Expatriate Medical and Dental Plans

Effective 1/1/25

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

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

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

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

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

About This Summary Plan Description

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

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

Questions?

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

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

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

For additional resources, consult the *Contacts* section of the Guide.

The JPMorgan Chase U.S. Benefits Program is available to most employees on a U.S. payroll who are regularly scheduled to work 20 hours or more a week and who are employed by JPMorgan Chase & Co. or one of its subsidiaries to the extent that such subsidiary has adopted the JPMorgan Chase U.S. Benefits Program. This information does not include all of the details contained in the applicable insurance contracts, plan documents, and trust agreements. If there is any discrepancy between this information and the governing documents, the governing documents will control. 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.

Table of Contents — Page

Your Options by Group

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

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

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

Already Enrolled?

If you are already enrolled in the Expatriate Medical Plan, visit the Expatriate Health Benefits Resources page on the JPMC intranet for information and access to Preparing for Care resources and Customer Support tools for Expatriate Medical Plan participants.

Expatriate Plan Highlights

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

Eligibility and Enrollment

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

Who's Eligible?

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

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

Who's Not Eligible?

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

Examples of such individuals include an:

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

Eligible Dependents

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

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

- Your spouse or domestic partner (see "Domestic Partners" on page 7 for more information); and
- Your and/or your spouse's/domestic partner's children up to the last day of the month in which they reach age 26, regardless of student or marital status, financial dependence on parents, residency with parents, or eligibility for coverage under another health plan. To cover your domestic partner's children, you must elect coverage for your domestic partner.

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

Important Note on Dependent Eligibility

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

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

Spouse

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

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

Children

"Children" include the following:

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

Domestic Partners

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

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

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

OR

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

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

Please Note: If you are covering a domestic partner who is not a tax dependent, imputed income for that domestic partner will be applied. Information about domestic partner coverage and the various tax consequences is available via the Expatriate Health Benefits Resources page on the JPMC intranet.

Qualified Medical Child Support Orders

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

Enrolling

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

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

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

Coverage Levels

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

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

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

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

You are responsible for understanding the dependent eligibility rules and abiding by them (see "Important Note on Dependent Eligibility" on page 7.

An Important Note on Dependent Coverage

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

Cost of Coverage

You and JPMorganChase share the cost of coverage.

During your designated enrollment period, your cost for each Plan will be available on the Benefits Web Center via the Expatriate Health Benefits Resources page on the JPMC intranet.

Before-Tax Costs

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

Domestic Partner Costs

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

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

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

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

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

Enrolling a Domestic Partner

Additional information on enrolling and the tax consequences of covering a domestic partner can be found via the Expatriate Health Benefits Resources page on the JPMC intranet.

How to Enroll

Participation in the Plans is optional.

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

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

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

If you're starting your expatriate assignment and are enrolling for the first time, you need to make your choices online in the Benefits Web Center via the Expatriate Health Benefits Resources page on the JPMC intranet or over the phone through 1-844-ASK-JPMC.

Enrollment elections must be made as explained below:

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

You can access your benefits enrollment materials online from your work device via the Expatriate Health Benefits Resources page on the JPMC intranet.

Enrolling During Your Expatriate Assignment

During Annual Benefits Enrollment, you can make and confirm your elections for the following calendar year from your work device through the Benefits Web Center via the Expatriate Health Benefits Resources page on the JPMC intranet or through 1-844-ASK-JPMC. At the beginning of each enrollment period, you'll receive instructions on how to enroll.

You'll also receive information about the choices available to you and their costs at that time on Benefits Web Center. You need to review your available choices carefully and enroll in the Plans that best meet your needs. You can't change your choices during the year unless you have a Qualified Status Change (QSC). Please see "Changing Your Coverage Midyear" on page 11 for more information.

Enrolling if You Have a Qualified Status Change (QSC)

If you're enrolling during the year because you have a Qualified Status Change (QSC), you'll have 31 days from the date of the change in status (including losing coverage under a spouse's plan, the birth or adoption of a child, etc.) to make your new choices from your work device through the Benefits Web Center via the Expatriate Health Benefits Resources page on the JPMC intranet or through 1-844-ASK-JPMC.

Please see "Changing Your Coverage Midyear" on page 11 for more information.

Coverage if You Do Not Enroll

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

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

If you have a Qualified Status Change (QSC) that allows you to enroll in the Expatriate Medical Plan and/or Expatriate Dental Plans and you do not enroll within the designated 31-day period, coverage for certain benefits will be effective as of the date you contact 1-844-ASK-JPMC. You may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact 1-844-ASK-JPMC. Otherwise, you will not be able to make the change in coverage until the next Annual Benefits Enrollment.

Please see “Changing Your Coverage Midyear” on page 11 for more information.

When Coverage Begins

If You Enroll at the Start of Your Expatriate Assignment

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

If You Make Changes to Your Elections During Annual Enrollment

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

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

The coverage you elect as a result of a qualifying event (such as marriage, divorce, or the birth or adoption of a child or a work-related event such as an adjustment to your regularly scheduled work hours that results in a change in eligibility) will take effect as of the day of the qualifying event, if you enroll within 31 days of the event and if you have already met the Plans’ eligibility requirements. If you miss the 31-day deadline, coverage for certain benefits will be effective as of the date you contact 1-844-ASK-JPMC. You may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact 1-844-ASK-JPMC. Otherwise, you will not be able to make the change in coverage until the following Annual Benefits Enrollment.

Please see “Changing Your Coverage Midyear” on page 11 for more information.

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

When Payroll Contributions Begin

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

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

Changing Your Coverage Midyear

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

You need to enroll and/or add your eligible dependents **within 31 days of the qualifying event** (90 days if the qualifying event is the birth or adoption of a child) for benefits to be effective on the date of the event. **Please Note:** See “Coverage if You Do Not Enroll” on page 10 for details on what happens if you miss the 31-day enrollment period. (You will have 90 days from the QSC to add any newly eligible dependents should that dependent pass away within this 90-day period; please contact 1-844-ASK-JPMC if this situation applies to you.)

You can make these elections through the Benefits Web Center via the Expatriate Health Benefits Resources page on the JPMC intranet or through 1-844-ASK-JPMC.

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

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

* Also applies to a domestic partner relationship.

HIPAA Special Enrollment Rights

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

If you or your eligible dependent declined coverage under the Medical Plan, you may enroll for medical coverage within 31 days of one of the following events for coverage to be effective the date of the event. If you miss the 31-day deadline, coverage for certain benefits will be effective as of the date you contact 1-844-ASK-JPMC. To have retroactive coverage, you will be required to pay for your coverage on an

after-tax basis for the period before you first contact 1-844-ASK-JPMC. Otherwise, you will not be able to make the change until the following Annual Benefits Enrollment:

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

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

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

When Coverage Ends

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

Expatriate Medical Plan

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

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

Key features include:

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

Privacy Information

The privacy of your health information is important to you and to JPMorganChase. We are committed to protecting your personal health information, and complying with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). When you participate in health and benefits plans and related activities, any personally identifiable health information, including biometric wellness screening results and wellness assessment answers, will be maintained and used in accordance with appropriate notices, privacy policies and applicable law (For detailed information regarding HIPAA Privacy Rights, please see "Privacy Notice" in the *Plan Administration* section.)

For more information, go to the Privacy Notice of Protected Health Information page, available via the Expatriate Health Benefits Resources page on the JPMC intranet.

How Your Medical Benefits Work

If You Receive Care in the United States

When you need health care services in the United States, you can choose to receive your care from an in-network or out-of-network medical provider. (See "If You Receive Care Outside the United States" on page 17 if you will be receiving care outside the U.S.)

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

In-Network Care in the United States

- The Plan generally pays 100% of the cost for preventive care without a deductible and 80% of the cost of most other covered services, such as hospitalization, after you meet the annual deductible.
- See “Coinsurance Paid by the Expatriate Medical Plan” on page 24 for tables that show the coinsurance percentage paid by the Expatriate Medical Plan on an in-network and out-of-network basis in the U.S.

In-Network Hospital Admissions

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

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

Out-of-Network Care in the United States

- You may use any licensed provider. **Note**: Charges from out-of-network providers are typically higher than the pre-negotiated fees charged by in-network providers.
- Covered services will be reimbursed at the out-of-network level of benefits, subject to reasonable and customary (R&C) charges. These charges are based on average claims data in your area and are determined by Cigna to be appropriate fees for medical services. **Please Note:** You will be responsible for paying all charges above the R&C amount. Charges in excess of reasonable and customary levels are not considered a covered expense, and they are therefore not applied towards your annual out-of-pocket maximum.
- The Plan generally pays 60% of medically-necessary eligible expenses (subject to reasonable and customary charge limits) after you meet the annual deductible.
- You may need to pay for services at the time you receive care and submit a claim for reimbursement to Cigna Healthcare International. Please see “Filing a Claim for Benefits” on page 48 for more information. Certain providers may choose to accept a guarantee of payment directly from Cigna Healthcare International. You would then be responsible for the difference not paid by the Plan.
- See “Coinsurance Paid by the Expatriate Medical Plan” on page 24 for tables that show the coinsurance percentage paid by the Expatriate Medical Plan on an in-network and out-of-network basis in the U.S.

Out-of-Network Expenses

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

Prescription Drug Purchases at Retail Pharmacies in the United States

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

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

Please Note: If you do not show your Cigna Healthcare International ID card at a network pharmacy, you will have to pay for the prescription drug and submit a claim form to Cigna Healthcare International to be reimbursed for the amount covered by the Expatriate Medical Plan (see “Filing a Claim for Benefits” on page 48.)

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

Important Note About Prescription Drugs

Due to U.S. and/or foreign laws, some controlled medications are limited to a 3-month supply at one time or may have other distribution limits.

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

To determine whether your medication is subject to Cigna Healthcare International’s utilization management program, please contact Cigna Healthcare International.

Mail-Order Prescription Drug Purchases in the United States

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

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

For current prescriptions, you can move them to Express Scripts Pharmacy. Simply call (800) 835-3784 and have your doctor’s contact information and prescription medication name(s) and dosage(s) ready.

Two ways to place a new order

1. **Electronically:** For fastest service, ask your doctor’s office to send your prescription electronically to Express Scripts Home Delivery, NCPDP 2623735.
2. **By fax:** Have your doctor’s office call 888.327.9791 to get a Fax Order Form.

For new orders, please allow 10 to 14 days after Express Scripts Home Delivery Pharmacy receives your request. Refills ship within two business days of receipt of your request.

To determine whether your medication is subject to Cigna Healthcare International’s utilization management program, please contact Cigna Healthcare International.

Purchase or Transport of Prescription Drugs Outside the United States

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

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

Out-of-Network Pharmacy Benefits in the United States

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

If you purchase your prescription drugs through an out-of-network pharmacy in the United States, you will have to pay for the prescription drug and submit a claim form to Cigna Healthcare International to be reimbursed for the amount covered by the Expatriate Medical Plan (see “Filing a Claim for Benefits” on page 48.) Home delivery pharmacy is only available In-Network in the United States.

To determine whether your medication is subject to Cigna Healthcare International’s utilization management program, please contact Cigna Healthcare International.

If You Receive Care Outside the United States

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

- You may use any licensed provider.
- The Plan offers 100% coverage with no deductible for many preventive screenings.
- The Plan generally pays 80% of the cost of most other covered services after you pay the annual deductible.
- The Plan offers 75% coverage without a deductible for eligible prescription drug expenses.
- Generally, you must pay for services at the time you receive care and file a claim to be reimbursed. Certain providers may accept assignment of benefits and choose to accept payment directly from Cigna Healthcare International. You would then be responsible for the difference not paid by the Plan. Visit the Cigna Envoy website at www.cignaenvoy.com to identify providers in your location who will bill Cigna Healthcare International directly.
- If you expect to incur a large expense(s), you can ask Cigna Healthcare International to contact your health care provider in an effort to arrange for a guarantee of payment letter to be issued to the provider. (It remains the choice of the provider to accept this arrangement.)
- Call the Cigna Healthcare International Customer Service Center or check the Provider Directory on the Cigna Envoy website at www.cignaenvoy.com to locate out-of-network providers in your location who will bill Cigna Healthcare International directly.

Did You Know?

Expatriate Medical Plan participants and their families assigned to and/or from a CignaLinks® have access to quality, affordable health care providers through Cigna’s partnership with local insurers and TPAs. Staying within the CignaLinks network allows members to have certain medical services covered at the plan coinsurance or, in some instances, in full.

Purchase or Transport of Prescription Drugs

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

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

If You Use a Pharmacy Outside of the United States

If you purchase your prescription drugs through a pharmacy located outside of the United States, you will have to pay for the prescription drug and submit a claim to Cigna Healthcare International to be reimbursed for the amount covered by the Expatriate Medical Plan (see "Filing a Claim for Benefits" on page 48.)

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

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

CignaLinks® Network Care Outside the United States

CignaLinks® offers a network of quality doctors, hospitals, and clinics in select locations outside the United States and is available to assignees located in or originating from those locations.

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

Country[1]	Cigna*Links*® Partner	Discounted Fees	In-Network Coinsurance[2]	Comment
Australia	GU Health	Not applicable	100% for most persons not eligible for Medicare	Those eligible for Australian Medicare have coverage coordinated with Medicare. Customers should submit their claims to Medicare first for consideration, and then to GU Health. Hospital services and ancillary services, including chiropractors, podiatrists, osteopaths, and physiotherapists covered at 100%. Dental services are covered for "Regulated Members" (Medicare Eligible) through GU.
Bahrain	Cigna Insurance Middle East	Yes	100%	Precertification may be required for some services.
Brazil	Gama Saúde	Yes	100%	Precertification may be required for some services.

Country[1]	Cigna*Links*® Partner	Discounted Fees	In-Network Coinsurance[2]	Comment
Canada	Cowan	Yes	100% major medical; 80% pharmacy/ paramedical services	Precertification may be required for some services.
Hong Kong	QHMS	Yes	80%	Global plan limits waived on all services (80% for physician services and 100% for I/P and O/P Hospital Fees)
Indonesia	Parkway Health	Not applicable	100%	
Kuwait	Cigna Insurance Middle East	Yes	100%	
Malaysia	Parkway Health	Not applicable	100%	
Nigeria	MSO	Yes	80%/100%	80% for physician services and 100% for I/P and O/P Hospital Fees
Oman	Cigna Insurance Middle East	Yes	100%	Precertification may be required for some services.
Qatar	Cigna Insurance Middle East	Yes	100%	Precertification may be required for some services.
Saudi Arabia	Cigna KSA	Yes	100%	Local limitations and/or exclusions apply; some dental and vision expenses also covered (call Cigna Global or for more information).
Singapore	Parkway Health	Yes	100%	
South Africa	MSO	Yes	80%/100%	80% for physician services and 100% for I/P and O/P Hospital Fees
Spain	Cigna Spain	Yes	100%	
United Arab Emirates	Cigna Insurance Middle East	Yes	100%	Local limitations and/or exclusions apply in select locations (e.g., Abu Dhabi and Dubai); some dental and vision expenses also covered (call Cigna Global for more information).
United Kingdom	Cigna UK	Yes	80%	Discounts apply only for services at in-network clinics and hospitals. Dental services are covered as well.

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

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

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

Multiple ID Cards in Some Locations

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

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

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

Forms Required for ID Cards in Some Locations

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

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

Forms are available on the Cigna*Links*® page via the Expatriate Health Benefits Resources page on the JPMC intranet.

How the Expatriate Medical Plan Pays Benefits

The Expatriate Medical Plan pays the full cost for preventive care received outside the U.S. or in-network in the U.S., including physical exams and recommended wellness/cancer screenings. For most other medical costs, after you satisfy the annual deductible, you pay your share of medical costs through coinsurance until you reach the annual out-of-pocket maximum.

Did You Know?

The annual deductible is waived in certain CignaLinks locations, reducing your overall costs. See 'CignaLinks® Network Care Outside the United States" on page 18 for more information.

Don't Forget that Health Advocate Can Help!

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

When you call Health Advocate, you will be assigned a personal health advocate who will work with you through the entire process, so you will have an advocate who is familiar with your case. **This program is available on a limited basis when receiving care outside the United States.** For more information, go to the Know Where to Solve Your Health Care or Insurance Issues page, available via the Expatriate Health Benefits Resources page on the JPMC intranet or call Health Advocate at (866) 611-8298. Personal health advisors are available Monday – Friday, from 8 a.m. to 9 p.m. Eastern time.

The Annual Deductible

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

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

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

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

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

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

The Annual Out-of-Pocket Maximum

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

The following table shows the out-of-pocket maximums (excluding deductibles) for the different coverage levels.

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

The Per-person Deductible and Out-of-Pocket Maximum Provision

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

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

Example: Amounts Applied Toward Deductibles for In-Network Care Received in the U.S.	
On behalf of you (meets per-person deductible)	$350
On behalf of your spouse/domestic partner	$250
On behalf of one child	$175
On behalf of a second child	$275
TOTAL (meets family deductible)	**$1,050**
In this example, you have met the $350 per-person deductible, and the combined costs for you and all of your dependents have satisfied the family deductible ($1,050). So any additional reasonable and customary (R&C) charges for medically necessary covered services would be reimbursable at 80% until your out-of-pocket maximum is met, even if they were on behalf of a person who has not yet met the $350 per-person deductible. No other covered family members need to meet their per-person deductible for the rest of the year.	

Example: Amounts Applied Toward Family Out-of-Pocket Maximum for In-Network Care Received in the U.S.	
On behalf of you (meets per-person out-of-pocket maximum)	$1,700
On behalf of your spouse/domestic partner	$1,300
On behalf of one child	$1,150
On behalf of a second child	$950
TOTAL (meets family out-of-pocket maximum)	**$5,100**
In this example, one person has met the $1,700 per-person out-of-pocket maximum (you), and the combined out-of-pocket costs after meeting the deductible, have reached $5,100. So, any additional reasonable and customary (R&C) charges for medically necessary covered services would be reimbursable at 100% for the remainder of the year, even if they were on behalf of a person who has not yet met the per-person out-of-pocket maximum. No other covered family members need to meet their per-person out-of-pocket maximum for the rest of the year.	

Maximum Lifetime Benefit

There is no dollar limit on the amount the Expatriate Medical Plan would pay for essential benefits during the period you and your covered dependents are enrolled in the Plan. However, there is a $35,000 lifetime infertility services maximum ($15,000 is the Lifetime cap on Fertility Drugs). There is also a lifetime limit of 365 days for care received in a skilled nursing facility. The infertility services and skilled nursing facility lifetime maximum benefits apply to care received in/out-of-network in the U.S. and care received outside the U.S.

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

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

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

You do not gain a new benefit maximum if you switch your coverage between the U.S. domestic and expatriate plans. In addition, any benefits that were applied to a lifetime maximum provision under prior U.S. medical plans of JPMorganChase (such as the Point of Service High/Low and Medical Plan Option 1 or 2) and medical plans of a heritage organization that was acquired by JPMorganChase will also be applied to the lifetime benefit maximums of the Expatriate Medical Plan.

Coinsurance Paid by the Expatriate Medical Plan

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

Please Note

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

Out of Network Coverage

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

Eligible Preventive Care

Please Note: A medical service will only be covered at 100% if it is coded as **preventive**. Before receiving any service, you should check with your physician to be sure the procedure is considered, and will be submitted to the claims administrator, as preventive medical care rather than as a diagnostic service. Cigna determines the eligible preventive care services covered at 100%. See “Preventive Care Services” page 29 for more information about eligible preventive care services.

	Care Received Inside the United States		Care Received Outside the United States
Provision	**In-Network**	**Out-of-Network**	
Routine Physical Exams at the following frequency: • From birth to 12 months: seven exams • Age 13 – 24 months: three exams • Age 2 and over: one exam every year	100%	60% after deductible	100%
Routine Immunizations (adult and child; including immunizations related to travel)	100%	60% after deductible	100%

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Routine Mammograms (annually age 40 and up)	100%	60% after deductible	100%
Routine Gynecological Exams and Pap Smears, including related laboratory fees (annually; age guidelines apply)	100%	60% after deductible	100%
Routine Prostate Specific Antigen (PSA) Test (annually age 40 and up)	100%	60% after deductible	100%
Routine Digital Rectal Exam (annually age 40 and up)	100%	60% after deductible	100%
Routine Fecal Occult Blood Test (annually age 50 and up)	100%	60% after deductible	100%
Routine Sigmoidoscopy/ Colonoscopy (baseline screening beginning at age 45 and over; follow-up screening every five years)	100%	60% after deductible	100%
Routine Eye Exams (maximum one exam every 12 consecutive months)	100%	60% after deductible	100%
Routine Hearing Exams (maximum one exam every 24 months)	100%	60% after deductible	100%

Outpatient Services

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Doctor's Office Visits (to family practitioners, internists, pediatricians, and OB/GYNs, and consultations, specialist visits, convenience care clinic visits and second surgical opinions; also includes tests, injection drugs, supplies, and other services authorized by the Plan and provided during the visit and billed by the physician)	80% after deductible	60% after deductible	80% after deductible
X-rays and Labs (when performed to diagnose a medical problem or treat an illness or injury)	80% after deductible	60% after deductible	80% after deductible
Surgery/Major Medical	80% after deductible	60% after deductible	80% after deductible
Infertility Services (includes diagnostic procedures, in vitro fertilization, artificial insemination, etc.; limited to combined in-/out-of-network/outside the U.S. maximum of $35,000 lifetime for each covered employee and/or spouse/domestic partner*)	80% after deductible	60% after deductible	80% after deductible
Speech, Physical, or Occupational Therapy — outpatient (combined in-/out-of-network/ outside U.S. limit of 60 visits/calendar year per therapy type*)	80% after deductible	60% after deductible	80% after deductible
Spinal Treatment/ Chiropractic Care (coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year*)	80% after deductible	60% after deductible	80% after deductible

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Mental Health Care Office visits are not subject to the deductible	80% after deductible	60% after deductible	80% after deductible
Substance Use Care Office visits are not subject to the deductible	80% after deductible	60% after deductible	80% after deductible

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

Inpatient Services

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Hospital (based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases; excluding emergency room care)	80% after deductible	60% after deductible	80% after deductible
Surgery/Major Medical	80% after deductible	60% after deductible	80% after deductible
Skilled Nursing Facility (must be ordered by physician as medically necessary; limited to combined in-/out-of-network/outside U.S. maximum of 365 days per lifetime for each covered individual)	80% after deductible	60% after deductible	80% after deductible
Hospice Care	80% after deductible	60% after deductible	80% after deductible
Mental Health Care	80% after deductible	60% after deductible	80% after deductible
Substance Use Care	80% after deductible	60% after deductible	80% after deductible
Home Health Care (medically necessary only; limited to combined in-/out-of-network/outside U.S. maximum of 200 visits/calendar year; one visit = four hours)	80% after deductible	60% after deductible	80% after deductible

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Durable medical equipment	80% after deductible	60% after deductible	80% after deductible
Prosthetics	80% after deductible	60% after deductible	80% after deductible

Prescription Drugs

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Prescription drugs ($15,000 lifetime maximum for infertility drugs; exclusive of treatment)	75% (deductible waived)	60% (deductible waived)	75% (deductible waived)

Other Services

Provision	Care Received Inside the United States		Care Received Outside the United States
	In-Network	Out-of-Network	
Hospital — emergency room	80% after deductible	60% after deductible	80% after deductible

If You Need Urgent and/or Emergency Care

If you have a medical emergency that's sudden, urgent, and life-threatening, you should go to the nearest physician, hospital emergency room, or other urgent care facility. Your emergency care will be covered at 80% after deductible for emergency room visits or at 100% after a $150 copayment per visit at urgent care facilities.

What Is Covered

The Expatriate Medical Plan covers a wide variety of services, as long as the services are medically necessary (please see the definition of "Medically Necessary" in "Defined Terms" on page 51). However, covered services under the Expatriate Medical Plan may differ from the lists below and/or be subject to limits or restrictions. For specific information on covered services, please contact Cigna Healthcare International.

Certain Limitations

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

Preventive Care Services

Preventive care services covered at 100% are determined by Cigna Healthcare International 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.

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

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

- Routine care including:
  - PAP tests (one per year, includes related laboratory fees);
  - Prostate exams (age 40 and over, one exam per year);
  - Flexible sigmoidoscopy (age 45 and over, one baseline screening, and one follow-up screening every five years);
  - Screening colonoscopy (age 45 and over, one baseline screening and one follow-up screening every five years);
  - Fecal occult blood test (age 45 and over, one test per year);
  - Routine physical exams (office visit with appropriate laboratory and radiology services);
  - Mammography screenings (age 40 and over, one mammogram per year);
  - Routine screenings during pregnancy (e.g., for gestational diabetes and bacteriuria);
  - Breast pumps (please contact your health care company for details regarding which breast pumps are fully covered); and
  - Well-child/adult care office visits (plus immunization and labs):
    - Birth to age 12 months: seven exams
    - Age 13 – 24 months: three exams
    - Age 25 – 36 months: three exams
    - Age 3 and over: one exam per year

Preventive Care Must Be Coded Properly

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

Inpatient Hospital and Related Services

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

- Allergy testing and treatment, when provided as part of inpatient care for another covered condition;
- Anesthetics and their administration;
- Bariatric surgery subject to claims administrator guidelines;
- Basic metabolic examinations;
- Cosmetic surgery when needed to:
  - Reconstruct or treat a functional defect of a congenital disorder or malfunction;
  - Treat an infection or disease;
  - Treat an injury or accident; or
  - Reconstruct a breast after mastectomy. Coverage for the following services is available in a manner determined in consultation with you and your physician:
    - Reconstruction of the breast on which the mastectomy was performed;
    - Surgery and reconstruction for the other breast to produce a symmetrical appearance; and
    - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.
- Diagnostic services, including:
  - EEG, EKG, and other diagnostic medical procedures;
  - Laboratory and pathology tests; and
  - Radiology services.
- Electrocardiographic and physiotherapeutic equipment usage;
- Hemodialysis for kidney failure;
- Intensive care unit service;
- Maternity care, including:
  - Any required care for an illness or injury that the newborn develops either before or after birth as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames;
  - Care required due to miscarriage or ectopic pregnancy;
  - Coverage of eligible expenses if your covered child has a baby, but not including nursery or other expenses incurred by the newborn child;
  - Delivery by a certified, registered nurse or midwife in a birthing center;
  - Drugs, medications, and anesthesia;
  - Normal or cesarean section delivery;

- Routine medical and hospital nursery care for your covered newborn child, as long as you and your newborn are enrolled in the appropriate coverage category within prescribed time frames;
- Circumcision by a licensed provider (for your covered newborn child), as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames; and
- A semi-private room. The period of hospitalization for childbirth (for either the mother or the covered newborn child) is up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. (However, your attending physician — after consulting with the mother — may decide to discharge the mother or newborn child earlier.)

Please Note

You have 90 days from the date of birth or adoption of a child to add your newly eligible dependents to the Plan. Please see "Eligible Dependents" on page 6 and "Changing Your Coverage Midyear" on page 11 for more information.

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

This list is subject to change at any time.

Multiple Surgical Procedure Reduction Policy

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

- 100% of the coinsurance percentage amount for the primary or major surgical procedure;
- 50% of the coinsurance percentage amount for the secondary procedure; and
- If more than two procedures are performed, please check with Cigna Healthcare International for coverage details.
- Please see contact information for Cigna Healthcare International at the beginning of this *Expatriate Medical and Dental Plans* section, on page 1.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act of 1998

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

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

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

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

Outpatient Services

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

- Acupuncture when used as a form of pain control and performed by a licensed provider (check with Cigna Healthcare International);
- Allergy testing and treatment;
- Chemotherapy and radiation treatments;
- Chiropractic care when medically necessary as determined by Cigna Healthcare International to diagnose or treat illness, injury, or disease. Coverage is limited to 20 visits per year and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
- Diagnostic services, including:
  - EEG, EKG, and other medical electronic procedures;
  - Laboratory and pathology tests; and
  - Radiology services.
- Education therapy, but only for participants with a diagnosis of diabetes mellitus;
- Eye exams for patients with diabetes (covered as a specialist office visit);
- Hemodialysis provided at a free-standing facility such as a dialysis center, or your home, when ordered by a licensed provider;
  - Licensed, general hospital emergency room use for treatment of an injury or sudden illness, including:
  - Emergency treatment rooms;
  - Laboratory and pathology tests;
  - Licensed providers' services;
  - Supplies and medicines administered during the visit; and
  - Radiology services.
- Licensed provider-prescribed respiratory therapy approved by Cigna Healthcare International;
- Mental health care/substance use care;

- Occupational therapy rendered by a licensed therapist, up to a combined total of 60 visits per calendar year for care received in-/out-of-network and outside the U.S.;
- Outpatient surgery and related follow-up care;
- Physical therapy rendered by a licensed therapist, up to a combined total of 60 visits per calendar year for care received in-/out-of-network and outside the U.S.;
- Podiatric care when medically necessary as determined by Cigna Healthcare International to diagnose or treat illness, injury, or disease. Coverage ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
- Prenatal care;
- Speech therapy rendered by a licensed therapist, up to a combined total of 60 visits per calendar year for care received in-/out-of-network and outside the U.S.; and
- Temporomandibular joint syndrome (TMJ) medical treatment only, including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery up to $1,000 combined for in-/out-of-network care and care received outside the United States (appliances are not covered).

This list is subject to change at any time.

Other Covered Services

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

- Compression stockings (two pair per calendar year for the following conditions only: diabetes, varicose veins, varicose ulcers, stasis dermatitis, post-phlebitic syndrome, and lymphedema);
- Dental procedures resulting from a congenital disorder or medical disorder or accidental injury (treatment must be received within 12 months of the accident). Includes surgical removal of wisdom teeth only if procedure is done in medical setting. **Please Note:** The charges must not be covered by the Expatriate Dental Plan;
  - Gender Affirmation Surgery (may be referred to by our health care companies as Gender Reassignment Surgery or GRS). To be eligible, the participant must meet certain medically established guidelines that are outlined in your health care companies clinical polices (which may align with the WPATH Standards of Care v7), for obtaining the surgery which require the participant to, among other things:Be at least 18 years old;
  - Have a GID (Gender Identity Disorder) diagnosis;
  - Have been approved for hormone therapy;
  - Have at least one year's real life experience living and working in desired gender; and
  - Have two letters endorsing surgery, including one from a mental health provider at the doctorate level.
- Follow-up procedures such as electrolysis, breast augmentation surgery, and facial surgery will *not* be covered.
- Surgery must be preauthorized by the medical plan administrator whether in or out-of-network or outside the United States.
- Hearing aid evaluations and hearing tests;
- Hearing aids up to $3,000 every 36 months;
- Home health care approved by Cigna Healthcare International. The attending physician must submit a detailed description of the medical necessity and scope of services to Cigna Healthcare International.

The following are covered if ordered by the physician under the home health care plan and provided in the patient's home. (Please check with Cigna Healthcare International for any age or frequency limitations.):

- Part-time or intermittent nursing care provided or supervised by a registered nurse (R.N.);
- Part-time or intermittent home health services, primarily for the patient's medical care;
- Physical, occupational, speech, or respiratory therapy by a licensed qualified therapist;
- Nutrition counseling provided by or under the supervision of a registered dietitian; and
- Medical supplies, laboratory services, drugs, and medications prescribed by a physician.

- Intensive behavior therapy, such as Applied Behavior Analysis (ABA) for Autism Spectrum Disorder, subject to precertification from Cigna Healthcare International;
- Local ambulance service or air ambulance to the nearest hospital if medically necessary and confirmed by a licensed provider;
- Medical equipment and supplies including blood and blood plasma (unless donated on behalf of the patient); artificial limbs (excluding replacements), artificial eyes and larynx (including fitting); heart pacemaker; surgical dressings; casts; splints; trusses; orthopedic braces; crutches; wheelchair; walker; cane; insulin pump; Athner monitor; custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot; hospital bed; ventilator; iron lung; ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters; and other items necessary to the treatment of an illness or injury that are not excluded under the Plan. Prior authorization or precertification may be required for coverage of some medical equipment and supplies. Cigna Healthcare International may authorize purchase of an item if more cost-effective than rental.
- Medically necessary visits to licensed physicians, surgeons, and chiropractors, whether in the office or in your home;
- Nutritional support, including nutritional counseling (limited to three visits for diabetes and three visits for non-diabetes counseling, for a total of six visits) and durable medical equipment to treat inborn errors of metabolism and/or to function as the majority source of nutrition*, as long as each of the following conditions are met:
  - Without enteral (feeding tube) feedings, the individual is unable to obtain sufficient nutrients to maintain appropriate weight by dietary and/or oral supplements;
  - The administration of enteral nutrition requires ongoing evaluation and management by a physician; and
  - The individual has one of the following conditions that is expected to be permanent or of indefinite duration:
    - An anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel;
    - Disease of the small bowel that impairs absorption of an oral diet; or
    - A central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition

  * When assessing the "majority source of nutrition," the following considerations apply:
  - Enteral feeding constitutes over 50% of caloric nutritional intake as determined by clinical information submitted by the provider for review;

  - Calories from parenteral (intravenous) nutrition should not be considered when assessing for the sole source of nutrition; i.e., transitioning to enteral feedings; and
  - Parenteral feedings are covered when considered “medically necessary” and used when oral or enteral alone are not possible.
- Oxygen and supplies for its administration;
- Prosthetic devices and supplies, including fitting, adjustments, and repairs, if ordered by a licensed provider. Please check with Cigna Healthcare International for frequency or other limitations. (**Please Note:** Dentures, bridges, etc., are not considered medical prosthetic devices.);
- Radiation, chemotherapy, and kidney dialysis;
- Rental or purchase of durable medical equipment as determined by Cigna Healthcare International, if ordered by a licensed provider. Please check with Cigna Healthcare International for frequency or other limitations;
- Services and supplies that are part of an alternate care proposal. This is a course of treatment developed and authorized by Cigna Healthcare International as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless specified otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, copayments, and deductible will apply to these services;
- Skilled nursing facility for up to 365 days per lifetime (combined in-/out-of-network care and care received outside the United States) under the Expatriate Medical Plan and for up to 120 days per lifetime combined in-network and out-of-network under the Medicare Indemnity Plans. The lifetime maximums reflect services received across the Expatriate Medical Plan, Medical Plan Option 1 and Option 2, and under prior medical plans of JPMorganChase (such as the Point Service High/Low) and the medical plans of a heritage organization that was acquired by JPMorganChase;
- Urgent care;
- Voluntary sterilization; and
- Wigs up to a $500 per year limit, for burns, chemotherapy or radiation, accidental injury, following a diagnosis of Alopecia, or for other medically necessary reasons.

This list is subject to change at any time.

Hospice Care

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

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

Hospice services include:

- Hospice room and board while the terminally ill person is an inpatient in a hospice;
- Outpatient and other customary hospice services provided by a hospice or hospice team; and
- Counseling services provided by a member of the hospice team.
- These services and supplies are eligible only if the hospice operates as an integral part of a hospice care program, and the hospice team includes at least a doctor and a registered graduate nurse. Each service or supply must be ordered by the doctor directing the hospice care program and be:

- Provided under a hospice care program that meets standards set by Cigna Healthcare International. If such a program is required by law to be licensed, certified, or registered, it must meet that requirement; and
- Provided while the terminally ill person is in a hospice care program.
- Hospice benefits also include eligible expenses for counseling services for the family unit, if ordered and received under the hospice care program. Benefits will be paid if:
  - On the day before the terminally ill person passed away, he/she was:
    - In a hospice care program;
    - A member of the family unit; and
    - A covered participant.
  - The charges are incurred within three months after the death of the terminally ill person.

This list is subject to change at any time.

Fertility Treatment Procedures

There are special covered procedures that induce pregnancy but do not treat the underlying medical condition. They include (but are not limited to) artificial insemination and in-vitro fertilization. Infertility services are subject to a $35,000 combined lifetime maximum benefit for each covered individual (yourself and/or your spouse/domestic partner). This limit applies to all benefits combined in a lifetime, and applies regardless of whether the services were received in-/out-of-network or outside the United States or under a U.S. domestic Medical Plan, such as Option 1, Option 2 and the Medicare Indemnity and under prior U.S. medical plans of JPMorganChase (such as the Point of Service High/Low) and the medical plans of a heritage organization that was acquired by JPMorganChase. This limit does not apply to the diagnosis of infertility and/or its cause. All procedures and access will be governed by Cigna Healthcare International's protocols for determining appropriateness of care.

Planning Treatments That May Cause Infertility

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

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

— in vitro fertilization; and

— embryo cryopreservation.

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

Infertility Diagnostic Services

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

Coverage Limitations

As mentioned earlier, certain covered services are limited to a specific number of visits or days of limitations, subject to applicable deductibles, coinsurance and/or copayments. These limitations are included in the coverage tables under “Coinsurance Paid by the Expatriate Medical Plan” on page 24.

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

What Is *Not* Covered

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

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

- Care from a person who is a member of your family or your spouse/domestic partner’s family;
- Charges for the difference between a private and semi-private hospital room;
- Correction of weak, unstable, or flat feet; arch supports; corrective shoes; shoe orthotics (except for custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot); or treatment of corns, calluses, or chronic foot strain;
- Cosmetic surgery treatment, except to repair damage from accident or injury; treat a functional birth defect; reconstruct a breast after mastectomy and/or reconstruction of the non-affected breast to produce a symmetrical appearance; or treat an infection or disease;
- Custodial services, including custodial nursing care and group homes;
- Donor expenses with regard to infertility treatment;
- Educational therapy (except for members with a diagnosis of diabetes) and social or marital counseling;
- Expenses for which you’re not obligated to pay (for example, if a licensed provider or hospital waives an expense, the Plan will not pay any benefit to you or a licensed provider);
- Expenses in excess of reasonable and customary (R&C) charges;
- Expenses submitted later than 365 days from the date in which services were provided;
- Experimental, investigational, or unproven services, devices, or supplies (see the definition of “Experimental, Investigational, or Unproven Services” in “Defined Terms” on page 51);
- Hospital admissions and other services that began before the participant’s effective date of coverage under the Expatriate Medical Plan;
- Inpatient private duty nursing;
- Non-medical charges for care in a nursing or convalescent home or long-term custodial care, even if prescribed by a licensed provider;

- Non-prescription contraceptive devices, unless medically necessary (prescription oral contraceptives are covered under the Expatriate Medical Plan);
- Non-surgical correction of temporomandibular joint (TMJ) syndrome, such as appliances or devices;
- Nutritional support expenses including but not limited to:
  - regular grocery products (including over-the-counter infant formulas such as Similac, Nutramigen, and Enfamil) that meet the nutritional needs of the patient;
  - infant formula that is not specifically made to treat inborn errors of metabolism;
  - medical food products that:
    - are prescribed without a diagnosis requiring such food;
    - are used for convenience purposes;
    - have no proven therapeutic benefit without an underlying disease, condition, or disorder;
    - are used as a substitute for acceptable standard dietary interventions;
    - are used exclusively for nutritional supplementation; and
    - are required due to food allergies.
  - nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals.
- Personal hospital services, such as television, telephone, etc.;
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments if required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage, or adoption;
- Refractive eye examinations for new lenses or the cost of eyeglasses or contacts. This does not apply to the first pair of contact lenses or the first pair of eyeglasses following either cataract surgery or a diagnosis of Keratoconus;
- Refractive eye surgery including, but not limited to, Lasik or Radial Keratotomy;
- Reproductive education and prevention classes;
- Reversals of sterilization;
- Routine dental care (please see the *Expatriate Dental Plan* section on page 40 for information about services covered under the Expatriate Dental Plan);
- Services, supplies, or treatment for weight loss outside of those covered under the Prescription Drug Plan, nutritional supplements, or dietary therapy; please note: medications for weight loss are covered and may be subject to Prior Authorization;
- Sickness or loss covered by workers' compensation laws or automobile insurance;
- Sickness or loss that is later determined to be the legal responsibility of another person or company;
- Treatments, services, or supplies that are not medically necessary or not approved by a licensed provider or services provided outside the scope of a provider's license;
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias (sexual behavior that is considered deviant or abnormal);

- Unbundled medical expenses — charges billed separately when considered by Cigna Healthcare International in its sole discretion to be part of a global procedure; and
- A procedure or surgery to remove fatty tissue such as abdominoplasty, brachioplasty, mastopexy, thighplasty, or panniculectomy.

This list is subject to change at any time.

Expatriate Dental Plan

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

Key features include:

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

Pre-Determination of Benefits

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

Find a U.S. Dental Provider

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

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

How Your Dental Benefits Work

Dental benefits are paid according to the schedule of benefits shown under "Coinsurance" on page 42. If you receive services in the United States, you have to decide whether to receive your care through a Cigna Dental PPO Network provider or through a provider who is not part of the network.

In-Network Care

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

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

Out-of-Network Care

You may go to any general dentist or specialist at any time without a referral. If you see a non-network dentist, there is no penalty, but you may have to file your own claim if the dentist does not bill Cigna Healthcare International directly. (See “Filing a Claim for Benefits” on page 48).

How the Expatriate Dental Plan Pays Benefits

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

The Annual Deductible

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

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

The following table shows the deductibles for restorative care:

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

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

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

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

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

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

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

Coinsurance

After you meet the applicable deductible, the Expatriate Dental Plan will pay a percentage of in-network dentists' negotiated fees, or, for out-of-network expenses, a percentage of the reasonable and customary (R&C) charges for eligible expenses (see "Defined Terms" on page 51 for the definition of "Reasonable and Customary"). The exact percentage depends on the type of care you receive. You'll pay the remaining amount as coinsurance, plus any amounts above R&C charges. Please see the chart below for the applicable coinsurance rate. The coinsurance amount does not vary based on whether or not the care is received inside or outside of the United States.

Pre-Determination of Benefits

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

Preventive Care

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

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

Basic Restorative Care

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

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

Major Restorative Care

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

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

Orthodontia

Orthodontia care is only covered for your covered children who are under age 19. Please see "Orthodontic Covered Services" on page 43 for additional information.

Care Received	Coinsurance
Orthodontia	50%

Maximum Benefits

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

Orthodontic Covered Services

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

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

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

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

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

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

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

Maximum Benefits

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

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

Lifetime Orthodontia Maximum Includes All Dental Plans

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

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

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

What Is Covered

The Expatriate Dental Plan covers a wide variety of services, as long as the services are necessary and their costs do not exceed reasonable and customary (R&C) charges. (Please see "Defined Terms" on page 51 for the definitions of "Necessary Services" and "Reasonable and Customary Charges.") The following lists include examples of covered services, but the lists are not exhaustive and coverage remains subject to any Plan requirements or limitations. For specific information on covered services and frequency limits, please contact Cigna Healthcare International. The list of covered services may change at any time.

Preventive Care Services

Covered preventive care services include the following services (please see the chart under "Preventive Care" on page 42 for age and frequency limitations):

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

Basic Restorative Care Services

Covered basic restorative care services include:

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

Major Restorative Care Services

Covered major restorative care services include:

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

Alternate Benefit Provision

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

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

For example:

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

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

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

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

What Is *Not* Covered

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

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

The Plan does not cover any of the following services:

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

- Charges in connection with:
  - A service to the extent that it is more than the usual charge made by the provider for the service when there is no insurance;
  - Appliances or restorations needed to alter vertical dimensions or restore occlusion, or for the purposes of splinting or correcting attrition, abrasion, or erosion; or
  - Replacement of lost, missing, or stolen appliances or appliances that have been damaged due to abuse, misuse, or neglect.
- Treatment for problems of the jaw joint, including:
  - Craniomandibular disorder;
  - Temporomandibular joint syndrome (TMJ), other than what is noted in “What Is Covered” on page 44; and
  - Other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves, and other tissues related to that joint.
- Expenses submitted later than 365 days from which services were provided.
- Installation of prosthetic devices (including bridges and crowns) while not covered or which were installed more than 31 days after coverage ends.
- Loss — or portion of a loss — for which mandatory automobile no-fault benefits are recovered or recoverable.
- Partial or full removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth (including congenitally missing teeth) missing before the person became covered under this Plan. The exclusion does not apply if the denture, bridge, or bridgework also includes replacement of a natural tooth that:
  - Is removed while the person is covered; and
  - Was not an abutment to a partial denture, removable bridge, or fixed bridge installed during the prior five years.
- Procedures related to occupational illness or injury.
- Replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for a replacement or modification of a crown or gold restoration or inlay/onlay within five years after that denture, bridgework, crown, inlay/onlay, or gold restoration was installed.
- Expenses or charges with respect to services rendered by hospitals, clinics, laboratories (except dental X-rays are covered), or other institutions.
- Services and supplies included as covered medical expenses under:
  - Any other employer-sponsored plan that covers you, including Medicare;
  - Any other governmental health program, except the U.S. Medicaid program; or
  - The Expatriate Medical Plan.
- Services and supplies rendered in a veteran’s facility or government hospital, or services furnished in whole or in part under the laws of the United States or any of its state or political subdivisions.
- Services furnished for cosmetic purposes. Facings on crowns or pontics — which are behind the second bicuspid — will always be considered cosmetic. This limitation does not apply if the service is needed as a result of accidental injuries sustained while a person is covered.
- Services not reasonably necessary as determined by Cigna Healthcare International.
- Services to the extent that a benefit for those services is provided under any other program paid in full or in part, directly or indirectly, by JPMorganChase. This includes insured and uninsured programs. If

a program provides benefits in the form of services, the cash value of each service rendered is considered the benefit provided for that charge.

- Services to the extent that the charges are above the prevailing charge in the area for dental care of a comparable nature. A charge is above the prevailing charge to the extent that it's above the range of charges generally made in the area for dental care of a comparable nature. The area and that range are determined by Cigna Healthcare International.
- Treatment by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, a trustee, or a similar person or group.
- Expenses in connection with services, procedures, drugs, or other supplies that are determined by Cigna Healthcare International to be experimental, or still under clinical investigation by health professionals.
- Charges for oral hygiene programs, completion of claim forms by the provider on your behalf, and broken appointments.
- Services provided by a relative, or for which a charge would not normally be made.
- Treatment by anyone except a licensed dentist (except for cleaning or scaling of teeth and topical application of fluoride performed by a licensed dental hygienist, if rendered under the supervision and guidance of a licensed dentist).

Other Limitations

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

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

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

Filing a Claim for Benefits

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

Claims Deadline

To have your claim considered for benefits, all claims must be filed within 365 days from the date the service was rendered.. If you do not meet this deadline, your claim will be denied.

If a provider will not bill Cigna directly you will need to pay at the point of service and file a claim with Cigna Healthcare International to be reimbursed. You can submit your claim online or by mail, as described below. (An itemized bill may be submitted in lieu of the attending physician's statement.) Upon filing a claim you will be reimbursed based on the schedule of benefits described under "How the Expatriate Medical Plan Pays Benefits" on page 21 or "How the Expatriate Dental Plan Pays Benefits" beginning on page 41.

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

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

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

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

Online Claims Submissions

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

Paper Claims Submissions

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

Completed claim forms, with original itemized bills, should be sent to Cigna Healthcare International via:

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

Claims submitted with all necessary documentation for payment in U.S. dollars will generally be processed within 10 business days from the date complete information is received by Cigna Healthcare International, regardless of the language or currency.

Best practices for member claims submissions:

- All out-of-network claims should be sent directly to Cigna Healthcare.
- If you choose to mail or fax your claim(s), make sure your claim form is filled out completely, and don't forget to sign it!
- Fill out a separate form for each doctor or hospital visit.
- Be sure to add a diagnosis, type of treatment or explanation of treatment.

- Provide a detailed list of fees for each service rendered along with the date it was performed.
- Make and keep handy copies of your bills, receipts and claim forms.
- Clearly state how you would like to be reimbursed.

ePayment Plus & Wire Transfers

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

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

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

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

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

If You Have Questions About a Claim

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

You can also call Cigna Healthcare International at the telephone number on the back of your ID card.

If you are experiencing difficulty with a claim in the U.S., Health Advocate can also help you resolve benefit claim issues. (See “How the Expatriate Medical Plan Pays Benefits” on page 21 for more information about Health Advocate.)

Appealing a Claim

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

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

Help Pursuing Claims

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

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

If you would like to designate an authorized representative for claims related to eligibility to participate in a plan, please contact 1-844-ASK-JPMC.

Defined Terms

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

Alternate Benefits

If Cigna Healthcare International determines that a service less costly than the Covered Service the dentist performed could have been performed to treat a dental condition, the Plan will pay benefits based upon the less costly service if such service:

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

Before-Tax Contributions

U.S. home-based expatriate employees, and expatriate employees who are assigned to the United States, pay for coverage with before-tax dollars — contributions that are taken from your pay before U.S. federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before U.S. Social Security taxes are withheld. This lowers your U.S. taxable income and your U.S. income tax liability.

Claims Administrator

The claims administrator is the company that provides certain claims administration services for the Medical and Dental Plan.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue Medical and/or Dental Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. The *Health Care Participation* section provides details on COBRA coverage.

Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for COBRA continuation coverage.

Coinsurance

Coinsurance is the way you share costs for certain coverage options after you pay any applicable deductible. The Medical and Dental Plans pay either a percentage of reasonable and customary (R&C) charges or a percentage of the in-network dentist's negotiated fees for covered services, and you pay the remainder. The actual percentage depends on the option you've chosen and the type of covered service.

Coordination of Benefits

Coordination of benefits rules are the rules that determine how benefits are paid when a patient is covered by more than one group plan. Rules include:

- Which plan assumes primary liability;
- The obligations of the secondary claims administrator or claims payer; and
- How the two plans ensure that the patient is not reimbursed for more than the actual charges incurred.

In general, the following coordination of benefits rules apply:

- As a JPMorganChase employee, your JPMorganChase coverage is considered primary for you.
- For your spouse/domestic partner or child covered as an active employee and/or retiree of another employer, that employer's coverage is considered primary for him or her.
- For children covered as dependents under two plans, the primary plan is the plan of the parent whose birthday falls earlier in the year (based on month and day only, not year).

Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee) or covered by U.S. Medicare. These rules do not apply to any private insurance you may have. Please see "If You Are Covered by More Than One Plan" in the *Plan Administration* section for more details.

Copayment

A copayment (also known as a copay) is the fixed dollar amount you pay for certain covered services under the Expatriate Medical and Dental Plans. For example, the Expatriate Medical Plan requires a $150 copayment for an Urgent Care visit. The actual amount of the copayment will vary based on the services provided.

Covered Expenses

Covered expenses are the in-network negotiated fees or the reasonable and customary (R&C) charges for medically necessary covered services or supplies that qualify for full or partial reimbursement under the Expatriate Medical and/or the Expatriate Dental Plans.

Covered Services	While the Plans provide coverage for numerous services and supplies, there are limitations on what's covered. For example, under the Expatriate Medical Plan, experimental treatments, most cosmetic surgery expenses, and inpatient and outpatient private duty nursing are not covered. Medical procedures are generally reimbursable only if they meet the definition of "Medically Necessary" (see "Medically Necessary," below). Under the Expatriate Dental Plan, a crown, bridge, or gold restoration is not covered if a tooth was prepared for it before the person became covered under the Plan. So, while a service or supply may be necessary, it may not be covered under the Expatriate Dental Plan. Please see "What Is Covered" on page 44 for more details.
Deductible	The deductible is the amount you pay up front each calendar year for covered expenses before the Expatriate Medical Plan and/or Expatriate Dental Plan generally begins to pay benefits for many expenses. Amounts in excess of reasonable and customary (R&C) charges and ineligible charges do not count toward the deductible.
Experimental, Investigational, or Unproven Services	Experimental, investigational, or unproven services are medical, surgical, diagnostic, psychiatric, mental health, substance abuse and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the claims administrator makes a determination about coverage in a particular case, are determined to be: ▪ Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or ▪ Subject to review and approval by any institutional review board for the proposed use; or ▪ The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or ▪ Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed. The claims administrator, in its judgment, may determine an experimental, investigational or unproven service to be covered under the Medical Plan for treating a "life-threatening" sickness or condition if the claims administrator determines that a service: ▪ Is safe with promising effectiveness; ▪ Is provided in a clinically controlled research setting; and ▪ Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. **Please Note:** For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. If services are denied because they are deemed to be experimental, investigational, or unproven, and the service is then considered an approved service by the claims administrator within six months of the date of service, you may resubmit your claim for payment.
Explanation of Benefits	An explanation of benefits (EOB) is a statement that the claims administrator prepares, which documents your claims and provides a description of benefits paid and not paid under the Expatriate Medical Plan and the Expatriate Dental Plan.
Home Health Care	Home health care is an alternative to inpatient hospitalization during a patient's recovery period. If the attending physician believes that part-time care will suffice in treating the sickness or injury, the physician can prescribe a schedule of services to be provided by a state-licensed home health care agency. This schedule may include administration of medication, a regimen of physical therapy, suctioning or cleansing of a surgical incision, or the supervision of intravenous therapy.

In-Network	"In-network" describes a covered service that is performed by a physician, dentist, hospital, lab, or other health care professional who is part of a health care company's network and who has agreed to pre-negotiated fees. When a service is performed in-network, benefits are generally paid at a higher level than they are when a service is performed out-of-network.
Maximum Annual Benefit	The maximum annual benefit is the most the Expatriate Dental Plan will pay for covered preventive and restorative dental services for each participant in a year.
Maximum Lifetime Benefit	The maximum lifetime benefit is he most the Expatriate Medical Plan or Expatriate Dental Plan will pay for covered services in each participant's lifetime.
Maximum Lifetime Orthodontia Benefit	The maximum lifetime orthodontia benefit is the most the Expatriate Dental Plan will pay for covered orthodontia services for each participant's lifetime. Any benefits that have been applied to a maximum provision under a U.S. domestic dental plan of your heritage organization will also be applied to the lifetime maximum for the Expatriate Dental Plan.
Medically Necessary	Medically necessary health care services and supplies are services or supplies that are determined by the claims administrator to be medically appropriate and: ▪ Necessary to meet the basic health needs of the covered person; ▪ Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply; ▪ Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator; ▪ Consistent with the diagnosis of the condition; ▪ Required for reasons other than the convenience of the covered person or his or her physician; and ▪ Demonstrated through prevailing peer-reviewed medical literature to be either: – Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed. or – Safe with promising effectiveness: ○ For treating a life-threatening sickness or condition; ○ In a clinically controlled research setting; and ○ Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. **Please Note:** For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or condition does not mean that it is a medically necessary service or supply as defined above. The definition of "medically necessary" used here relates only to coverage, and may differ from the way in which a physician engaged in the practice of medicine may define "medically necessary." Finally, to be considered necessary, a service or supply cannot be educational or experimental in nature in terms of generally accepted medical standards.
Missing Tooth Exclusion	The missing tooth exclusion refers to an ineligible charge for a partial or full removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth missing before the person became covered under the Expatriate Dental Plan. This exclusion does not apply if the denture, bridge, or bridgework also includes replacement of a natural tooth that: ▪ Is removed while the person is covered; and ▪ Was not an abutment to a partial denture, removable, or fixed bridge installed during the prior five years.

Multiple Surgical Procedure Reduction Policy	The multiple surgical procedure reduction policy means that surgical procedures that are performed on the same date of service are subject to the multiple surgical procedure reduction policy. On an in-network basis, 100% of the negotiated charges are reimbursable for the primary/major procedure, 50% of negotiated charges are reimbursable for the secondary procedure, and 50% of negotiated charges are reimbursable for all subsequent procedures. On an out-of-network basis, 100% of the reasonable and customary (R&C) charges are reimbursable for the primary/major procedure, 50% of R&C charges are reimbursable for the secondary procedure, and 50% of R&C charges are reimbursable for all subsequent procedures. Participants undergoing surgery are urged to discuss this policy with their health care provider.
Necessary Services	Necessary services are services or supplies that are accepted and used by the dental community as appropriate for the condition being treated or diagnosed. The services or supplies also must be prescribed by a dentist for the diagnosis or treatment of the condition to be considered necessary. Some prescribed services may not be considered necessary and may not be covered under the Expatriate Dental Plan. Cigna International will determine whether a service or supply is necessary. Finally, to be considered necessary, a service or supply cannot be cosmetic, educational, or experimental in nature and must be in accordance with generally accepted dental standards
Non-Duplication of Benefits	Non-duplication of benefits is a provision that requires that the Plans do not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. You are entitled to receive benefits up to what you would have received under the JPMorgan Chase Expatriate Medical or Expatriate Dental Plan if it were your only source of coverage, but not in excess of that amount. If you have other coverage that is primary to the JPMorganChase expatriate plan, the claims administrator will reduce the amount of coverage that you would otherwise receive under this Plan by any amount you receive from your primary coverage. Please see the definition of “Coordination of Benefits” in this section for more information.
Out-of-Network	“Out-of-network” describes a covered service that is performed by a physician, dentist, hospital, lab, or other health care professional who is not part of a health care company’s network and who has not agreed to pre-negotiated fees. When a service is performed out-of-network, benefits are generally paid at a lower level than they are when a service is performed in-network and are generally limited to reasonable and customary charges.
Out-of-Pocket Expense	Your out-of-pocket expense is the amount you pay for eligible expenses when you receive treatment. This includes your deductible, coinsurance and copayments.
Out-of-Pocket Maximum	The out-of-pocket maximum is a “safety net” that protects you from having to pay high expenses in the event of a serious medical situation. The out-of-pocket maximum is the most you would need to pay in a calendar year in addition to the deductible for medically necessary covered services under the Expatriate Medical Plan. Once the out-of-pocket maximum is reached, the Expatriate Medical Plan will pay 100% of negotiated rates for medically necessary covered in-network care and 100% of reasonable and customary (R&C) charges for medically necessary covered out-of-network services for the rest of the year. However, amounts that you pay toward your deductibles, copayments, and amounts above R&C charges for out-of-network care do **not** count toward your out-of-pocket maximum.
Pre-Determination	Pre-determination is an itemization of the proposed course of treatment (including recent pre-treatment X-rays), which you should submit before work is begun, if you anticipate that charges will be more than $300. A dental consultant will review the proposed treatment before work begins and the claims administrator will inform you and your dentist of the amount of covered charges. That way, you’ll understand the benefits that will be paid before treatment begins. Benefits will be paid according to the Plan provisions in effect when the services are actually rendered. The amount may change if the treatment changes from that which was predetermined or if frequency limits apply. Except in the case of an emergency, you may not want to begin the course of treatment until you know what amount the Expatriate Dental Plan will pay.

Primary Plan	The primary plan is the plan that provides initial coverage to the participant. If the participant is covered under both the JPMorgan Chase Expatriate Medical Plan and/or Dental Plans and another plan, the rules of the primary plan govern when determining the coordination of benefits between the two plans. Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee) or covered by U.S. Medicare. These rules do not apply to any private insurance you may have. Please see "If You Are Covered by More Than One Plan" in the *Plan Administration* section for more details.
Qualified Status Change	The JPMorganChase benefits you elect during each Annual Benefits Enrollment will generally stay in effect throughout the plan year, unless you elect otherwise, because of a Qualified Status Change (QSC). If you have a QSC, you have 31 days from the qualifying event to make benefits changes; 90 days from the qualifying event if the event is the birth or adoption of a child. The benefits you elect will be effective the date of the event if you make the elections timely. (**Please Note:** You will have 90 days from the QSC date to add any newly eligible dependents to the JPMC Medical Plan should that dependent pass away within this 90-day period.) **Please Note:** Any changes you make during the year must be consistent with your QSC. Please see "Changing Your Coverage Midyear" on page 11.
Reasonable and Customary Charges	Reasonable and customary charges ("R&C charges," also known as "eligible expenses") are the actual charges that are considered for payment when you receive medically necessary care for covered services from an out-of-network provider under the Expatriate Medical and/or Expatriate Dental Plans. R&C means the prevailing charge for most providers in the same or a similar geographic area for the same or similar service or supply, as determined in the sole discretion of the claims administrator. These charges are subject to change at any time without notice. Reimbursement is based on the lower of this amount and the provider's actual charge. If your provider charges more than the R&C charges considered under the Expatriate Medical Plan and/or Expatriate Dental Plans, you'll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered eligible expenses. Therefore, they don't count toward your deductible, benefit limits, or out-of-pocket maximums.
Self-Insured	A self-insured plan is a plan where the sponsor (in the case of the Expatriate Medical Plan and the Expatriate Dental Plan, JPMorganChase) is responsible for the payment of medical and dental claims under the Plans. This makes these plans self-insured.
Spouse	The term "spouse" refers to any person to whom you are legally married as recognized by U.S. federal law. If JPMorganChase employs your spouse, domestic partner, or child, he or she can enroll in coverage as an employee or as your dependent, but not as both. If you want to cover your eligible child(ren), you or your spouse/domestic partner may provide this coverage. If you are covering a spouse/domestic partner who is also a JPMorganChase employee (i.e., company couple), you should update the "dependent is also an employee" indicator on the Dependent Enrollment page of the Benefit Web Center, available via the Expatriate Health Benefits Resources page on the JPMC intranet.