[9] *If you fill your prescription with a brand-name drug when a direct generic equivalent is available, you will pay the entire cost difference (a medical exceptions process is available). Some medications require prior authorization, have associated quantity limits or are excluded from coverage on CVS Caremark's standard drug list. Criteria must be met for coverage. An independent committee made up of pharmacists, physicians and medical ethicists reviews and approves the drug lists (also known as formularies). For more information, please visit www.caremark.com.*

[10] *CVS Caremark creates and maintains the standard preventive drug list. Drugs may qualify as preventive care based on guidance from sources including but not limited to the U.S. Preventive Services Task Force, Internal Revenue Service and U.S. Department of the Treasury.*

[11] *Per person rule applies. See page 4.*

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 66,000 nationwide.

Long-Term Drugs

- **Maintenance Choice® Program** 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 and pay 2x the copay for a 30-day supply (which is often a lower cost than if you were to refill the prescription each month at a retail pharmacy). Maintenance Choice® allows you to obtain your prescription drugs through either mail order or by picking them up at a participating retail pharmacy.
- **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.

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 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.

Free Preventive Drugs

To encourage preventive care, covered preventive generic and brand drugs are covered at 100% ($0 copay). Preventive drugs are mediations 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 Brand and Generic Preventive Drug List is a list of preventive 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. Please note: certain drugs, products, or categories may not be covered regardless of their appearance on the list. Step therapy, prior authorization or quantity limits may apply. Mandatory Generic Drug Program applies.

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

JPMorganChase 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:

- 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.

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.

If you choose to take a non-covered drug, you will pay the **full cost** of the drug. This could be a costly option. Non-sedating antihistamines (NSAs) like Clarinex® and Allegra® are not covered under the Prescription Drug Plan.

CVS administers a program for injectable or infusion medications administered in the provider's office under supervision. To find out if medications you may be taking fall under this specialty medication ordering program, call CVS at 1-866-209-6093 or Centivo at 833-543-4676.

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,
- A digital copy of your prescription drug coverage ID card
- Cost differences between generic and brand name drugs, and
- Lists of covered and preferred drugs.

The 2025 Wellness Incentive Program

When you enroll in the Centivo Select Plan, you're eligible to receive funding in a Medical Reimbursement Account (MRA), which you can use to pay for eligible out-of-pocket medical and prescription drug expenses. You don't contribute to your own MRA; rather, it's funded by JPMorganChase when you participate in certain activities.

Wellness Rewards through the MRA – For those enrolled with Centivo
Centivo Select Plan participants can earn up to a maximum of $200 per year, either through an annual physical or GYN visit. No other activities are eligible for wellness incentives in the Centivo Select Plan. Cigna will be the administrator of your MRA.

Save $500-$1,000 on your medical payroll contributions.

If you completed the biometric wellness screening and online wellness assessment by the Nov 22, 2024 deadline, you are eligible to save $500 on your medical payroll contributions – and double that if your covered spouse/domestic partner did the same.

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, A1C, cholesterol, triglycerides, body mass index (BMI) and waist circumference. There are five 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** > Wellness Activities & Services > Well Screening and Assessment. 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.
- JPMorganChase does not receive the data from your wellness screening and wellness assessment. That information goes directly to your healthcare company. See Privacy information on page 22 for more details.

Important Notes:

- New hires: Employees who become eligible for benefits coverage — and/or add a spouse/domestic partner to medical coverage — after September 1, 2024, will automatically save $500 (individuals) or $1,000 (couples) on both 2024 and 2025 medical payroll contributions without completing the wellness screening and wellness assessment in 2024.
- Leaves of absence: Employees who are on an approved leave of absence for 45 consecutive days between September 1 and November 22, 2024, and do not complete their biometric Wellness Screening and online Wellness Assessment during that time will automatically save $500 in 2025 on their medical payroll contributions (or $1,000 if they cover a spouse/domestic partner).
- Timing: Please note that it takes time to process paperwork on whether or not each covered employee and their covered spouse/domestic partner completed both the wellness screening and the wellness assessment before the deadline. Because of this, *all* employees will see the savings reflected in their payroll contributions at the beginning of the year -- $500 savings for individuals or $1,000 savings for couples. By March 2025, we will know whether or not you completed both the wellness activities before the deadline. At that time, if you are determined not to have completed both actions, you will lose these savings and your payroll contributions will increase in March. The $500 or $1,000 increase will be applied in equal installments to each paycheck from the first effective paycheck in March 2025 through December 2025. You have until June 30, 2025, to open a case with Cigna if you believe your wellness screening and wellness assessment were completed by the deadline.
- MRA Balance transfers: All unused MRA funds at the end of 2024 will be rolled over into your 2025 MRA account. If you move from Aetna into the Centivo Select Plan in 2025, your 2024 MRA balance will automatically transfer to Cigna in April 2025. Upon termination, unused MRA funds are forfeited unless you are eligible to enroll in retiree medical coverage or elect COBRA. More information can be found in the As You Leave Guide found on My Health > 2025 Benefits Resources.

Health Care Spending Account (HCSA)

What is an HCSA? Also known as a Flexible Spending Account, a Health Care Spending Account (HCSA) is a tax-free way for you to pay for eligible out-of-pocket health care expenses.

During Annual Benefits Enrollment, you can elect to contribute to a Health Care Spending Account (HCSA) up to the annual maximum of $3,300 for 2025 (amounts are subject to change each year) 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 pays first for medical and prescription drug out-of-pocket costs (i.e., copayments). After your MRA funds are depleted, your HCSA pays for eligible out-of-pocket medical and prescription drug expenses. For eligible out-of-pocket dental and vision expenses, your HCSA funds can be used even if you have not depleted your MRA funds since these expenses cannot be paid from MRA funds.

You may use your HCSA for these eligible out-of-pocket medical and prescription drug expenses after your MRA funds are used:

- Medical and prescription drug out-of-pocket costs (i.e., copayments); **and**
- Costs for non-covered prescription drugs, such as non-sedating antihistamines (e.g., Clarinex, Allegra), with a prescription from your doctor.

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

- Prescription drugs that are excluded from the CVS Caremark covered drug lists,
- Costs for over-the-counter medications for which you have a prescription, and
- Out-of-pocket costs under any Dental Plan or Vision Plan you may be enrolled in.

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 $640 remaining in your HCSA at the end of 2024 will be automatically carried over to your 2025 HCSA to use toward 2025 expenses. Any amount over $640 in your HCSA, after processing claims for the 2024 plan year, **will be forfeited**. Keep in mind that this rule will apply each year going forward (amounts are subject to change each year). The 2025 maximum that can be carried over to 2026 is $660.

Be sure to factor in any unused MRA funds from the prior year when considering any HCSA elections during Annual Enrollment each year. Any unused MRA funds at year-end will automatically carry over to the next year, and MRA funds are used first (before HCSA funds) for eligible medical and prescription drug expenses.

Who Administers Your HCSA?

Cigna will be the administrator of your HCSA.

HCSA Claim Filing Deadline

The claim filing deadline for 2025 expenses is March 31, 2026. Be sure to file your claims with your 2025 HCSA administrator (Cigna) before the deadline.

If you were previously enrolled in the HCSA and decide not to participate in 2025, any unused amounts under $25 will be forfeited. Even if you do not elect the HCSA in 2025, amounts of $25 or more up to IRS limit will remain available for eligible health care expenses.

Comparing Your MRA and HCSA

	Medical Reimbursement Account (MRA) (a feature of the JPMC Medical Plan)	**Health Care Spending Account (HCSA)** (an account you elect separately)
Enrollment	There is no enrollment required for the MRA. It is included when you enroll in the JPMC Medical Plan.	You must make an active election to participate each year; prior year elections do not automatically carry over. As part of election, you decide how much to set aside up to an annual maximum of $3,300 for 2025.
Funding	Your MRA is funded by JPMorganChase when you complete certain Wellness Incentive Activities. You cannot contribute your own dollars. 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. The 2025 maximum that can be carried over to 2026 is $660. **Unused amounts over $660 will be forfeited.**
Eligible expenses	The MRA can be used only for eligible out-of-pocket medical and prescription drug expenses (i.e., copayments). MRA funds cannot be used for other expenses (e.g., dental and vision). For more details, go to My Health > Benefits Enrollment > 2025 Benefits Resources > **MRA, HCSA and Payment Options**.	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** Dental and vision out-of-pocket expenses, which cannot be paid out of your MRA. For more details, go to My Health > Benefits Enrollment > 2025 Benefits Resources > **MRA, HCSA and Payment Options**.

Payment Method for your MRA/HCSA – Debit Card

(Automatic Claim Payment not available with Centivo Select Plan)

Centivo Select Plan participants will receive a debit card from Cigna, which accesses funds from both your MRA and HCSA (if applicable). With the Centivo Select Plan, you should be prepared to pay the copayment during your visit. You have the option of using this debit card or paying out-of-pocket for covered expenses.

When you use your debit card, your MRA funds will be used first for eligible medical and prescription drug expenses. Once your MRA funds are depleted, your HCSA (if applicable) will then be applied. Keep in mind that you will need to keep your receipts and be prepared to substantiate any debit card claims, as required by IRS rules. Failure to provide the required substantiation will result in the temporary deactivation of your debit card, and you will be required to repay the amount of the unsubstantiated/ineligible expense before the card is reactivated.

If you pay using personal funds and later decide you wish to be reimbursed from your MRA or HCSA, you must submit an online claim form or a paper claim form (via mail or fax). The form can be found on your Cigna portal account or on **My Health** > Medical, Rx, MRA & Spending Accounts > Claims and Other Forms.

Get Help with Ongoing Health Conditions

The Centivo Select Plan emphasizes a strong primary care connection, requiring members to choose a PCP. Having a PCP who knows you and your health will help you make the best treatment decisions and improve your healthcare experience. For help with ongoing health conditions, your PCP may refer you to a Baylor Scott & White (BSW) care manager (or you can ask your PCP and request one).

Here are some common ongoing health conditions that a BSW care manager can help with:

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

The BSW care manager (who stays in close communication with your PCP and any specialists or facilities you may be working with) can coach/educate about these conditions, review medications, reinforce treatment plans and behavior modifications, as well as help address social barriers.

Expert Medical Advice

If enrolled in the JPMC Medical Plan, you and your covered family members have access to Expert Medical Advice through Included Health. 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.

For more information, go to **My Health** > Expert Medical Advice, Maternity, LGBTQ+, & Family Building > Expert Medical Advice

To access, contact Included Health:

- Online: www.includedhealth.com/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: Included Health)

LGBTQ+ Health Concierge Service

LGBTQ+ Health Concierge Service — delivered by Included Health — is an advocate in your corner who shares your needs and concerns. Available at no additional cost to all employees and their dependents who are enrolled in the JPMC U.S. Medical Plan, this personalized service is tailored to the needs of the LGBTQ+ community to help them:

- Find in-network, LGBTQ+ affirming providers
- Connect with community support and resources
- Navigate gender-affirming care as a transgender or non-binary person
- Understand plan benefits and coverage that may pertain to them, such as PrEP and gender-affirming procedures

Learn more. For more information go to **My Health** > Expert Medical Advice, Maternity, LGBTQ+, & Family Building > LGBTQ+ Health Concierge Service

To access, contact Included Health:

- Online: www.includedhealth.com/jpmc *(you'll need to register the first time you access the website)*
- Phone: 1-877-266-2861, Mon. – Fri., 9 a.m. – 8 p.m. ET.

Onsite JPMC Health & Wellness Centers

The JPMorganChase Health & Wellness Centers offer employees the convenience of onsite medical support when an unexpected illness arises, need a wellness screening as part of company's commitment to health, and/or need other health related services. The Centers are designed to supplement routine health care by offering access to care for a medical emergency, injury, or the sudden onset of an illness. The Centers' medical staff can provide treatment as needed, discuss medical issues, and provide guidance with respect to appropriate next steps. More information is available on My Health > Wellness Activities and Services > JPMC Health & Wellness Centers.

Employee Assistance Program / Spring Health Services

JPMC has partnered with Spring Health for our U.S. Employee Assistance Program (EAP). **Our goal: Accessible, affordable, high-quality mental health support when you need it – because life can be hard, and we've got your back.**

Our partnership with Spring Health provides mental health support that can help you take a proactive approach to managing your mental health over time. Services are available at no cost to all U.S. benefits-eligible employees and their eligible dependents (age 6+). For additional details, see Dependent Eligibility Requirements. Your care with Spring Health is private and confidential.

Highlights of Spring Health Services:

- **A personalized mental health care plan:** Take a short assessment to get a personalized care plan and access to a clinical Care Navigator, who can help you act on our plan and stay on track.
- **Counseling / therapy:** 8 free sessions a year with a broad and diverse network of qualified mental health professionals; 24/7 access to scheduling, and appointment availability within a few days.
- **Continuation of care:** Continued access to your Spring Health counselor / therapist within the Centivo Select Plan after your 8th session at an in-network rate, covered at 100%.
- **Coaching:** 6 free sessions a year to help you set and meet your goals for mental strength and conditioning and better manage life's daily challenges.

- **Mental strength exercises:** Access to Moments, a digital library of articles and self-guided exercises to help you improve your mental strength.

For more information

- Learn more about our Spring Health program or get started today at the Spring Health site to leverage these services for you and/or your eligible dependents.
- go/springhealth
- jpmc.springhealth.com
- For questions, please contact Spring Health support or call **1-877-576-2007** (M-F, 8am-11pm ET), Crisis support: 24/7 (option 1 for Spanish and option 2 for English). If a life threatening emergency, please call **911**.

Your care with Spring Health is private and confidential.

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, your MRA, wellness activities, helpful documents 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: From your intranet browser, **hr.jpmorganchase.com/hr > My Health**
- From internet: **myhealth.jpmorganchase.com**

Spouse/domestic partner 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.

Who to call with Benefits Questions

Go to My Health > Benefits Enrollment > 2025 Benefits Resources > Who to call with benefits questions

Your Privacy is Important

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

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

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. JPMorganChase expressly reserves the right to amend, modify, reduce, change or terminate its benefits and plans at any time. The JPMorgan Chase U.S. Benefits Program does not create a contract or guarantee of employment between JPMorganChase and any individual. JPMorganChase or you may terminate the employment relationship at any time.