The Dental Plan

Effective 1/1/25

The JPMorgan Chase Dental Plan ("Dental Plan" or "Plan") is designed to provide you and your family with access to high quality, cost-effective dental care. The Plan offers you and your enrolled dependents coverage for a wide range of preventive care, basic and major restorative care, and orthodontia dental services.

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

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

Important Note: The DMO and DHMO are fully insured dental options for which the benefit payments are the responsibility of the insurance carrier (Aetna for the DMO and Cigna for the DHMO). In the event that there is a discrepancy between the information provided in this Guide and the Plan contracts issued by the carrier (Aetna and Cigna), the Plan contracts will govern.

About this Summary Plan Description

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

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

Questions?

For questions or concerns regarding this Dental Plan, contact the claims administrator for the dental option you chose:

- MetLife Preferred Dentist Program (PDP) Option: MetLife Dental at (888) 673-9582
- Aetna, Inc. Dental Maintenance Organization (DMO) Option: Aetna at (800) 843-3661
- Cigna Dental Health Maintenance Organization (DHMO) Option: Cigna Dental Health at (800) 790-3086

For additional resources, consult the *Contacts* section.

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

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Dental Plan Highlights

My Health

My Health is your central online resource for the JPMorganChase benefits plans. From **My Health**, you can easily connect to the dental option websites to find in-network provider directories, check claims status, and much more.

Your Choices

The Dental Plan offers most eligible participants two to three options to choose from, depending on your home ZIP code. One option, the PDP Option, is available in all locations. The other option, an HMO-like option, will offer most participants either the DMO and/or the DHMO, depending on your home ZIP code.

Preferred Dentist Program (PDP) Option

The PDP Option, administered by MetLife, lets you choose between receiving in-network or out-of-network care each time you need dental work. You will generally pay less for your care when you use a MetLife in-network dental provider for two reasons:

- In-network care is generally covered at a higher percentage with lower annual deductibles than out-of-network care; and
- In-network dentists have agreed to charge lower, negotiated fees for their services when treating JPMorgan Chase Dental Plan participants.

Dental Maintenance Organization (DMO) or the Dental Health Maintenance Organization (DHMO) Option (depending on your home ZIP code)

The DMO Option, administered by Aetna Inc., and the DHMO Option, administered by Cigna, offer you a broad range of dental services on a pre-paid basis. You will be able to choose one or the other of these options, depending on your home ZIP code. In some ZIP codes, both the DMO and the DHMO will be offered. If you enroll, you agree to receive care solely from dentists associated with the network for your option, and in return, you will have no deductibles to meet and no claim forms to file. The DMO and DHMO administrators actively work to keep dental care costs low by requiring DMO and DHMO dentists to meet strict quality standards, screening for cost-effective practice patterns, and negotiating fees charged for services.

Your Coverage Levels

If you elect coverage, you can choose to cover:

- Yourself only;
- Yourself and your spouse/domestic partner; or yourself and your child(ren); or
- Your family (yourself, your spouse/domestic partner, and your children).

Disabled Dependents Over Age 26

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

Covered Services

Depending on the option you choose, covered services can include some or all of the following:

- Preventive care services, such as oral exams, fluoride treatment, prophylaxis, X-rays (excluding intra-oral X-rays), sealants and emergency palliative treatment.
- Basic restorative care services, such as fillings, extractions, oral surgery, anesthesia and antibiotic injections.
- Major restorative care services, such as services to replace lost teeth, and inlays, onlays, and crowns, and their repair or recementing.
- Orthodontia services.

Cost of Coverage

You and JPMorganChase share the cost of coverage under each of the Dental Plan options. You pay for coverage through payroll contributions with before-tax dollars, in equal installments.

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

- The Dental Plan option you choose; and
- The "coverage level" you choose (described under "Coverage Levels" in the *Health Care Participation* section).

The cost of coverage for each option offered under each of the coverage levels will be available on the Benefits Web Center.

Your contributions toward the cost of coverage start when your coverage begins. Your contributions are automatically deducted from your pay.

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

Tax Treatment of Domestic Partner Coverage/Gross-Up Policy

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

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 for 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.

Enrolling a Domestic Partner

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

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

Health Care Spending Account and Automatic Claim Substantiation

Generally, if you participate in a Health Care Spending Account (HCSA), your medical and/or dental HCSA claims may be automatically substantiated if you participate in a medical or dental plan administered by the same carrier that administers your HCSA — either Aetna or Cigna. For example, if Cigna administers your HCSA and you participate in a Cigna Medical or Cigna DHMO Plan, then if your provider submits an invoice for services that are not otherwise covered at 100% by your respective Cigna Medical or Cigna DHMO Plan, the payment for your portion of the costs will be automatically substantiated because Cigna administers your HCSA.

The Preferred Dentist Program (PDP) Option

The Preferred Dentist Program (PDP) Option is administered by MetLife. The PDP Option lets you choose between receiving in-network or out-of-network care each time you need dental work. You will generally pay less for your care when you use a MetLife in-network dental provider for two reasons:

- In-network care is generally covered at a higher percentage with lower annual deductibles than out-of-network care; and
- In-network dentists have agreed to charge lower, negotiated fees for their services.

With the PDP Option…

- You can receive in-network or out-of-network care at any time and still receive benefits.
- In-network preventive care is covered at 100% with no deductible.
- There's no deductible for out-of-network preventive care.
- Orthodontia is covered with no deductible.
- Combined in-network and out-of-network annual limits apply to preventive and restorative care.
- Combined in-network and out-of-network lifetime limits apply to orthodontia benefits.
- Claim forms are not needed for in-network providers.

How the PDP Option Works

The PDP Option has networks of participating dentists and other dental providers who have agreed to a negotiated fee arrangement for covered dental services when treating JPMorganChase participants. However, you can also choose to receive care from any other dental provider and still receive benefits.

If you're interested in enrolling in the PDP Option, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You may view an online provider directory by accessing MetLife's website (https://www.metlife.com/info/JPMC-dental/) or the Benefits Web Center via **My Health**. You can also call MetLife at (888) 673-9582 if you need help finding a provider.

Pre-Treatment Estimates

Under the Preferred Dentist Program (PDP) Option, you may want to consider having your dentist submit a pretreatment estimate to MetLife if the cost is expected to exceed $300. When your dentist suggests treatment, they can send a claim form, along with the proposed treatment plan and supporting documentation, to MetLife. An explanation of benefits (EOB) will be sent to you and the dentist detailing an estimate of what services MetLife will cover and at what payment level. Actual payments may vary from the pretreatment estimate depending upon annual maximums, deductibles, plan frequency limits and other plan provisions at time of payment. Except in the case of an emergency, you may not want to begin the course of treatment until you know what amount your JPMorgan Chase Dental Plan option will pay.

How the PDP Option Pays Benefits

Please Note: The way benefits are paid depends on whether you receive your care in-network or out-of-network. The following chart shows how the PDP Option pays benefits.

Benefit Provision	In-Network	Out-of-Network
Annual Deductible		
• Preventive	• None	• None
• Restorative	• $50 individual; $150 family	• $100 individual; $300 family
• Orthodontia	• None	• None
Preventive (no deductible)	100% coverage*	90% coverage*
• Oral exams	• Maximum two per calendar year	• Maximum two per calendar year
• Prophylaxis (cleaning)	• Maximum two per calendar year	• Maximum two per calendar year
• Fluoride	• Maximum one per calendar year, and only covered for participants who are under age 19	• Maximum one per calendar year, and only covered for participants who are under age 19

Benefit Provision	In-Network	Out-of-Network
• Full mouth X-ray	• Maximum one per every 60 months	• Maximum one per every 60 months
• Bitewing X-ray	• Maximum one per calendar year**	• Maximum one per calendar year**
• Sealants	• Maximum two treatments per tooth (permanent molars only) per lifetime; under age 19	• Maximum two treatments per tooth (permanent molars only) per lifetime; and only covered for participants who are under age 19
Basic restorative (fillings, extractions, periodontal, oral surgery, anesthesia, including non-intravenous conscious sedation when medically necessary)	80% coverage, after deductible*	70% coverage, after deductible*
Major restorative (dentures, inlays, onlays, crowns, bridges, root canal)	60% coverage, after deductible*	50% coverage, after deductible*
Orthodontia* **	50% coverage*	50% coverage*
Maximum Benefits		
• Combined annual for preventive and restorative	• Maximum $2,000****	• Maximum $1,500****
• Lifetime orthodontia	• Maximum $2,500****	• Maximum $2,000****

* All in-network percentages above apply to dentists' negotiated fees. All out-of-network percentages apply to reasonable and customary (R&C) charges.

** Two times per calendar year for covered participants under age 19.

*** Please see "Orthodontic Covered Services" on page 8 for additional information.

**** Reflects a combined amount for both in-network and out-of-network; includes any benefits already applied to any lifetime maximum for orthodontia under the Dental Plan.

Please Note: Wherever benefits are limited to a certain number of visits, combined in-network and out-of-network visits will count toward the benefit limit. For more details on coverage limitations, see "What Is *Not* Covered" on page 15.

Annual Deductible

Under the PDP Option, if you elect coverage for yourself or yourself plus one dependent:

- Each covered person must pay all eligible expenses for which a deductible applies, 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 for which a deductible applies, incurred by you and/or your covered dependents, combine to meet the family deductible.
- If no one person meets the individual deductible, but combined participant expenses meet the total deductible amount, no further deductible is required.

The maximum deductible any one covered person must pay is equal to the individual amount. After one person meets the individual deductible, that person will pay no further deductible, but other covered persons must continue to pay deductibles until the total is satisfied.

Please Note: There are separate deductibles (in-network and out-of-network) for restorative care.

An Example: Amounts Applied Toward In-Network Restorative Care Deductibles	
On behalf of you	$50
On behalf of your spouse/domestic partner	$50
On behalf of child #1	$30
On behalf of child #2	$20
Total	$150
In this example, four people have met the family annual deductible for in-network restorative care. So, any other covered person's in-network restorative care would be reimbursed by the Plan, even if it were on behalf of a person who has not yet met the $50 individual annual deductible. No other covered family members need to meet their in-network restorative care deductible for the rest of the year. **Please Note:** No more than $50 of expenses per individual will be applied towards the family deductible.	

Coinsurance

After you meet the applicable deductible, the Plan will pay a percentage of in-network dentists' negotiated fees, or, for out-of-network expenses, a percentage of the reasonable and customary (R&C) charges for eligible expenses (see "Defined Terms" beginning on page 19 for the definition of "Reasonable and Customary"). The exact percentage depends on the type of care and whether the care was received on an in-network or out-of-network basis. Please see "How the PDP Option Pays Benefits" on page 5 for the applicable coinsurance rate. You'll pay the remaining amount as coinsurance, plus any amounts above R&C charges.

Alternate Benefit Provision

Under the Preferred Dentist Program (PDP) Option, generally benefits will be limited to the R&C charge for the least expensive method of treatment that is appropriate and that meets acceptable dental standards — as determined by MetLife, the claims administrator. Under the Plan's alternate benefit provision, if MetLife determines in its sole discretion that a service less costly than the covered service the dentist performed could have been performed to treat a dental condition, the Plan will pay benefits based upon the less costly service if such service:

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

For example:

- When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, MetLife may base the benefit determination upon the amalgam filling, which is the less costly service;
- When a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, MetLife may base the benefit determination upon the filling, which is the less costly service;

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

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

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

If a planned dental service is expected to cost more than $300, you have the option of requesting a pretreatment estimate of benefits. The dentist should submit a claim form detailing the proposed treatment plans and supporting documentation. MetLife will provide you and your dentist with an Explanation of Benefits detailing an estimate of what services MetLife will cover and at what payment level. Actual payments may vary from the pretreatment estimate depending upon annual maximums, deductibles, plan frequency limits and other plan provisions at time of payment.

Maximum Benefits

There are limits on the benefits you can receive from the PDP Option. The maximum benefit for in-network preventive and restorative care is $2,000 per person per year and the maximum benefit for out-of-network preventive and restorative care is $1,500 per person per year. The lifetime maximum benefit for orthodontia is $2,500 per person in-network and $2,000 per person out-of-network. **Please Note:** These maximums reflect a *combined* amount for both in-network and out-of-network care, so out-of-network care will count against your in-network benefit maximum and vice versa.

Orthodontic Covered Services

Orthodontia is covered for adults, and for dependent children up to maximum age of 26, if the appliance is installed while dental coverage is in effect. The orthodontic appliance is a device used for influencing tooth position and may be classified as fixed or removable, active or retaining, and intraoral or extraoral.

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

The benefit payable for the initial placement will not exceed 20% of the amount charged by the dentist. If the initial placement was made before the patient became covered under the JPMorgan Chase Dental Plan, the benefit payable will be reduced by the portion attributable to the initial placement.

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

- Dental coverage is in effect for the patient receiving the orthodontic treatment; and
- Proof is given to MetLife that the orthodontic treatment is continuing.

If the periodic follow-up visits began before the patient became covered under the JPMorgan Chase Dental Plan:

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

The Dental Maintenance Organization (DMO)

The DMO Option offers you a broad range of dental services on a pre-paid basis. The DMO Option is available in many locations and is administered by Aetna, Inc. You agree to receive care solely from dentists associated with the DMO Option network, and in return, you will have no deductibles to meet and no claim forms to file. Aetna actively works to keep dental care costs low by requiring DMO dentists to meet strict quality standards, screening for cost-effective practice patterns, and negotiating fees charged for services.

How the DMO Option Works

If you decide to enroll in the DMO Option for the first time or add new dependents for coverage under this option, you must select a primary care dentist in order to receive care. **Please Note:** You can choose a different DMO dentist for yourself and each covered dependent. Changes to your primary care dentist must be made by the 15th of the month in order to be effective the first of the following month.

If you're interested in enrolling in the DMO, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You can view an online provider directory by visiting the Benefits Web Center on **My Health**. Once enrolled, you can view an online provider directory by accessing www.aetna.com. You can also call Aetna at (800) 843-3661 if you need help finding a provider. You should check with the dentist before scheduling an appointment or receiving services to confirm that he or she is participating in the network.

With the DMO Option…

- Preventive care is covered at 100%.
- Orthodontia is covered.
- There are no annual deductibles.
- There are no claim forms to file for in-network care. In limited circumstances, out-of-network care is permitted; you are responsible for filing a claim form to receive reimbursement for DMO out-of-network services.
- There are no lifetime limits on benefits (except orthodontia and sealants).
- You only receive benefits if you use a DMO dentist; however, you can change your DMO dentist during the year. **Please Note:** Requests to change your DMO dentist must be received by the 15th of the month in order to take effect the first of the next month.
- You and your dependents can each have different DMO dentists.
- You and your dependents will receive a DMO ID card following your enrollment.

How the DMO Option Pays Benefits

If you enroll in the DMO Option, you agree to receive care solely from dentists participating in the managed care network. Limited out-of-network coverage may be available based on state mandates or in the case of certain, out-of-area emergencies, as noted below. If you receive any out-of-network care, you must file a claim to receive benefits. Check your Aetna DMO coverage certificate or contact customer service at the number on your ID card for details.

Benefit Provision	Coverage
Annual Deductible	
• Preventive	• None
• Restorative	• None
• Orthodontia	• None
Preventive	100% coverage
• Oral exams	• Maximum two per calendar year
• Fluoride	• Maximum two per calendar year, and only covered for participants who are under age 19
• Prophylaxis (cleaning)	• Maximum two per calendar year
• Full mouth X-ray	• One full mouth X-ray limited to one set every three rolling years
• Bitewing X-ray	• Maximum two per calendar year
• Sealants	• Maximum two treatments per tooth (permanent molars only) per lifetime and only covered for participants who are under age 19
Basic restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)	90% coverage
Major restorative (dentures, inlays, onlays, crowns, bridges)	60% coverage
Orthodontia	50% coverage
Maximum Benefits	
• Combined annual for preventive and restorative	• No maximum
• Lifetime for orthodontia	• One course of treatment per individual per lifetime
Out of Area Emergency Palliative Dental Care Out-of-Area Emergency Dental Care consists of necessary covered dental services given to covered persons by a Non-Participating (out-of-network) dental provider for the palliative (pain relieving; stabilizing) treatment of an emergency condition (if there is severe pain, swelling or bleeding). The emergency care is rendered outside of the 50 mile radius of the covered person's home address. Coverage for Out-of-Area Emergency Dental Care is subject to specific limitations described in the DMO Option. The JPMC DMO Option covers 100% of billed charges for out of area emergency care; benefits are limited to a $100 maximum and subject to R&C.	100% coverage for reasonable and customary charges, up to a maximum benefit of $100 per incident. If you receive any out-of-network care, you must file a claim to receive benefits.

The Dental Health Maintenance Organization (DHMO) Option

The DHMO Option offers you a broad range of dental services on a pre-paid basis. The DHMO Option is available in many locations and is administered by Cigna. You agree to receive care solely from dentists associated with the DHMO Option network, and in return, you will have no deductibles to meet and no claim forms to file. Cigna actively works to keep dental care costs low by requiring DHMO dentists to meet strict quality standards, to be screened for cost-effective practice patterns, and to charge negotiated fees for services.

How the DHMO Option Works

If you decide to enroll in a DHMO option for the first time or add new dependents for coverage under this option, you must select a primary care dentist in order to receive care. You only receive benefits if you use a Cigna DHMO dentist; however, you can change your dentist during the year. **Please Note:** Requests to change your DHMO dentist will take effect on the first of the month following the date the request was made. If you need assistance, prior to the first of the following month, you can call Cigna at (800) 790-3086.

If you're interested in enrolling in the DHMO, you should consult the participating provider directory. The directory lists the dentists who are members of the network. You may view an online provider directory by visiting the Benefits Web Center on **My Health**. Once enrolled, you can view an online provider directory by accessing http://mycigna.com. You can also call Cigna at (800) 790-3086 if you need help finding a provider.

With the DHMO Option…

- Preventive care is covered at 100%.
- Orthodontia is covered.
- There are no annual deductibles.
- There are no claim forms to file.
- There are no lifetime limits on benefits (except orthodontia).
- You only receive benefits if you use a Cigna DHMO dentist; however, you can change your dentist during the year. **Please Note:** Requests to change your DHMO dentist will take effect on the first of the month following the date the request was made.
- You and your dependents can each have different DHMO dentists.
- You and your dependents will receive a DHMO ID card following your enrollment.

How the DHMO Option Pays Benefits

Like the DMO Option, the Cigna DHMO Option is a managed care dental option that offers access to a national network of dentists. If you enroll in this option, you agree to receive care solely from dentists participating in the network. Limited out-of-network coverage may be available based on state mandates or in the case of certain, out-of-area emergencies, as noted below. If you receive any out-of-network care, you must file a claim to receive benefits. Check your Cigna DHMO coverage certificate or contact customer service at the number on your ID card for details.

Benefit Provision	Coverage
Annual deductible	
• Preventive	• None
• Restorative	• None
• Orthodontia	• None
Preventive	100% coverage
• Oral exams	Oral evaluations are limited to a combined total of four of the following evaluations during a 12 consecutive month period: • Periodic oral evaluations; • Comprehensive oral evaluations; • Comprehensive periodontal evaluations; and • Oral evaluations for patients under three years of age
• Fluoride	• Maximum two per calendar year • Topical fluoride applications in excess of the two per calendar year are covered for a $15 copayment.
• Prophylaxis (cleaning)	• Maximum two per calendar year • Cleanings in excess of the two per calendar year are covered for a $40 copayment for an adult and a $30 copayment for children.
• Full mouth X-ray	• Maximum one every three years
• Bitewing X-ray	• 100% coverage
• Sealants	• 100% coverage
Basic restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)	90% coverage (with the exception of certain oral surgery services covered at 50% or 60%)
Major restorative (dentures, inlays, onlays, crowns, bridges)	60% coverage (a few procedures, such as recementations, adjustments, tissue conditioning, and repairs are covered at 90%)
Surgical placement of Implant body	90% coverage, limited to one per year
Orthodontia	50% coverage
Maximum Benefits	
• Combined annual for preventive and restorative	• No maximum
• Lifetime for orthodontia	• 24 months of interceptive and/or comprehensive treatment (cases beyond 24 months or atypical cases require additional payment by the patient)

Benefit Provision	Coverage
Emergency Care Away From Home If you have an emergency while you are out of your service area or unable to contact your in-network general dentist, you may receive emergency covered services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your in-network general dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your patient charge schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of $100 per incident (where allowable by state law). To receive reimbursement, send appropriate mycigna.com reports and X-rays to Cigna Dental.	100% coverage for reasonable and customary charges, up to a maximum benefit of $50 per incident. If you receive any out-of-network care, you must file a claim to receive benefits.

What Is Covered

Each of the Dental Plan options covers a wide variety of services, as long as the services are necessary and their costs either do not exceed negotiated fees for in-network services, or are not reasonable and customary (R&C) charges for out-of-network services if allowed for under an option . (Please see "Defined Terms" beginning on page 19 for the definitions of "Necessary Services" and "Reasonable and Customary Charges.") Covered services and frequency limits under each JPMorgan Chase Dental Plan option may differ. The following lists include examples of covered services, but the lists are not exhaustive and coverage remains subject to any Plan requirements or limitations. For specific information on the PDP, DMO and DHMO's covered services and frequency limits, please contact the appropriate claims administrator (MetLife, Aetna, or Cigna) directly, using the telephone numbers provided under "Where to Submit Claims" on page 18. The list of covered services may change at any time.

Preventive Care Services

Covered preventive care services include the following services (please see "How the PDP Option Pays Benefits" on page 5, "How the DMO Option Pays Benefits" on page 9 and "How the DHMO Option Pays Benefits" on page 12 for age and frequency limitations):

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

Basic Restorative Care Services

Covered basic restorative care services include:

- Consultations (two per calendar year under the PDP and DMO; no frequency limit under the DHMO);
- Extractions;
- Fillings;
- Injections of antibiotic drugs; (**Please Note:** The DMO and PDP cover injections of antibiotic drugs as a Major Restorative Care Service);
- Most periodontal or other gum disease treatment;
- Periodontal maintenance (four visits per calendar year under PDP combined with regular cleanings; under DMO and DHMO, two visit per calendar year covered only after active periodontal therapy);
- Oral surgery (except as covered by the *Medical Plan* section);
- Administration of general anesthesia in conjunction with oral surgery when medically necessary (may be subject to certain limits as defined by the carrier);
- Periodontal scaling/root planing (one per quadrant per 24 months under PDP and DMO; limited to 4 quadrants per consecutive 12 months under DHMO);
- Periodontal surgery (one per quadrant per 36 months under PDP and DMO; one per site, or per tooth, under DHMO);
- Repair or recementing of crowns, inlays, or onlays; dentures; or bridgework;
- Relines/rebases
  - MetLife PDP and Aetna DMO: one per denture per 36 months, after six months from installation
  - Cigna DHMO: one per denture per 36 months, within first six months after insertion; replacement limit of one every five years; and
- Root canal treatments. (**Please Note:** The Dental DMO/DHMO Option covers root canal as a Basic Care Service. The PDP Option covers root canal as a Major Restorative Care Service.)

Major Restorative Care Services

Covered major restorative care services include:

- Crowns/inlays/onlays (one per tooth per five calendar years);
- Root canal treatments (**Please Note:** The PDP Option covers root canal as a Major Restorative Care Service. The Dental DMO/DHMO Option covers root canal as a Basic Care Service.);
- Injections of antibiotic drugs (**Please Note:** The DMO Option covers injections of antibiotic drugs as a Major Restorative Care Service. The PDP and DHMO Options cover injections of antibiotic drugs as a Basic Care Service.);
- Only appliances related to temporomandibular joint dysfunction (TMJ) (PDP and DMO: subject to a lifetime maximum of $500; the DHMO covers one appliance per 24 months, not subject to a lifetime maximum).
- Initial placement and replacement of dentures and bridges — if the original appliance is at least five years old and cannot be repaired;
- Services necessary to replace teeth lost while coverage is in effect;
- Treatment for harmful habits as described and determined by the claims administrator;

- Treatment for accidental injury (eligible dental expenses are covered under the Dental Plan; eligible medical expenses are covered under the Medical Plan.); and
- Implant(s). Benefits may also be available for the final restoration or prosthesis (crown or partial denture) over the implant. A pre-treatment estimate should be submitted for a dental consultant to evaluate the claim to determine if any benefits are payable.

Orthodontia

Please review the information on orthodontia in the PDP, DMO and DHMO sections:

- For the PDP, orthodontia is for covered at a percentage for both children and adults. Please see "How the PDP Option Pays Benefits" on page 5 and "Orthodontic Covered Services" on page 8.
- For the DMO, orthodontia is covered at a percentage for both children and adults. Please see "How the DMO Option Pays Benefits" on page 9.
- For the DHMO, orthodontia is covered at a percentage for both children and adults. Please see "How the DHMO Option Pays Benefits" on page 12.

What Is Not *Covered*

While the JPMorgan Chase Dental Plan options cover a wide range of dental services, some expenses are not covered. These include but are not limited to those listed below.

For specific information on the PDP, DMO and DHMO's coverage exclusions and limits, please contact the appropriate claims administrator (MetLife, Aetna, or Cigna) directly (using the telephone numbers provided under "Where to Submit Claims" on page 18). The list of covered services and the list of excluded services may change at any time.

Not Exhaustive and Subject to Change

This list of excluded services is not exhaustive, may vary by Plan option, and may change at any time.

- Any of the following services:
  - A gold restoration or crown, unless:
    - It is treatment for decay or traumatic injury, and teeth can't be restored with a filling material; or
    - The tooth is an abutment to a covered partial denture or fixed bridge.
  - An appliance — or modification of one — if an impression for it was made before the person became covered.
- Any of the following services incurred more than 31 days after the date the person's coverage ends:
  - A crown, bridge, or gold restoration for which the tooth was prepared while the person was covered;
  - An appliance — or alteration of one — for which an impression was made while the person was covered; or
  - Root canal therapy for which the pulp chamber was opened while the person was covered.
- Charges in connection with:
  - A service to the extent that it is more than the usual charge made by the provider for the service when there is no insurance;
  - Appliances or restorations needed to alter vertical dimensions or restore occlusion, or for the purposes of splinting or correcting attrition, abrasion, or erosion; or
  - Replacement of lost, missing, or stolen appliances or appliances that have been damaged due to abuse, misuse, or neglect.

- Treatment for problems of the jaw joint, including:
  - Craniomandibular disorder;
  - Temporomandibular joint syndrome (TMJ), other than what is noted in “What Is Covered” on page 13, or
  - Other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves, and other tissues related to that joint.
- Expenses submitted later than December 31 of the year following the year in which services were provided.
- Installation of prosthetic devices (including bridges and crowns) while not covered or which were installed more than 31 days after coverage ends.
- Loss — or portion of a loss — for which mandatory automobile no-fault benefits are recovered or recoverable.
- Loss — or portion of a loss — resulting from war or act of war, declared or undeclared.
- Procedures related to occupational illness or injury.
- Replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for a replacement or modification of a crown or gold restoration or inlay/onlay within five years after that denture, bridgework, crown, inlay/onlay, or gold restoration was installed.
- Expenses or charges with respect to services rendered by hospitals, clinics, laboratories (except dental X-rays are covered), or other institutions.
- Services and supplies included as covered medical expenses under:
  - Any other employer-sponsored plan that covers you, including Medicare;
  - Any other governmental health program, except Medicaid; or
  - Your JPMorgan Chase Medical Plan option.
- Services and supplies rendered in a veteran’s facility or government hospital, or services furnished in whole or in part under the laws of the United States or any of its state or political subdivisions.
- Services furnished for cosmetic purposes. Facings on crowns or pontics — which are behind the second bicuspid — will always be considered cosmetic. This limitation does not apply if the service is needed as a result of accidental injuries sustained while a person is covered.
- Services that are not necessary services as determined by the claims administrator.
- Services to the extent that a benefit for those services is provided under any other program paid in full or in part, directly or indirectly, by 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 same or similar geographic area for dental care of a comparable nature. The geographic area and that range are determined by the claims administrator.
- Treatment by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, a trustee, or a similar person or group.
- Expenses in connection with services, procedures, drugs, or other supplies that are determined by the claims administrator to be experimental, or still under clinical investigation by health professionals.

- Charges for oral hygiene programs (in home care), completion of claim forms by the provider on your behalf, and broken appointments.
- Services provided by a relative or a domestic partner, or for which a charge would not normally be made.
- Treatment by anyone except a licensed dentist (except for cleaning or scaling of teeth and topical application of fluoride performed by a licensed dental hygienist, if rendered under the supervision and guidance of a licensed dentist).
- Mail order orthodontics.

In addition, the DMO Option does not cover services provided to a person age five or older if that person becomes covered other than:

- As described for any period of enrollment agreed to by JPMorganChase and Aetna, Inc. This limitation does not apply to charges incurred:
  - After the end of the 12-month period starting on the date the person became covered;
  - As a result of accidental injuries sustained while the person was covered; or
  - Preventive service, unless listed above.
  - During the first 31 days the person is eligible for this coverage.

Dentures/Bridgework Limitations

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

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

Claiming Benefits

The following explains when and how to file claims for dental expenses under the PDP Option. If you're enrolled in the DMO or DHMO Option, you usually don't need to file a claim. For more information on your rights with respect to claims, please see the *Plan Administration* section.

Your Dental Identification (ID) Cards

After you enroll you will receive a personalized identification (ID) card. Please carry your ID card(s) with you at all times since it contains information that will help verify your coverage when you present the card during dentists' visits.

How to File Claims

Rules regarding claims depend on which Dental Plan option you're enrolled in and where you receive your care, as follows:

PDP Option	• **In-Network Benefits**: Generally, you do not have to file a claim form. • **Out-of-Network Benefits**: Generally, you must file a claim form. (Some dentists may submit claims electronically on your behalf; you should check with your dentist.) Once the claims administrator has reviewed and approved your completed claim form, you'll be reimbursed for the appropriate portion of the cost. Claim forms for out-of-network benefits are available on **My Health.**
Dental Maintenance Organization (DMO) Option and Dental Health Maintenance Organization (DHMO) Option	You do not have to file a claim form for in-network care. Claim forms for out-of-network emergency services, as defined by the Plan, are available on **My Health.**

To have your claim considered for benefits, you need to file your claim by December 31 of the year following the year in which the services were provided. If you fail to meet this deadline, your claim will be denied. Be sure to attach itemized bills or receipts to your claim form, and keep copies for your records. Separate claim forms must be submitted for each family member for whom a claim is made. After you submit a claim, you will receive a written explanation of how the benefit was paid.

If your dentist submits a paper claim, make sure he or she uses the proper claim form, and that your identification number or Social Security number and signature are included with the information provided. Payment of benefits can be made to you or your dentist. If payment is to be made to your dentist, you should specify this on your claim form by signing the form and dating the appropriate box. If you don't indicate who the payment should be made to, it will be made to you.

Where to Submit Claims

Where you send your completed claims depends on which Dental Plan option you're enrolled in and which organization administers your claims.

The claims administrators' contact information is listed in the following table:

Claims Administrators' Contact Information

Claims Administrator	Address and Telephone Number
MetLife Preferred Dentist Program (PDP) Option	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 (888) 673-9582 8 a.m. to 11 p.m. Eastern Time, Monday – Friday
Aetna, Inc. Dental Maintenance Organization (DMO) Option	Aetna, Inc. P.O. Box 14094 Lexington, KY 40512 (800) 843-3661 8 a.m. to 6 p.m. Eastern Time, Monday – Friday

Claims Administrator	Address and Telephone Number
Cigna Dental Health Maintenance Organization (DHMO) Option	Cigna Dental Health P.O. Box 188045 Chattanooga, TN 37422-8045 (800) 790-3086 24/7

Appealing a Claim

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

Help Pursuing Claims

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

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

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

Defined Terms

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

Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical, Dental, Vision and Spending Accounts Plans' payroll contributions are generally taken on a before-tax basis.
Claims Administrator	The claims administrator(s) are the company(ies) that provide certain claims administration services for the Plan and its options.
Coinsurance	Coinsurance is the way you share costs for certain coverage options after you pay any applicable deductible. Certain Dental Plan options pay either a percentage of reasonable and customary (R&C) charges or a percentage of the in-network dentist's negotiated fees for covered services, and you pay the remainder. The actual percentage depends on the option you've chosen and the type of covered service.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue Dental Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. The *Health Care Participation* section provides details on COBRA coverage.

Coordination of Benefits	Coordination of benefits rules are the rules that determine how benefits are paid when a patient is covered by more than one group plan. Please see “If You Are Covered by More Than One Health Care Plan” in the *Plan Administration* section for more information.
Covered Expenses	The in-network negotiated fees or reasonable and customary (R&C) charges for out-of-network services if allowed for under an option for necessary covered services or supplies that qualify for full or partial reimbursement under the Dental Plan.
Covered Services	Covered services are services and procedures generally reimbursable by the Plan when they are “necessary.” (See the definition of “Necessary Services” in this section.) While the Plan provides coverage for numerous services and supplies, there are limitations on what’s covered. So, while a service or supply may be necessary, it may not be covered under the JPMorgan Chase Dental Plan. Please see “What Is Covered” on page 13 for more details.
Deductible	The deductible is the amount you pay in a calendar year for covered expenses before the Preferred Dentist Program (PDP) Option begins to pay benefits. Amounts in excess of reasonable and customary (R&C) charges do not count toward the deductible.
Eligible Dependents	Under the Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see “Your Eligible Dependents” in the *Health Care Participation* section for more information.
Explanation of Benefits (EOB)	An explanation of benefits (EOB) is a statement that the claims administrator prepares, which documents your claim and provides a description of benefits paid and not paid under the Dental Plan.
Fully-Insured	Dental Plan options for which the benefit payments are the responsibility of the insurance carrier (DMO and DHMO).
In-Network/ Out-of-Network	“In-network” and “out-of-network” are terms referring to whether a covered service is performed by a dentist who is part of the network associated with the Dental Plan (in-network) or by a dentist who is not part of the network (out-of-network). When a service is performed in-network, benefits are generally paid at a higher level than they are when a service is performed out-of-network.
Maximum Annual Benefit	The maximum annual benefit is the most the Preferred Dentist Program (PDP) Option will pay for covered preventive and restorative services for each participant in a year.
Necessary Services	Necessary services are services or supplies that are accepted and used by the dental community as appropriate for the condition being treated or diagnosed. The services or supplies also must be prescribed by a dentist for the diagnosis or treatment of the condition to be considered necessary. Some prescribed services may not be considered necessary and may not be covered under the JPMorgan Chase Dental Plan. The claims administrator will determine whether a service or supply is necessary. Finally, to be considered necessary, a service or supply cannot be cosmetic, educational, or experimental in nature and must be in accordance with generally accepted dental standards.
Non-Duplication of Benefits	Non-duplication of benefits is a provision that requires that the Dental Plan does not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. You are entitled to receive benefits up to what you would have received under the JPMorgan Chase Dental Plan if it were your only source of coverage, but not in excess of that amount. If you have other coverage that is primary to the JPMorgan Chase Dental Plan, the claims administrator will reduce the amount of coverage that you would otherwise receive under this Plan by any amount you receive from your primary coverage. Please see the definition of “Coordination of Benefits” in this section for more information.
Pre-Authorization/ Pre-Determination	Pre-determination is an itemization of the proposed course of treatment (including recent pre-treatment X-rays), which you should submit before work is begun, if you anticipate that charges will be more than approximately $300. A dental consultant will review the proposed treatment before work begins and the claims administrator will inform you and your dentist of the amount of covered charges. That way, you’ll understand the benefits that will be paid before treatment begins. Benefits will be paid according to the Plan provisions in effect when the services are actually rendered. The amount may change if the treatment changes from that which was predetermined or if frequency limits apply. Except in the case of an emergency, you may not want to begin the course of treatment until you know what amount your JPMorgan Chase Dental Plan option will pay.

Reasonable and Customary (R&C) Charges	Reasonable and customary charges (“R&C charges,” also known as “eligible expenses”) are the actual charges that are considered for payment when you receive medically necessary care for covered services from an out-of-network provider under the Dental Plan. R&C means the prevailing charge for most providers in the same or a similar geographic area for the same or similar service or supply. These charges are subject to change at any time without notice. Reimbursement is based on the lower of this amount and the provider’s actual charge. If your provider charges more than the R&C charges considered under the Plan, you’ll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered eligible expenses. Therefore, they don’t count toward your deductible, benefit limits, or maximums.
Self-Insured	A self-insured option is an option where the sponsor (in the case of the PDP option, JPMorganChase) is responsible for the payment of dental claims under the Dental Plan. This makes the option self-insured. JPMorganChase is responsible for the payment of dental claims under the PDP Option.