# The JPMorgan Chase U.S. Medical Plan

## Effective 1/1/25

*The JPMC U.S. Medical Plan (the Medical Plan or the Plan) provides comprehensive coverage for a broad range of health care services and prescription drugs. For many in-network routine services, including primary care and specialist office visits, basic lab services, urgent care, and emergency room visits there is no in-network deductible or coinsurance. Instead, there are fixed dollar copayments ("copays") for these covered services. Less routine services, such as inpatient hospital, outpatient surgery, radiology, etc., are subject to an annual deductible and coinsurance. And, if your deductible, coinsurance and copays add up to the out-of-pocket maximum in a plan year, the Plan pays 100% of your eligible in-network costs for the remainder of that year.*

*In addition to providing coverage in the event of illness, the Medical Plan offers coverage for eligible preventive care and eligible preventive prescription drugs (generic and brand) at 100% ($0 cost share), an integrated Wellness Program to help you and your family stay healthy and a Medical Reimbursement Account (MRA) to help you pay for eligible out-of-pocket medical and prescription drug costs. You can earn funds for your MRA when you participate in certain wellness incentive activities.*

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

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

**About this Summary Plan Description**

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

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

**For U.S. Benefits-Eligible Employees Living in California**

If you are an eligible U.S. employee living in California, your JPMorganChase medical coverage may include the Kaiser HMO option, described in the *Kaiser HMO* section.

**For U.S. Benefits-Eligible Employees Living in the Dallas-Fort Worth, Texas area**

If you are an eligible U.S. employee living in the Dallas-Fort Worth, Texas area, your JPMorganChase medical coverage may include the Centivo Select Plan option, described in the *Centivo Select Plan* section.

## *Two Options*

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

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

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

**For employees living in Florida, Louisiana, Oklahoma, and Georgia**

Effective August 1, 2024, expanded services are available through Included Health for employees and their covered dependents enrolled in the JPMorganChase U.S. Medical Plan who live in Florida, Georgia, Louisiana and Oklahoma.

Included Health's Care Coordinators will help you and your covered dependents understand your health care benefits and support your health care needs. Included Health's care coordinators can help you:

- Understand your Aetna or Cigna health insurance coverage and cost
- Find solutions to health care insurance problems such as coordinating authorization for services, understanding medical bills and resolving billing errors
- Manage your health through care and disease management services for new and ongoing chronic conditions
- Find quality, in-network Aetna and Cigna providers, get treatment decision support and second medical opinions
- Get virtual primary care and urgent care services (subject to cost share based on the JPMorganChase Medical Plan)

Included Health's expanded services work in coordination with your JPMorganChase Medical Plan so you can get the most out of your health care. You'll still have the same access to your Aetna or Cigna network of providers, covered services and spending accounts. Your Medical ID card (from Aetna or Cigna) will have Included Health's contact information as their services replace Aetna and Cigna's call centers. Your health care company (Aetna or Cigna) is still responsible for authorizing services.

### Our Health Care Companies

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

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

**Provider Directories**

You can easily check which health care providers participate in the various Medical Plan options by accessing your health care company's website at **My Health,** available at hr.jpmorganchase.com/hr on the JPMorganChase intranet or at myhealth.jpmorganchase.com if not on the JPMorganChase intranet.

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

## *The Medical Reimbursement Account*

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

### Questions?

For questions or concerns regarding the Medical Plan, please contact your health care company (Aetna or Cigna) or the Prescription Drug Plan administrator, CVS Caremark. For employees living in Florida, Georgia, Louisiana and Oklahoma, please contact Included Health for questions or concerns regarding the Medical Plan.

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

Cigna
(800) 790-3086
24/7

Included Health (for employees living in Florida, Georgia, Louisiana and Oklahoma)
(833) 938-9874
24/7

CVS Caremark
(866) 209-6093
24/7

For additional specialty resources, consult the *Contacts* section.

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

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# Medical Plan Coverage Highlights

## My Health

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

## Your Medical Plan Options

**Plan Option 1 and Plan Option 2** of the Medical Plan, each offered through Aetna and Cigna. The way you pay for covered services works the same way under both Plan Option 1 and Plan Option 2. For most in-network routine services, you will pay a copayment with no deductible. Less routine in-network services are subject to an annual deductible and coinsurance after you meet the deductible. Once you meet the Medical Plan's annual out-of-pocket maximum (with a combination of your deductible, coinsurance and copayments), the Plan covers eligible services at 100% for the remainder of the year. There are separate deductibles, out-of-pocket maximums, and coinsurance amounts for in-network and out-of-network services.

Both options cover the same medically necessary services and supplies, including prescription drugs and pre-existing conditions. However, Plan Option 1 has higher payroll contributions but generally lower deductibles, copays and out-of-pocket maximums, while Plan Option 2 has lower payroll contributions but generally higher deductible, copays and annual out-of-pocket maximums.

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

You can visit any provider each time you need care, even if the provider is not in the network. But even though there is an out-of-network benefit available, you are strongly encouraged to stay in-network. Selecting out-of-network providers and services cost more for all employees and JPMorganChase. Selecting in-network providers and services will reduce your out-of-pocket costs.

## For In-Network Care

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

## The Out-of-Pocket Maximum

The plan's out-of-pocket maximum — your financial "safety net" — limits the total amount you are required to pay out-of-pocket each year, including deductible, coinsurance and copayments. The out-of-pocket maximum includes medical services only; there is a separate out-of-pocket maximum for prescription drugs. Note that there are separate out-of-pocket maximums for in-network and out-of-network medical charges. The "per person" rule allows an employee or any covered dependent(s) to reach an individual out-of-pocket maximum, after which it is satisfied for the year for that person. See "Per Person Rule for Out-of-Pocket Maximums" on page 18 for more information on the "per person" rule.

| | |
|---|---|
| **For Out-of-Network Care** | ▪ You generally must meet an annual deductible before the coinsurance applies for covered services.<br>▪ Benefits for out-of-network care generally have a higher cost share (e.g., coinsurance) than for in-network care. Note, however, that benefits for emergency room and ambulance services are subject to the same copayments with in-network and out-of-network providers.<br>▪ There is a separate, higher out-of-pocket maximum for out-of-network charges.<br>▪ Benefits for out-of-network care are limited to reasonable and customary (R&C) charges after you meet the out-of-network deductible. These R&C charges are based on average claims data in your area and are determined by your health care company to be appropriate fees for medical services. You are responsible for any amount above the R&C charges.<br>▪ It's important to understand that if you are using out-of-network providers (doctors, facilities or other service providers), it is your responsibility to check with your health care company to see if there is a prior authorization or medical necessity requirement that you need to meet before receiving any out-of-network treatment, service or procedure. Otherwise, the treatment, service or procedure may not be covered by the Plan and you will be responsible for the full cost. |
| **Prescription Drug Coverage** | Prescription drug benefits are part of your coverage. The Prescription Drug Plan has a different plan design than other Medical Plan features, with copays based on the drug category and where you fill your prescription. Covered preventive generic and brand drugs are covered at 100% ($0 cost share), with no copay. There is no deductible for prescription drug coverage and a separate annual out-of-pocket maximum. |
| **Medical Reimbursement Account (MRA)** | When you enroll in Plan Option 1 or Plan Option 2, you are eligible to receive funding in a tax-free account, the Medical Reimbursement Account (MRA), that you can use to pay for eligible medical and prescription drug out-of-pocket expenses. Your MRA is funded by JPMorganChase when you complete certain wellness incentive activities. You cannot contribute your own dollars. Your MRA account balance rolls over year to year. |
| **Your Coverage Level** | You can choose to cover:<br>▪ Yourself only;<br>▪ Yourself and your spouse/domestic partner; or Yourself and your child(ren); or<br>▪ Your family (yourself, your spouse/domestic partner, and your children). |
| **Contribution Rates** | Payroll contribution rates vary by the number and types of dependents whom you choose to cover — for example, 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). Contributions will also vary based on your Total Annual Cash Compensation, geographical location, Medical Plan option you select, you and your covered spouse's/domestic partner's tobacco user status, and you and your covered spouse's/domestic partner's completion of the wellness screening and assessment. The amount you pay does not differ depending on whether you choose Aetna or Cigna as your health care company. |
| **Covered Services** | Covered services will generally include:<br>▪ Hospitalization;<br>▪ Surgical procedures;<br>▪ Physician's office visits;<br>▪ Lab services/X-rays;<br>▪ Emergency room services;<br>▪ Maternity care;<br>▪ Mental health and substance abuse care; and<br>▪ Prescription drugs.<br>The Medical Plan also covers various preventive care services. Services and procedures must be considered medically necessary to be covered. |

## Resources

Resources are available to help you make health care decisions, including:

- Nurse Line;
- Expert Medical Advice;
- Health Advocate;
- Condition Management;
- Treatment Decision Support; and
- Maternity Support Program.

More information is available on **My Health**.

# Medical Plan Options

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

Here's how the two Medical Plan options compare:

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

# Cost of Coverage

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

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

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

- The Medical Plan option you choose (described under "Medical Plan Options" on page 9);
- The number and type of eligible dependents you cover (described under "Eligible Dependents" in the *Health Care Participation* section);
- The level of your Total Annual Cash Compensation (see "Total Annual Cash Compensation" on page 10);
- You and your covered spouse's/domestic partner's wellness screening and wellness assessment completion status;
- Your and/or your covered spouse's/domestic partner's tobacco user status (see "Tobacco User Status" on page 11); and
- Where you live.

If you cover your children, you will be charged per child 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).

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

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

## Tax Treatment of Domestic Partner Coverage/Gross-Up Policy

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

JPMorganChase is required to report the entire value of the medical coverage for a "Domestic Partner" as taxable (or "imputed") income to you and to withhold for federal, state and FICA taxes on the imputed income. The imputed income includes the amount that both you and 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 by calling 1-844-ASK-JPMC, you will not be subject to taxation of imputed income on the tax dependent's coverage.

## Total Annual Cash Compensation

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

Your TACC is:

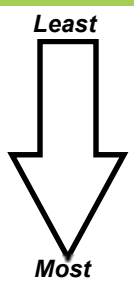
- Your annual rate of base salary plus applicable job differential pay (for example, shift pay) as of each August 1, plus
- Any cash earnings from any incentive plans (for example, annual incentive compensation, commissions, draws, overrides, and special recognition payments or incentives) that are paid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

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

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

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

**Please Note:** Your TACC is measured as of August 1 and remains unchanged for purposes of determining Medical Plan contributions and the deductible, copayments and the annual out-of-pocket maximum for the next calendar year. If you change pay tiers due to an increase in TACC, you may experience a larger than average increase in medical payroll contributions the next year.

| Tier | Total Annual Cash Compensation | Employee Pays |
|---|---|---|
| 1 | < $59,999 |  |
| 2 | $60,000–$79,999 | |
| 3 | $80,000–$99,999 | |
| 4 | $100,000–$149,999 | |
| 5 | $150,000–$249,999 | |
| 6 | $250,000–$349,999 | |
| 7 | $350,000 and above | |

## Tobacco User Status

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

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

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

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

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

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

For more information on the Tobacco Cessation Program**,** type go/Wellness on the JPMC's intranet browser.

**How Tobacco User Is Defined**

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

## Regional Cost Categories

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

The Regional Cost Category for your home state or region will be a factor in determining your medical payroll contributions, along with the other factors described in "Cost of Coverage" on page 9.

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

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

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

# *How Your Medical Plan Works*

The Medical Plan provides comprehensive coverage for a broad range of health care services and prescription drugs.

Plan Option 1 and Plan Option 2 cover the same services and prescription drugs. What differs between the two options are:

- the payroll contributions required for each option;
- the annual deductibles;
- the cost share you pay for certain services, as explained in the following sections; and
- the annual out-of-pocket maximums.

Whether you choose Plan Option 1 or Plan Option 2, Aetna or Cigna, your JPMC Medical Plan includes prescription drug coverage administered by CVS Caremark. For a description of coverage for prescription drugs, please see “The Prescription Drug Plan” on page 29.

# In-Network Medical Costs, Deductibles, and Out-of-Pocket Maximums

**The Copays Shown Are Your Maximum Cost**

Important! These in-network copay amounts are maximum amounts — if the service costs less than the copay, then you pay the lesser amount.

See "Covered Service Categories" on page 20 for a detailed description of the types of services that fall into each category below. This table highlights costs for in-network services. Out-of-network coverage is available for Options 1 and 2.

| | Plan Option 1 | | Plan Option 2 | |
|---|---|---|---|---|
| | TACC[1]: <$100K | TACC: $100K+ | TACC: <$100K | TACC: $100K+ |
| **General Plan Information** | | | | |
| ***Network*** | Aetna or Cigna | | Aetna or Cigna | |
| ***Out-Of-Network Coverage*** | Yes | | Yes | |
| ***Primary Care Provider Selection Required*** | No | | No | |
| ***Specialist Referral Required*** | No | | No | |
| **(a) Routine, Urgent, and Emergent Care** | | | | |
| ***Preventive Care*** | $0 | | | |
| ***Primary Care Office Visit (PCP, Pediatrician, OB/GYN)*** | $15 | | | |
| ***Telehealth*** | | | | |
| ***Behavioral/Mental Health Office or Virtual Visits[2] with psychologist/therapist or Psychiatrist*** | | | | |
| ***Specialist Office Visit*** | $50 | $75 | $75 | $100 |
| ***Physical , Speech , Occupational Therapy[3]*** | $25 | $25 | $35 | $35 |
| ***Chiropractic Visit*** | $50 | $50 | $50 | $50 |
| ***Basic Labs*** | $20 | $20 | $35 | $35 |
| ***Urgent Care*** | $50 | $75 | $75 | $100 |
| ***Ambulance*** | $250 | $250 | $250 | $250 |
| ***Emergency Room*** | $300 | $500 | $600 | $800 |
| **(b) Medical Deductible for Other Medical Care Services Below** | | | | |
| ***Employee Only Coverage[4]*** | $250 | $750 | $850 | $1,750 |
| ***Employee + Spouse/Domestic Partner or EE + Child(ren)*** | $400 | $1,400 | $1,600 | $2,800 |
| ***Employee + Family (EE + Spouse/DP + Child(ren))*** | $700 | $1,800 | $2,300 | $4,000 |

| | Plan Option 1 | | Plan Option 2 | |
|---|---|---|---|---|
| | TACC[1]: <$100K | TACC: $100K+ | TACC: <$100K | TACC: $100K+ |
| **(c) Other Medical Care** | | | | |
| ***Inpatient Hospital Admission*** | If medical deductible (b) is not met, member pays 100% of costs. If medical deductible (b) is met, member pays 20% of costs. | | | |
| ***Outpatient Procedure / Surgery*** | | | | |
| ***Advanced Imaging (CT/MRI)*** | | | | |
| ***Standard Radiology*** | | | | |
| ***Durable Medical Equipment*** | | | | |
| **(d) Out of Pocket Maximum (your "safety net," the most you will pay in a year medical services; includes what you spend in a + b + c)** | | | | |
| ***Employee Only Coverage[4]*** | $1,250 | $2,000 | $2,800 | $4,000 |
| ***Employee + Spouse/Domestic Partner or EE + Child(ren)*** | $2,500 | $3,400 | $4,700 | $5,900 |
| ***Employee + Family (EE + Spouse/DP + Child(ren))*** | $3,500 | $5,100 | $6,600 | $8,400 |

1 Total Annual Cash Compensation (see "Total Annual Cash Compensation" on page 10).

2 Certain mental health / substance use services, including but not limited to Inpatient partial hospitalization, transcranial magnetic stimulation (TMS), electroconvulsive therapy, and Intensive-out-patient (IOP) will be subject to 20% coinsurance, please contact your health care company to determine whether a deductible will apply.

3 See "Covered Service Categories" on page 20 for limits. For those individuals with a mental health diagnosis, the cost share for these services will be subject to 20% coinsurance (no deductible) rather than the copayment amounts noted in this chart.

4 Also serves as the per person amount for other coverage levels.

## Out-of-Network Medical Costs, Deductibles, and Out-of-Pocket Maximums

| | Plan Option 1 | | Plan Option 2 | |
|---|---|---|---|---|
| | TACC: <$100k | TACC: $100k+ | TACC: <$100k | TACC: $100k+ |
| **Medical Deductible** | | | | |
| ***Employee-Only Coverage[1]*** | $2,750 | | $4,750 | |
| ***Employee + Spouse/Domestic Partner or Employee + Child(ren)*** | $4,125 | | $7,125 | |
| ***Employee + Family (Employee + Spouse/Domestic Partner + Child(ren))*** | $5,500 | | $9,500 | |

| | Plan Option 1 | | Plan Option 2 | |
|---|---|---|---|---|
| | TACC: <$100k | TACC: $100k+ | TACC: <$100k | TACC: $100k+ |
| **Cost Share** | | | | |
| ***Preventive Care*** | 50% after deductible | | 50% after deductible | |
| ***Primary Care Office Visit (PCP, Pediatrician, OB/GYN)*** | 50% after deductible | | 50% after deductible | |
| ***Telehealth*** | Not covered | | Not covered | |
| ***Mental Health Office Visits*** | 50% after deductible | | 50% after deductible | |
| ***Specialist Office Visit*** | 50% after deductible | | 50% after deductible | |
| ***Physical/Occupational/Speech Therapy*** | 50% after deductible | | 50% after deductible | |
| ***Chiropractic Visit*** | 50% after deductible | | 50% after deductible | |
| ***Basic Labs*** | 50% after deductible | | 50% after deductible | |
| ***Urgent Care*** | 50% after deductible | | 50% after deductible | |
| ***Inpatient Hospital Admission*** | 50% after deductible | | 50% after deductible | |
| ***Outpatient Procedure/Surgery*** | 50% after deductible | | 50% after deductible | |
| ***Standard Radiology*** | 50% after deductible | | 50% after deductible | |
| ***Advanced Imaging (MRI, CT)*** | 50% after deductible | | 50% after deductible | |
| ***Durable Medical Equipment (DME)/Prosthetics/Appliances*** | 50% after deductible | | 50% after deductible | |
| ***Ambulance*** | $250 copay (no deductible) | | $250 copay (no deductible) | |
| ***Emergency Room*** | $300 copay (no deductible) | $500 copay (no deductible) | $600 copay (no deductible) | $800 copay (no deductible) |
| **Medical Out-of-Pocket Maximum** | | | | |
| ***Employee-Only Coverage[1]*** | $8,750 | | $10,750 | |
| ***Employee + Spouse/Domestic Partner or Employee + Child(ren)*** | $12,125 | | $15,125 | |
| ***Employee + Family (Employee + Spouse/Domestic Partner + Child(ren))*** | $17,500 | | $21,500 | |

[1] Also serves as the per person amount for other coverage levels

## Highlights

- Plan benefits are offered through a network of participating health care providers (for example, doctors, hospitals, labs, and outpatient facilities).
  - — Even though there is an out-of-network benefit available, JPMorganChase strongly encourages you to stay in-network. Selecting out-of-network providers and services cost more for all employees and JPMorganChase. Selecting in-network providers and services will reduce your out-of-pocket costs.
- **For in-network care:**
  - — For most routine services, such as primary care and specialist office visits, basic labs, urgent care, emergency room care, etc., you pay only the copay — a fixed dollar amount — associated with each covered service.
  - — Less routine services, such as inpatient hospitalization or outpatient surgery, are subject to the annual deductible, then coinsurance.

— You are not required to select or assign a Primary Care Physician.

— You do not need referrals to see a specialist.

- **Important:** In-network preventive care, including physical exams and recommended preventive screenings, is covered at 100% with no copays; and in-network primary care and mental health care office visits are covered after a $15 copayment.
  - Primary care providers include family practitioners, internists, pediatricians, OB/GYNs, nurse practitioners and Convenience Care Clinics. Internists must be contracted with Aetna or Cigna as a Primary Care Physician (PCP).
  - Mental health care providers include psychologists, therapists, psychiatrists, and social workers.
  - Go to **My Health** > My Medical Plan Website to search for in-network providers.

    For employees living in Florida, Georgia, Louisiana and Oklahoma, go to **My Health >** Access Aetna/Cigna Medical Benefits through Included Health to search for in-network providers.

- The plan's out-of-pocket maximum — your financial "safety net" — limits the total amount you are required to pay out-of-pocket each year. Note that there are separate out-of-pocket maximums for in-network and out-of-network charges. In addition, there is a separate out-of-pocket maximum for prescription drugs.
- **Out-of-network information:**

  — Benefits for out-of-network care are subject to a separate, higher deductible and coinsurance.

  — You must meet an annual deductible before the coinsurance applies for most covered services.

  — There is a separate, higher out-of-pocket maximum for eligible out-of-network charges.

  — Benefits for out-of-network care are limited to reasonable and customary (R&C) charges after you meet the out-of-network deductible. These R&C charges are based on average claims data in your area and are determined by your health care company to be appropriate fees for medical services. You are responsible for any amount above the R&C charges. This can result in significant out-of-pocket expenses for you.

  — It's important to understand that if you are using out-of-network providers (doctors, facilities or other service providers), it is your responsibility to check with your health care company to see if there is a prior authorization or medical necessity requirement that you need to meet before receiving any out-of-network treatment, service or procedure. Otherwise, the treatment, service or procedure may not be covered by the Plan and you will be responsible for the full cost.

- Prescription drug copays are based on the drug category and where you fill your prescription. Covered preventive generic and brand drugs are covered at 100% with no copay.
- Plan Option 1 and Plan Option 2 are paired with a Medical Reimbursement Account (MRA) you can use to help pay for covered out-of-pocket medical and prescription drug expenses. The MRA is funded by JPMorganChase when you take action and complete designated wellness activities. Employees cannot contribute funds to an MRA.

## The Annual Deductible

Certain expenses are subject to an annual deductible. The annual deductible is the amount you must pay "up front" each calendar year before the Plan begins to pay benefits for certain covered expenses.

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

- Eligible preventive care that is received from in-network providers is covered in full at no cost to you without having to satisfy the deductible;
- For most routine services, such as primary care and specialist office visits, telehealth visits, basic laboratory services, urgent care, emergency room visits, ambulance, etc., you pay only the copayment — a fixed dollar amount — associated with each covered service.
- For more information on what is considered "eligible preventive care" and "primary care," please see the chart "Copayment or Coinsurance Paid for Covered Benefits" beginning on page 27.

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

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

### Per Person Rule for Deductibles

If you elect coverage for yourself, you must pay up front for certain less routine services (such as inpatient hospitalization or outpatient surgery) until you meet the per-person deductible. After you meet the annual per-person deductible, the Plan will begin to pay its portion of covered expenses — known as the coinsurance rate (20% for in-network services) — for these certain services.

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

However, no individual must satisfy more than the per-person deductible amount. This means that once an individual's expenses meet the per-person deductible, the Plan will begin to pay benefits for that person, even if the family has not yet met the full deductible for the coverage level.

## The Annual Out-of-Pocket Maximum

Under Plan Option 1 and Plan Option 2, the annual out-of-pocket maximum is the maximum amount you must pay in annual deductibles, coinsurance, and copays during a plan year toward eligible expenses. There is a separate out-of-pocket maximum for prescription drug expenses.

There are separate out-of-pocket maximums for in-network and out-of-network charges.

The out-of-pocket maximum varies based on coverage level and TACC, which provides greater financial protection for lower-paid employees, as shown in the following table.

The out-of-pocket maximum functions as your "financial safety net." It prevents you from having to pay very high health care expenses in the event of a serious medical situation. Once the in-network out-of-pocket maximum is reached, you pay no deductible, coinsurance, or copays for covered in-network care for the rest of the year. Once the out-network out-of-pocket maximum is reached, you pay no deductible, coinsurance, or copays for covered out of-network care for the rest of the year.

Amounts that you pay toward costs above the reasonable and customary charges for out-of-network care do not count toward your out-of-pocket maximum.

## Per Person Rule for Out-of-Pocket Maximums

For the out-of-pocket maximums, the "per person" rule allows the employee or any covered dependent(s) (e.g., spouse/domestic partner or child) to reach an individual out-of-pocket maximum, after which the out-of-pocket maximum is satisfied for the year for that person. Covered individuals who have not met the out-of-pocket maximum may combine to meet the remainder of the out-of-pocket maximum for that particular coverage level. If no one person has met the individual out-of- pocket maximum, the expenses of all covered individuals can combine to meet the out-of-pocket maximum for that coverage level.

Note: There are separate safety nets for in-network and out-of-network services. The out-of-network, out-of-pocket maximum calculation does not include amounts above reasonable and customary (R&C) charges if you use out-of-network providers. An R&C limit is based on data in your area and determined to be an appropriate fee for a specific medical service.

**Example:** John is enrolled in Plan Option 1, has TACC less than $100,000 and is covering his spouse and two children. John's spouse, Mary, has a complicated surgery and is in an in-network hospital, with total charges of $50,000. The out-of-pocket expenses related to Mary will be $1,250 — the individual out-of-pocket maximum — since her total deductible and coinsurance payments for her services exceed the individual out-of-pocket maximum. Now that Mary has paid $1,250 and met the individual out-of-pocket maximum, all other eligible in-network expenses for Mary for the rest of the year will be covered at 100% by the plan. John and his children will continue to pay copays for in-network services they use during the year until:

- any one of them reaches $1,250 out-of-pocket and that individual will then have met their maximum (similar to Mary), or
- all three of them combined spend $2,250 ($3,500 family out-of-pocket maximum less $1,250 spent by Mary.

**Note:** If your coverage level changes during a calendar year as a result of Qualified Status Change (QSC), your annual deductible and/or annual out-of-pocket maximum increases or decreases accordingly. For example, your deductible will go back to the individual amount if you move from Employee + spouse/domestic partner or Employee + child(ren) to Employee-only during the year as a result of a QSC; please note that when this happens, your Employee only deductible will automatically be credited for any expenses incurred for you as an employee that accumulated towards your deductible.

## Maximum Lifetime Benefits

Generally, there is no dollar limit on the amount payable for covered benefits while you and your covered dependents are enrolled in the Medical Plan; However, there are lifetime maximums for Family Building Services and skilled nursing facility services. Skilled nursing facility coverage provides for up to 365 days per lifetime (combined in-network and out-of-network). For more details on Family Building lifetime maximums, please see "Family Building Benefit" on page 26.

## Choosing Between In- and Out-of-Network Care

Under the Medical Plan, you can choose to see any provider, but the Plan is intended to encourage the use of in-network care. You'll pay less when you receive your care through your health care company's network of physicians and facilities because network providers have agreed to charge negotiated discounted fees for their services. In addition, you only pay up to the copay amount for most routine in-network care. For services that apply to the deductible and coinsurance, in-network providers will not charge over the pre-negotiated rate for services. So, your share of charges, if any, is less for in-network care.

**Forgot Your ID Card?**

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

When you receive **in-network** care:

- You usually don't have to file any claim forms.

- Your out-of-pocket expenses will be lower compared to your expenses for the same type of care on an out-of-network basis. In-network doctors have agreed with Aetna and Cigna to charge pre-negotiated rates that are on average lower than the fee charged by doctors outside the network. You cannot be billed for any amounts above those charges.

When you receive out-of-network care:

- You may need to file a claim form to receive out-of-network benefits. Please see “Filing a Claim for Benefits” on page 48 for more information.
- Your out-of-pocket costs for medically necessary covered services generally will be higher than if you received in-network care. Benefits for out-of-network care are limited to reasonable and customary (R&C) charges after you meet the out-of-network deductible. You are responsible for any amount above the R&C charges, which can result in large out of pocket expenses for you.

In most cases, covered services performed by providers not participating in the network will be reimbursed at the out-of-network level of benefits, subject to reasonable and customary (R&C) charges. These charges are based on average claims data in your area and are determined by your health care company to be appropriate fees for medical services. Out-of-network charges are typically higher than the pre-negotiated fees that are covered for in-network care. **Please Note:** You will be responsible for paying any charges above the R&C amount. Charges in excess of reasonable and customary levels are not considered a covered expense under the Plan, and they therefore do not count toward the out-of-network deductible or out-of-pocket maximum.

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

## Out-of-Area Network Participants

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

## Covered Service Categories

The following chart is intended to describe the types of services that are covered within each Medical Service category defined in the preceding copay/coinsurance chart. This list is not exhaustive. For more detailed questions on how certain services will align or adjudicate, please contact your health care company, Aetna or Cigna, or Included Health if you live in Florida, Louisiana, Georgia, and Oklahoma.

| Medical Service | Description of Services |
|---|---|
| **Advanced imaging (CT/MRI) — per service** | Advanced imaging includes CAT Scan, MRI, and PET scans. Advanced imaging is subject to the annual deductible and coinsurance; including the costs associated with the image itself as well as cost associated with the radiologist's reading of the image.<br>Advanced imaging performed in a PCP, Specialist and/or Inpatient hospital/Outpatient facility settings is subject to the annual deductible and coinsurance. |
| **Ambulance** | Local emergency ambulance service or air ambulance to the nearest hospital if medically necessary and confirmed by a licensed provider. Non-emergency transportation is covered if it is provided by a licensed professional ambulance (either ground or air ambulance as determined appropriate) when the transport is from an out-of-network hospital to an in-network hospital; to a hospital that provides a higher level of care that was not available at the original hospital; to a more cost-effective acute care facility; or from an acute facility to a sub-acute setting.<br>**Please note** that Cigna administers the ambulance benefit on a per day basis, not per ride. |
| **Basic Lab** | Lab work includes tests such as complete blood count (CBC), basal metabolism, lipid panel, liver panel, hemoglobin A1C, etc. Generally, you will be assessed a single copay per blood draw even if multiple tests are performed on that single blood draw.<br>Labs also includes the following: hearing test, heart monitor, pre-admission testing and genetic testing (when approved as medically necessary). |
| **Chiropractic visit** | Chiropractic care when medically necessary as determined by Aetna/Cigna to diagnose or treat illness, injury, or disease. Coverage is limited to 20 visits per year (including initial consultation) and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance and/or managing pain. |
| **Durable medical equipment (DME)** | Durable medical equipment (DME) and supplies ordered or provided by a Physician. DME equipment/supplies or other items that are subject to the annual deductible and coinsurance include: crutches; wheelchair; walker; cane; insulin pump; surgical dressings; casts; splints; trusses; orthopedic braces; hearing aids[6]; custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot; hospital bed; ventilator; iron lung; artificial limbs (excluding replacements); artificial eyes and larynx (including fitting); heart pacemaker; ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers and bags; manual pump-operated enema systems and other items necessary to the treatment of an illness or injury that are not excluded under the plans.<br>For more details on covered DME, please contact Aetna or Cigna. Prior authorization or pre-certification may be required for coverage of some medical equipment and supplies. Aetna and Cigna may authorize purchase of an item if more cost-effective than rental. |

| Medical Service | Description of Services |
|---|---|
| **Emergency room (ER) visit** | All services performed during your emergency room (ER) visit will be covered by the single ER copay. This includes fees related to professional services (e.g., seeing a doctor), facility charges (e.g., cost of the ER itself), lab work, standard radiology, advanced imaging, any medications given in the ER[7], etc.<br>Emergency room visits will be covered as in-network and subject to the applicable in-network copay.<br>If you go to the emergency room and are subsequently admitted to the hospital, the ER copay will be waived and the inpatient hospital admission will be subject to the annual deductible and coinsurance. |
| **Inpatient hospital admission** | All services performed during your inpatient hospital stay will be subject to the annual deductible and coinsurance. Generally, a patient is considered inpatient if formally admitted to the hospital.<br>This includes fees related to:<br>• Professional services (costs related to the surgeon, assistant surgeon, anesthesiologist, radiologist, etc.),<br>• Facility charges (e.g. cost of the hospital room itself),<br>• Lab work, standard radiology, advanced imaging, and<br>• Any medications provided while in the hospital[7]<br>If you're provided with a durable medical equipment upon discharge (e.g., crutches or wheelchair), that will be subject to the annual deductible and coinsurance. |
| **Outpatient procedure/surgery** | This category includes procedures or surgeries performed in an outpatient facility, without an overnight stay, such as at an ambulatory surgical center.<br>The types of procedures performed at an outpatient facility include endoscopies (includes colonoscopies), cardiac catheterization, upper gastrointestinal, diagnostic colonoscopy, ovary removal, hernia repair, tonsil removal, cataract, kidney stone removal, etc. Please note: this is not meant to be an exhaustive list of services performed outpatient.<br>Outpatient Procedure/Surgery fees related to professional services (e.g., doctor or surgeon costs) and the facility charges (e.g., cost of the center itself) are subject to the annual deductible and coinsurance<br>Lab work, standard radiology (e.g., X-rays) and advanced imaging (e.g., CAT scans) performed at an outpatient facility will be assessed a separate cost share. Dialysis or an infusion performed during an outpatient facility visit[5] is subject to the annual deductible and coinsurance; this is inclusive of the costs of the associated infused drugs. |
| **Outpatient therapy for mental health, chemical, alcohol dependence** | Outpatient mental health/substance use therapy includes office visits with: Psychologists, Psychiatrists, Clinical Social Workers, Drug and Alcohol Counselors, Licensed Professional Counselors, Marriage/Family Therapists, Behavioral Health Nurse Practitioners, and Psychiatric Nurses.<br>Lab work, standard radiology (e.g., X-rays) and advanced imaging (e.g., CAT scans) performed during a mental health, chemical, alcohol dependence outpatient therapy visit will be assessed a separate cost share. |

| Medical Service | Description of Services |
|---|---|
| **Physical therapy (PT), speech therapy (ST), occupational therapy (OT) cognitive rehabilitation therapy services** | Physical, speech, occupational, and cognitive rehabilitation therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year per therapy type, when the underlying condition/diagnosis is medical in nature. For instance, the plan provides 60 PT visits in total (in- and out-of-network visits combined), 60 ST visits in total (in- and out-of-network visits combined), etc.<br>For those individuals with a mental health diagnosis[1], associated medical treatments for physical, occupational, speech therapy and cognitive rehabilitation therapy will not be subject to an annual visit limitation. Further, the cost share for these services will be subject to 20% coinsurance (no deductible) rather than the copayment amounts noted in "In-Network Medical Costs, Deductibles, and Out-of-Pocket Maximums" starting on page 13. |
| **Preventive care** | Preventive care services are covered at 100% in-network by the Medical Plan and include routine care such as:<br>• Routine annual physical exams<br>• Well-child/adult care office visits<br>• Immunizations<br>• Mammograms, breast ultrasounds, and PAP tests<br>• Prostate exams and colonoscopy exams<br>Detailed preventive care flyers from Aetna and Cigna, which will include the types of preventive care and any associated frequency, are available on aetna.com and mycigna.com.<br>Preventive care services are determined by your health care company based on guidelines and clinical recommendations developed for the general population by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorganChase does not make this determination. Age and frequency limits may apply. |
| **Primary care office visit (PCP, Pediatrician, OB/GYN)** | Primary care office visits are non-preventive care visits with the following types of clinicians: Primary Care physician (PCP), OB/GYNs, GYNs, Pediatricians, Family Practitioners, General Practitioners, Internal Medicine (contracted as PCPs with Aetna/Cigna), Certified Nurse Midwife, Nurse Practitioner, and Physician Assistants (within a PCP's office).<br>Convenience care clinics (e.g., CVS Minute Clinic®) are treated as a primary care office visit.<br>"Incidental" labs, such as a swab for strep throat, urine analysis for a urinary tract infection (UTI), etc., are included in the PCP copay (not a separate copay when performed as part of the office visit). Other lab work (e.g., blood draw), and all standard radiology (e.g., X-rays) and advanced imaging (e.g., CAT scans) performed during a PCP visit will be assessed a separate cost share based on the type of service. |

| Medical Service | Description of Services |
|---|---|
| **Specialist office visit**[2] | Office visit with a specialist, such as: ABA/BCBA therapist, acupuncturist, allergist[3], cardiologist, dermatologist, endocrinologist, oncologist, otorhinolaryngologist/otolaryngologist (ENT specialist), rheumatologist, reproductive endocrinologist, etc. Please note: this is not intended to be an exhaustive list of all specialists.<br>**Please note:** ABA therapy will be subject to 20% coinsurance (no deductible)[1], rather than the copayment amounts noted in "In-Network Medical Costs, Deductibles, and Out-of-Pocket Maximums" starting on page 13.<br>Dialysis or an infusion performed during a specialist office visit[4] will be assessed the Specialist Office visit copay; the cost of the associated infused drugs will be subject to a separate cost share.<br>Minor surgery performed at your specialist's office will be assessed the Specialist Office visit copay. Examples of minor surgery that could be performed at a specialist's office include: mole removal, ingrown toenail correction, breast biopsy, and vasectomy.<br>Minor in-office procedures performed during your specialist office visit will be included in the Specialist Office visit copay. Examples include withdrawing excess fluid from a joint.<br>Lab work, standard radiology (e.g., X-rays) and advanced imaging (e.g., CAT scans) performed at a specialist office visit will be assessed a separate cost share. |
| **Standard radiology** | Standard radiology includes radioisotopes, scans, sonograms, pre-admission X-ray, ultrasound, and X-rays and includes the costs associated with the image itself as well as cost associated with the provider's reading of the image. Standard radiology will follow Aetna and Cigna's individual definition of standard radiology; therefore please contact your health care company for a complete list.<br>Standard radiology performed in a PCP, Specialist and/or Inpatient hospital/Outpatient facility settings are subject to the annual deductible and coinsurance. |
| **Urgent care visit** | Visits to an urgent care facility. Please contact your health care company for information on in-network urgent care centers. |
| **Virtual doctor visits (also known as telemedicine), including Medical and Behavioral/Mental Health** | Connect to a doctor in minutes — anytime, anywhere — using a smartphone, phone, tablet or computer. Doctors can make diagnoses, provide advice and call in prescriptions to your local pharmacy.<br>Medical and Behavioral/Mental Health Virtual doctor visits are delivered through Aetna (via Teladoc) and Cigna (via MDLive). Go to **My Health** > Medical Specialty Services for details on how to access virtual doctor visits. |

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

[2] Certain mental health / substance use services, including Inpatient partial hospitalization, transcranial magnetic stimulation (TMS), electroconvulsive therapy, and Intensive-out-patient (IOP) will be subject to 20% coinsurance, please contact your health care company to determine whether a deductible will apply. Also, home health care visits and private duty nursing visits (when medically necessary and approved by your health care company) are assigned the specialist copay; 200 visit limit per year continues to apply.

[3] An office visit with your allergist is assigned the Specialist Office Visit copay. Any allergy shots or serums delivered during that office visit will be covered by the Specialist Office Visit copay (there will not be a separate copay assigned for this). If you are

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

4 The specialist office copay will apply for dialysis/infusions that occur in the specialist's office, when the provider is billing that visit as having occurred in the specialist's office; the cost of any drug infused (and associated administration cost) during an office visit is subject to the applicable specialty prescription drug copay. Some specialists may be associated with an outpatient facility and bill these services as an outpatient facility visit. If that is the case, you will be subject to the Outpatient Procedure/Surgery cost share (deductible then coinsurance). If you are uncertain as to how your provider bills, you can look at a prior Explanation of Benefits (EOB) and then discuss this with your health care company (Aetna or Cigna).

5 Deductible and coinsurance will apply for dialysis/infusions that occurs in the outpatient facility, including if your specialist bills the infusion/dialysis visit you had with him/her under an outpatient facility code rather than a specialist office visit code. If you are uncertain as to how your provider bills, you can look at a prior Explanation of Benefits (EOB) and then discuss this with your health care company (Aetna or Cigna).

6 Hearing aids are limited to $3,000 every 36 months.

7 Prescriptions given to you in the Emergency Room or hospital that you fill at a pharmacy are subject to the applicable prescription drug copays.

# Additional Plan Provisions

## Prior Authorization

Prior authorization is required for many services and procedures, including but not limited to hospital stays, some surgical procedures, and radiology (imaging).

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

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

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

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

## Hospital Notification

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

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

## Mental Health Benefits

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

## If You Need Emergency Care

If you have a medical emergency that's sudden, urgent and serious or life-threatening, you should go to the nearest physician, hospital emergency room, or other urgent care facility.

Care will be approved for local emergency ambulance service or air ambulance to the nearest hospital qualified to treat the condition if medically necessary and confirmed by a licensed provider. It is best for you or your doctor to call your claims administrator to arrange Air Ambulance transport as they can help identify best resources most easily.

If you go to the emergency room and are subsequently admitted to the hospital, the emergency room copay will be waived and instead you will be subject to the annual deductible and coinsurance for inpatient hospital charges.

### *Emergency Services from an Out-of-Network Provider*

Your coverage for emergency services will continue until your condition is stabilized and:

- Your attending physician determines that you are medically able to travel or be transported, by medical or non-emergency medical transportation, to another provider if you need more care;
- You are in a condition to be able to receive notice from and consent to the out-of-network provider delivering services for the services to be rendered; and
- In the case of a surprise bill from an out-of-network provider where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. Contact your claims administrator immediately if you receive such a bill.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are performed at a network facility by certain out-of-network providers, that are not available from a network provider, or which are emergency services (e.g., pathology). Your cost share for involuntary services will be calculated in the same way as if you received the services from a network provider. If you received a surprise bill, your cost share will be calculated differently. Contact your health care company immediately if you receive such a bill.

## Centers of Excellence (COEs) for Organ Transplants and Bariatric Surgery

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

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

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

## Nurse Line

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

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

Contact your health care company to learn more:

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

## Virtual Doctor Visits

Virtual doctor visits through Teladoc (an Aetna partner) and MDLive (a Cigna partner) allow you to connect to a doctor in minutes — anytime, anywhere — using a smartphone, tablet, or computer. Doctors can make diagnoses, provide advice and call in prescriptions to your local pharmacy. Register before you need care by going to **My Health**.

The copay for virtual doctor visits is $15 for medical doctors and mental health providers (psychiatrists and psychologists/therapists).

## Maternity Benefits

The Medical Plan will pay for most in-network maternity services through a global fee arrangement. Under such an arrangement, the cost share of services that a member will be assessed are:

- $15 copay for an initial office visit with OB/GYN (i.e., to confirm pregnancy)
- Standard copay or deductible and coinsurance for lab or radiology services (e.g., ultrasounds, amniocentesis, fetal stress tests and other related tests)
- Inpatient hospital stays for delivery and any provider services included in the global maternity fee are subject to deductible and coinsurance. Additional costs may apply for high risk or complex pregnancies.

If the obstetrician is out-of-network and/or does not have a global fee arrangement in place, the member will be charged for each visit and service based upon the cost share for that service.

## Family Building Benefit

The Medical Plan provides Family Building benefits with lifetime limits.

There is a $10,000 lifetime maximum for Family Building Benefits for both in-network and out-of-network care provided by the Medical Plans ($35,000 for both in-network and out-of-network care if you and/or your covered dependent contact WINFertility and complete a nurse consultation). Family Building Benefits include:

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

There is a separate $15,000/lifetime prescription drug benefit. For additional information on Family Building benefits see “The Prescription Drug Plan” on page 29.

### *Please Note*

These are lifetime limits and will carry over across health care companies and from prior JPMorganChase plans.

Amounts paid by the Plan (not your out-of-pocket expenses) apply to the lifetime Family Building benefit maximum.

Under the Medical Plan, cost share will be assessed based on the type and setting of the service you receive. For instance, a visit with a reproductive endocrinologist will be assigned a specialist copay, while in-vitro fertilization might be subject to deductible and coinsurance.

## Copayment or Coinsurance Paid for Covered Benefits

The following table shows the copayment or coinsurance required for covered expenses. Please also see "What Is Covered" on page 52 for a more detailed list of covered expenses under the Medical Plan.

### Covered Benefits: Eligible Preventive Care

| | Plan's Copayment/ Coinsurance for In-Network Care | Plan's Coinsurance for Out-of-Network Care* |
|---|---|---|
| **Eligible Preventive Care****<br>**Please Note:** Preventive care services will be covered at 100% only if they are performed by an in-network provider and are coded as preventive. Before receiving any service, you should check with your physician to be sure the procedure is considered, and will be submitted to your health care company, as preventive medical care rather than as a diagnostic service. Additional lab or other services performed during a preventive care visit that are not considered preventive in nature may not be free and/or covered. | | |
| ***Immunizations (routine adult and child; includes immunizations related to travel)*** | • 100% covered ($0 cost share) | • 50% coverage after deductible |
| ***Colon Cancer Screenings:***<br>• Fecal occult blood test (FOBT) or fecal immunochemical test (FIT): annually***<br>• Flexible sigmoidoscopy: every 5 years<br>• Double-contrast barium enema (DCBE): every 5 years***<br>• Colonoscopy: every 5 years<br>• Computed tomographic colonography (CTC)/virtual colonoscopy: every 5 years*** — Requires precertification | • 100% covered ($0 cost share) | • 50% coverage after deductible |
| ***Routine Gynecological Exams and Cervical Cancer Screenings (Pap Smears)*** | • 100% covered ($0 cost share)<br>• One exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines | • 50% coverage after deductible<br>• One exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines |

| | Plan's Copayment/ Coinsurance for In-Network Care | Plan's Coinsurance for Out-of-Network Care* |
|---|---|---|
| ***Routine Mammography Prostate Specific Antigen (PSA) Test, and Digital Rectal Exam*** | • 100% covered ($0 cost share)<br>• Age 40 and over: one exam per year based on age and gender | • 50% coverage after deductible<br>• Age 40 and over: one exam per year based on age and gender |
| ***Routine Annual Physical Exams*** | • 100% covered ($0 cost share)<br>• One exam annually | • 50% coverage after deductible<br>• One exam annually |
| ***Routine Screenings Provided During Pregnancy***<br>(For example, gestational diabetes and bacteriuria screenings, as well as items such as certain breast pumps) | • 100% covered ($0 cost share) | • 50% coverage after deductible |
| **Other Services** | | |
| ***Durable Medical Equipment and Prosthetics***<br>***(Includes certain**** glucose monitors, insulin pumps and related pump supplies)*** | • 20% after deductible | • 50% coverage after deductible |
| ***Lab*** | • $20 Plan Option 1<br>• $35 Plan Option 2 | • 50% coverage after deductible |
| ***Prescription Drugs*** | Please see "The Prescription Drug Plan" on page 29. | |
| ***Standard Radiology*** | 20% after deductible | • 50% coverage after deductible |

* Covered out-of-network expenses are subject to reasonable and customary (R&C) charges. You are responsible for paying any charges above the R&C amount.

** Your health care company determines which preventive care services performed by an in-network provider are free based on guidelines and clinical recommendations for the general population developed by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorganChase does not make this determination. Age and frequency limits may apply. Additionally, based on the medical finding resulting from preventive care, services may no longer be considered preventive and thus subject to member cost share. For a list of preventive services go to your health care company's website accessible via **My Health** > My Medical Plan Website.

*** Follow-up colonoscopy is covered as preventive at 100% in-network following a positive result.

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

# The Prescription Drug Plan

The Prescription Drug Plan is part of the JPMC Medical Plan and is administered by CVS Caremark — regardless of the health care company you choose. The covered drug lists are the same under Plan Option 1 and Plan Option 2 of the Medical Plan.

You will receive a separate prescription drug identification (ID) card from CVS Caremark in addition to your Medical Plan ID card.

### For Help with Prescription Drug Coverage

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

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

## How the Prescription Drug Plan Works

Highlights of prescription drug coverage are listed below; detailed information follows.

- There is no deductible for prescription drug coverage;
- Free preventive drugs. Covered preventive medications are covered at 100% ($0 cost) at network pharmacies. **Please Note**: Generic prescription contraceptives are also fully covered (as are brand-name, contraceptive drugs for which a generic is not available);
- Your copay for prescription drugs count toward the prescription drug out-of-pocket maximum that is separate from the medical out-of-pocket maximum;
- MRA funds can be used to pay for covered out-of-pocket prescription drug costs;
- If you have elected automatic claim payment, at the time of purchase, your MRA funds will automatically be used to offset your out-of-pocket cost after the Plan pays its share of the cost of your medication. If you elected or were automatically assigned the debit card, you may pay your out-of-pocket costs by using the card or your own funds. If you pay out-of-pocket, you can submit a claim form for reimbursement from the MRA. Once your MRA funds are depleted, you can use your HCSA for eligible prescription drug expenses if you elected to participate in the HCSA and have available funds.
  - If you elected autopay during enrollment, you are allowed to make a one-time mid-year switch to the debit card option that will be effective the first of the following month by calling 1-844-ASK-JPMC.

### Free Preventive Drugs

The CVS Caremark Brand and Generic Preventive Drug List is a list of drugs covered at 100% with no copays, as determined by CVS Caremark. To see a list of drugs in this category, visit CVS Caremark's website, which is accessible via **My Health**. **Please note,** only drugs on CVS Caremark's formulary are covered. Inclusion of a drug on the Preventive Drug List does not guarantee coverage. Step therapy, prior authorization, or quantity limits may apply. Mandatory Generic Drug Program applies.

- Discounted prices are available at network pharmacies (you'll generally pay more at an out-of-network pharmacy); if you use an out-of-network pharmacy that does not accept your prescription drug ID card, you will generally pay more and will need to file a claim for eligible reimbursement;
- Plan Option of having maintenance prescriptions filled through a convenient mail-order program or at a pharmacy; Maintenance Choice® offers advantageous pricing when you receive 90-day supplies of maintenance medication by mail or pick up your prescription at a participating pharmacy (including CVS retail pharmacies), where the same discounts are available;
- Traditional (non-specialty) and specialty lists of preferred/covered and excluded drugs; the most recent lists can always be found on the CVS Caremark website;
- Mandatory Generic Drug Program; if you fill a prescription for a brand-name medication when a generic equivalent is available, you will pay the difference in cost between the brand-name drug and generic drug, plus the generic copay.

**If You Take a Non-Covered Drug**

If you choose to take a non-covered drug, you will pay the full cost of the drug. This could be a costly option. Be sure to consider carefully how the costs of taking a non-covered drug could add up.

## Categories of Prescription Drugs

Your prescription drug coverage depends on the type of drug your doctor prescribes and where you fill your prescription. Prescription drugs are split into two main categories — traditional drugs and specialty drugs.

- **Traditional drugs**, also known as non-specialty drugs, are usually the ones which most people are familiar with and represent the majority of prescription drugs used. This includes medicines used to treat common conditions like high blood pressure, diabetes and asthma, and most short- term medicines used to treat acute conditions like coughs, flu and infections. Traditional drugs generally don't have special handling or shipping requirements, are available at most pharmacies, and are lower cost.
- **Specialty drugs** are generally used to treat complex medical conditions such as rheumatoid arthritis, multiple sclerosis and psoriasis. These drugs include biological drugs, often require special handling, such as refrigeration, and are generally not available at the majority of pharmacies. Additionally, specialty drugs are usually higher cost.

### *Covered Drug Lists and Types of Prescription Drugs*

JPMorgan Chase uses CVS Caremark's lists of covered and excluded drugs. An independent committee made up of pharmacists, physicians and medical ethicists reviews and approves the drug lists (also known as Formularies). These lists are subject to change quarterly by CVS Caremark. The following drug lists are available on CVS Caremark's website, on the Covered Drug List (Formulary) section of the Plan & Benefits tab, available through **My Health** > Medical, Rx, MRA & Spending Accounts > My Prescription Drugs:

- CVS Caremark Standard drug list: a guide that includes covered generic and preferred brand name traditional drugs.
- CVS Caremark Specialty drug list: a guide that includes covered generic and preferred brand name specialty drugs.

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

Below is a description of the types of drugs covered on the standard and specialty drug lists.

- **Generic Drugs:** Generics have equivalent ingredients to brand name drugs but can cost significantly less.
- **Preferred Brand Name Drugs:** Preferred brand name drugs have been patented by the companies that developed them and placed on a preferred drug list by CVS Caremark. They're generally more expensive than generic drugs but less expensive than non-preferred brand name drugs.
- **Non-Preferred Brand Name Drugs:** Non-preferred brand name drugs are brand name medications that are not on CVS Caremark's preferred drug list and are usually more expensive than generics and preferred brand name drugs. Often, they have either generic alternatives and/or one or more preferred brand name drug options that may be substituted for the non-preferred brand name drug.

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

## Prescription Drug Copays and Out-of-Pocket Maximums

There is no deductible for prescription drug coverage.

**Note:** The copay amounts shown in the following table are maximum amounts. If your prescription costs less, you will pay less.

| Prescription Drug Copays | Plan Option 1 | Plan Option 2 |
|---|---|---|
| **Preventive Drugs*(generic and brand)** | 100% coverage ($0 copay) | 100% coverage ($0 copay) |
| **Retail Pharmacy (up to a 30-day supply)** | | |
| ***Generic**** | $5 | $5 |
| ***Preferred Brand name**** | $50 | $100 |
| ***Non-preferred brand name**** | $150 | $250 |
| ***Specialty**** | $200 | $250 |
| **Mail Order Pharmacy or Maintenance Choice® (up to a 90-day supply; opt-out available)**** | 2 times Retail copay amount shown above | 2 times Retail copay amount shown above |
| **Annual Out-of-Pocket Maximum** | | |
| ***Employee-Only***** | $1,250 | |
| ***Employee + Spouse/DP or Child(ren)*** | $2,000 | |
| ***Employee + Spouse/DP + Child(ren)*** | $2,600 | |
| **CVS Caremark Excluded Drugs*** (Traditional and Specialty) | Not covered; you will pay the full cost for these drugs. | |

| Prescription Drug Copays | Plan Option 1 | Plan Option 2 |
|---|---|---|
| **Non-Sedating Antihistamines** (Also known as NSAs) | Not covered; you will pay the full cost for these drugs. | |

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

** The Maintenance Choice® program covers 90-day supplies of maintenance medication. Maintenance Choice® allows you to: 1) send your 90-day prescription to CVS Caremark and have your medicine delivered by mail to your home; or 2) fill your 90-day prescription at a participating pharmacy (including any CVS retail pharmacy). To find a participating pharmacy, please visit www.caremark.com If you "opt out" out of Maintenance Choice®, your prescription costs will generally be higher. Please see "Details About Maintenance Choice®" on page 32.

*** Also functions as a "per person" out-of-pocket maximum under the other coverage levels.

## Details About Maintenance Choice®

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

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

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

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

You may also "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any network pharmacy (see "Opting Out of Maintenance Choice®" on page 33).

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

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

Please note, the Maintenance Choice® program may not be available in some states. Please contact CVS Caremark for more details.

### *Opting Out of Maintenance Choice®*

You will generally pay the lowest price for maintenance medications if you use Maintenance Choice® to obtain a 90-day supply by mail or at a participating pharmacy (including CVS retail pharmacy). However, you may "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any network pharmacy, but you may pay more, as shown in the following table.

**Comparing per-Prescription Maximums Under Maintenance Choice® to Opting Out of Maintenance Choice® for Non-Specialty Drugs**

| | Plan Option 1 Maximum per-prescription charge | | Plan Option 2 Maximum per-prescription charge | |
|---|---|---|---|---|
| | ***Maintenance Choice® (obtain through mail or at a participating pharmacy, including CVS retail pharmacy)*** | ***Opt Out (obtain prescription at a non-CVS retail in-network pharmacy*)*** | ***Maintenance Choice® (obtain through mail or at a participating pharmacy, including CVS retail pharmacy)*** | ***Opt Out (obtain prescription at a non-CVS retail in-network pharmacy*)*** |
| ***Non-preventive Generic 90-day supply*** | $10 | $15 | $10 | $15 |
| ***Preferred brand-name 90-day supply*** | $100 | $150 | $200 | $300 |
| ***Non-preferred brand-name 90-day supply*** | $300 | $450 | $500 | $750 |

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

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

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

## Filing a Paper Prescription Drug Claim

If you purchase your prescription drugs through a non-network pharmacy or do not show your CVS Caremark ID card at a network pharmacy, you will have to pay for the prescription drug and then file a CVS Caremark Claim Form to be reimbursed for the Plan's share of the eligible expense. If you have funds in your MRA and/or HCSA, you can be reimbursed for your share of the expense by filing an MRA and/or HCSA Claim Form (see "If You Paid Out-of-Pocket for a Prescription Drug" on page 49). Reminder, you can only be reimbursed from your HCSA once your MRA is depleted.

**Forgot Your ID Card?**

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

## What's Covered and Not Covered

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

### Prescription Drugs Covered

| Drug | Coverage Status |
|---|---|
| ***Allergy Serums (oral immunotherapy drugs)*** | Covered but requires prior authorization |
| ***Aspirin*** | Covered — generic aspirin (81mg only) is fully covered as a preventive medication ($0 copay)<br>1) after 12 weeks of gestation in women who are at high risk for preeclampsia (Age limit: 12 or older, quantity limit: 100 units per fill);<br>2) for primary prevention of cardiovascular disease and colorectal cancer (Age limit: 50 to 59 years, quantity limit: 100 units per fill)<br>OTC products require prescription |
| ***Breast Cancer Drugs*** | Covered — generic anastrozole, exemestane, raloxifene, and tamoxifen are fully covered ($0 copay) as part of a treatment therapy for women at risk for breast cancer and/or diagnosed with breast cancer for age 35 or older |
| ***Contraceptives*** | Covered — generic prescription contraceptives are fully covered ($0 copay), as are brand-name prescription contraceptives for which a generic is not available, such as Lo Loestrin® 24 Fe.<br>**Please Note:** If a generic prescription becomes available for a brand-name contraceptive, the generic form of the contraceptive will be fully covered, while the brand-name version of the contraceptive would be covered according to the provisions for other brand-name medications (see chart under "What's Covered and Not Covered" on page 33). |
| ***Diabetic Supplies (includes certain glucose monitors, insulin pumps and related pump supplies)**** | Covered — except alcohol wipes |
| ***Diet Medications (anorexiants and anti-obesity)*** | Covered but requires prior authorization |
| ***Fluoride Supplements*** | Covered — generic fluoride supplements are fully covered ($0 copay) for children age 5 or younger |
| ***Fertility Drugs (exclusive of treatment)*** | Covered up to a $15,000 lifetime maximum (combined Retail Pharmacy Benefit and Maintenance Choice® program) per person. May require Prior Authorization. |
| ***Legend Vitamins*** | Covered |
| ***Male Impotency Drugs*** | Covered at 8 units per 30 days (24 units per 90 days through Maintenance Choice®). |
| ***Prescription Tobacco Cessation Products*** | Covered |

| Drug | Coverage Status |
|---|---|
| ***Proton Pump Inhibitors (PPIs) (such as Prilosec, Tagamet, and Nexium)*** | Covered subject to preauthorization, as described under "Coverage for Proton Pump Inhibitors" on page 36 |
| ***Respiratory Therapy Supplies*** | Covered — except nebulizers. |
| ***Solaraze (Diclofenac sodium gel 3%)*** | Covered but requires prior authorization. |
| ***Solodyn*** | Covered but requires prior authorization. |

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

## Prescription Drugs Not Covered by the Prescription Drug Plan

| Drug | Coverage Status |
|---|---|
| ***Allergy Serums (injectable)*** | Not covered |
| ***Blood Plasma/ Blood Transfusion Agents*** | Not covered |
| ***Botox and Myoblock*** | Not covered for cosmetic purposes; requires prior authorization for other uses. |
| ***Bulk Powders & Topical Analgesic (compounds)*** | Not covered* |
| ***Cosmetic Products (such as depigmenting agents, hair growth stimulants, hair removal agents)*** | Not covered |
| ***Non-Sedating Antihistamines (NSAs) (such as Clarinex and Allegra)**** | Not covered |
| ***Nutritional Supplements (injectable or oral)*** | Not covered |
| ***Over-the-Counter Drugs*** | Not covered (but still may be less expensive than related prescription drugs) |
| ***Renova*** | Not covered |
| ***Rx Devices Other Than Respiratory (such as elastic bandages and supports, GI-ostomy and irrigation supplies, other Rx devices)*** | Not covered |
| ***Select Medical Devices and Artificial Saliva products*** | Not Covered |
| ***Toxoids*** | Not covered (seasonal and non-seasonal vaccines, including flu and COVID-19 vaccines, are covered) |

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

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

## Coverage for Proton Pump Inhibitors

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

## Additional Plan Provisions

### *Mandatory Generic Drug Program*

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

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

### *Step Therapy Program*

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

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

### *Prior Authorization*

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

### *Quantity Restrictions on Covered Medications*

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

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

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

## Pharmacy Advisor

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

## Coverage for Specialty Drugs

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

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

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

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

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

You may contact CVS Caremark Specialty Customer Care at (800) 237-2767 from 6:30 a.m. to 8 p.m. Central time, Monday – Friday, and Saturday from 6 a.m. to 3 p.m. Central time, to arrange for expedited, confidential delivery of your specialty drug to the location of your choice. You will also have access to a pharmacist-led or nurse-led Care Team that can provide customized care, counseling on how to best manage your condition(s), patient education, and evaluation to assess your progress and to discuss your concerns.

# The Wellness Incentive Program and Medical Reimbursement Account (MRA)

JPMorganChase is committed to promoting a culture of health and well-being. Wellness is about more than just going to the doctor when you are sick. JPMorgan Chase's Wellness Programs provide resources and services that can help you take charge of your health and make informed health care decisions for you and your family, including free flu shots and health screenings to a wide array of programs that help you manage your weight, quit smoking, reduce stress, manage your overall well-being, and onsite support through our Health & Wellness Centers (for employees only).

**To Check Your MRA Balance**

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

JPMC offers a Wellness Incentive Program with ways to save and earn money toward your medical expenses by participating in certain activities:

- **Save $500 – $1,000 on your medical payroll contributions** by completing the biometric wellness screening and online wellness assessment by the defined deadline each year. You can save $500 on your medical payroll contributions for completing both activities — and double that if your covered spouse/domestic partner does the same. This applies to all of our medical plan providers — Aetna, Cigna, Centivo Select Plan, and Kaiser Permanente. These actions do not earn Medical Reimbursement Account (MRA) funds. Please note: You are not required to complete a wellness screening or take a wellness assessment or other medical examinations. However, only those who complete a wellness screening and wellness assessment will save on their medical payroll contributions.

## Wellness Screening and Wellness Assessment

A biometric wellness screening provides overall key indicators of your health. The wellness screening measures your blood pressure, blood sugar, cholesterol, A1C, triglycerides, body mass index (BMI) and waist circumference. You can get a free wellness screening at:

- A JPMorganChase onsite event, including at a JPMorganChase Health & Wellness Center (where applicable),
- A Quest Patient Service Center or lab;
- Your in-network health care provider's office; or
- A CVS MinuteClinic.

The online wellness assessment is an online survey that asks you questions about your biometric values, current health conditions and lifestyle. The wellness assessment can be completed at mycigna.com (even if you are enrolled with Aetna, Centivo Select, or Kaiser Permanente).

Together, the wellness screening and wellness assessment provide important indicators of your current health and potential health risks — you'll learn what you're doing well and what you can do to improve your health, like get a health coach, participate in a weight management program, or take advantage of other support that JPMorganChase offers.

- You and your covered spouse/domestic partner (if applicable) must complete both the wellness screening and assessment between November 18, 2023 and November 22, 2024 at 11:59 pm Eastern time in order to:
  - Save $500 in medical payroll contributions ($1,000 if covering a spouse/domestic partner) in 2025.

  Completing the free biometric wellness screening and wellness assessment do not earn MRA funds.

Please refer to go/ScreeningandAssessment for details, scheduling, and information about how to get a free wellness screening.

For more information on how to complete your annual wellness screening and wellness assessment, go to:

- Employees at work: go/ScreeningandAssessment
- Employees at home: myhealth.jpmorganchase.com
- Spouses and domestic partners: my.questforhealth.com (screening); mycigna.com (assessment)

## *Important Information*

The **2025** medical payroll contributions (payroll deductions for Medical Plan coverage) shown when you enroll on the Benefits Web Center assume you and your covered spouse/domestic partner completed the wellness screening and assessment between November 18, 2023 and November 22, 2024 (11:59 p.m. Eastern time). This means the $500 savings (or $1,000 if you cover a spouse/domestic partner) will be reflected in your 2025 medical payroll contributions. If you and/or your covered spouse/domestic partner didn't complete the wellness screening and assessment by the deadline, your medical payroll contributions will increase in March 2025. The $500 or $1,000 increase will be applied in equal installments to each pay from the first effective pay in March 2025 through December 2025.

**Note**: You have until June 30, 2025, to open a case with your health care company if you believe your wellness screening and wellness assessment were completed by the deadline and not reflected in your medical payroll contributions.

**Employees who become eligible for benefits coverage — and/or add a spouse/domestic partner to medical coverage — in 2025 (prior to September 1, 2025) will automatically save $500 (or $1,000 if covering a spouse/domestic partner) on 2025 medical payroll contributions without completing the wellness screening and assessment.**

**For employees currently on an approved Leave of Absence:** You and your covered spouse/domestic partner are encouraged to participate in the wellness screening and wellness assessment. However, if you are on an approved Leave of Absence for at least 45 consecutive days between September 1 and November 22, 2024, and do not complete your wellness screening and online wellness assessment during that period, you will not lose the $500 in 2025 medical payroll contribution savings ($1,000 if covering a spouse/domestic partner). Other provisions of the Medical Plan and Wellness Incentive Program will continue to apply, including the opportunity to earn MRA funds by completing Wellness Incentive Activities (maximum of $700 per employee).

**Earn up to $700 in your MRA** by completing certain activities during the year, such as meeting healthy outcomes (e.g., blood pressure target), getting preventive care (e.g., annual physical) or completing physical, emotional, or financial wellness activities. These incentives don't apply to those covered by Kaiser Permanente or to covered spouses/domestic partners. If you are enrolled in the Centivo Select Plan, please review the information available in the *Centivo Select Plan* section. Those who are not enrolled in the medical plan can earn up to $400 annually in taxable pay by completing certain Wellness Incentive Activities.

The Wellness Incentive Program is administered through Cigna, regardless of your health care company (Aetna, Cigna, Centivo Select Plan or Kaiser Permanente). Please note: If you're not enrolled in the JPMorgan Chase Medical Plan, your Wellness Incentive Program will still be administered by Cigna.

Medical Reimbursement Account (MRA) funds can be earned by completing the following Wellness Incentive Activities.

* Allow two to three weeks for processing before funds are deposited into your MRA account.

### *Healthy Outcomes*

As an incentive to stay healthy, you can earn $100 per activity, up to $200 per year to your MRA for achieving the following*:

- Body Mass Index or waist circumference target;
- Blood Pressure target.

* If it's unreasonably difficult due to a medical condition for you to achieve a standard under this category, you may be able to earn the reward by different means. Contact your health care company to work with you (and, if you wish, with your doctor) on an alternative.

### *Preventive Care*

The Medical Plan covers eligible in-network preventive care at 100% ($0 cost share). Out-of-network preventive care is also covered but you will have to meet a deductible and pay coinsurance. You can earn up to $300 per year to your MRA when you:

- Complete an annual physical /GYN exam to earn $200 to your MRA;
- Complete the following screenings to earn $100 to your MRA per activity:
  - Cervical or prostate screening;
  - Mammogram; and
  - Colon cancer screening.

### *Well-being Activities*

Complete well-being activities to improve your financial, emotional and physical well-being and earn up to $600 per year. Activities include:

- Financial Well-being (Financial Fitness) — earn up to $100 — provides personalized support and guidance to help you reach your financial goals
- Emotional Well-being (meQuilibrium) — earn up to $200 — helps you build resilience and manage stress
- Physical Well-being* (Personify Health, formerly Virgin Pulse)** — earn up to $300 — helps you build healthy habits

* If, due to medical reasons, you are unable to engage in physical activity tracking to earn points toward your wellness incentive, you can complete any combination of a variety of other activities available on the Virgin Pulse platform as a reasonable alternative to earn points toward the wellness incentive.

** Virgin Pulse is available to all benefits-eligible employees, but only those enrolled in JPMC Medical Plan Option 1 or 2 (Aetna or Cigna) can earn MRA funds for completed activities.

### *Not Enrolled in JPMC Medical Coverage*

Employees who do not enroll in the Medical Plan with Aetna/Cigna/Centivo Select Plan/Kaiser Permanente will still have the opportunity to complete Wellness Incentive Activities to earn up to $400 (in taxable income) during the plan year. Visit go/WellnessIncentiveProgram for details about eligible activities. This program is administered by Cigna.

## The Medical Reimbursement Account (MRA)

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

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

- You remain a JPMorganChase employee enrolled in the Medical Plan*; or
- You leave JPMorganChase and you are eligible for retiree medical plan coverage or you elect to continue your medical coverage through COBRA (see "What Happens to Your MRA If Your Employment with JPMorganChase Ends" on page 42).

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

See "MRA Payment Elections" on page 41 and "Using Your MRA and HCSA to Pay for Services" on page 46 for more information.

**Special rules for company couples:** MRA funds are earned by employees only, not spouses / domestic partners. If you are an employee but covered as a spouse/domestic partner of another JPMorganChase employee (i.e., company couple), you will not be eligible to earn MRA funds.

Your MRA and/or Spending Accounts (HCSA, DCSA) are administered by your health care company (Inspira Financial if enrolled with Aetna; Cigna if enrolled with Cigna), or Cigna if you are not enrolled in the JPMC Medical Plan (or are enrolled with Centivo Select Plan or Kaiser Permanente).

### *If you change health care companies*

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

## MRA Payment Elections

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

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

Your choice will also apply to your Health Care Spending Account (HCSA), if you elect to participate in that plan. If you do not make an election when you first enroll in the Medical Plan, you will be enrolled in the debit card payment method. Your election will remain in effect for future years, unless you make a change during a subsequent Annual Benefits Enrollment. If you are enrolled in the autopay option, you may make a one-time mid-year payment method change to the debit card option that will be effective the first of the following month.

Your MRA payment election determines how in-network claims are processed by your health care company. If an out-of-network provider agrees to submit a claim to your health care company on your behalf, your election would also apply to the processing of that claim.

- In automatic claim payment, your health care company will automatically pay your provider using your MRA funds first, then HCSA funds, to pay for your portion of eligible medical and prescription drug expenses.
- With a debit card, you are responsible for paying your provider for any out-of-pocket costs.

The claims payment process takes into account whether there is money in your MRA (and/or HCSA, if applicable) available to pay for all or part of your share of the covered medical or prescription drug expense. Please see "Using Your MRA and HCSA to Pay for Services" on page 46, which contains detailed instructions about payments at in-network and out-of-network providers.

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

## What Happens to Your MRA If Your Employment with JPMorganChase Ends

### *If your employment with JPMorganChase ends and you do not enroll in COBRA or retiree medical coverage, you:*

- Cannot earn additional Wellness funds beyond your termination of employment;
- Can use your remaining MRA balance for covered eligible out-of-pocket medical and prescription drug expenses incurred before the end of the month in which your employment ends. Claims for these costs must be submitted no later than one year following the end of the plan year in which you were enrolled. For example, if you terminated employment on September 23, 2025, you would have until December 31, 2026, to submit an MRA claim for covered expenses incurred through September 30, 2025. You will forfeit any remaining MRA funds.

### *If your employment with JPMorganChase ends and you enroll in COBRA or retiree medical coverage:*

- Your account balance will be available if you elect COBRA medical coverage (see "Continuing Coverage Under COBRA" in the *Health Care Participation* section). While you remain enrolled in COBRA medical coverage, you can use the remaining balance in your MRA to pay for your covered out-of-pocket costs related to covered medical and prescription drug expenses. You can also continue to earn Wellness funds for your MRA as if you were an active employee up to the full annual amount of $700.
- You qualify as "retired" from JPMorganChase (that is, at the time your employment ends with JPMorganChase, you are age 55 or older with at least 15 years of service, or age 50 or older with at least 20 years of service in the case of severance). If you retire from JPMorganChase, you can continue to access your MRA regardless of what medical coverage you have in retirement, whether it is through COBRA, the JPMorgan Chase Retiree Medical Plan, or another plan. However, you can no longer earn additional Wellness funds to increase your MRA balance.
- If you are enrolled in COBRA, the MRA can be used to pay for eligible out-of-pocket medical and prescription drug expenses. You may elect to use automatic claim payment or the debit card to pay for expenses from your MRA.
- If you are enrolled in the JPMorgan Chase Retiree Medical Plan, the MRA can be used to pay for eligible out-of-pocket medical and prescription drug expenses, and you will have to submit your claims for reimbursement.
- If you are covered by another plan (a non-JPMC plan), the expenses eligible for reimbursement from the MRA will be determined by the expenses covered by that plan. You will need to file an MRA and/or

HCSA Claim Form for reimbursement of your covered out-of-pocket medical and prescription drug expenses (see “Filing a Claim for Benefits” on page 48). Administrative fees for your MRA will apply and will be automatically deducted from your MRA each month. MRA balances less than $25 will be forfeited.

- If you are enrolled in JPMorgan Chase Retiree Medical Plan, administrative fees for your MRA will apply and will be automatically deducted from your MRA each month. MRA balances less than $25 will be forfeited.
- Your MRA will be managed by the last health care company in which you were enrolled while you were an active employee.

For more information, please see the **As You Leave Guide** on **My Health**.

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

## Covered MRA Expenses

You can use the funds in your MRA to pay for covered out-of-pocket medical and prescription drug expenses under the Medical Plan. Please see “What Is Covered” on page 52 for a list of covered expenses.

Expenses that are not covered under the Medical Plan are not eligible to be reimbursed by the MRA. Please see “What Is Not Covered” on page 63 for a list of excluded expenses. **Please Note**: While the MRA cannot be used to pay for expenses that are not considered covered expenses under the Medical Plan, such as charges above reasonable and customary levels for out-of-network care, or for dental or vision expenses, you may be eligible for reimbursement for these expenses from a Health Care Spending Account, if you choose to participate in that plan. Please see the *Spending Accounts* section for more information.

## Other Available Wellness Programs

While these programs are **not** eligible for Wellness funds in your MRA, there are benefits to participating in these wellness programs.

### *Health Coaching*

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

**You May Be Contacted by Your Health Care Company**

If your health care company feels you could benefit by working with a health coach based on its review of your wellness screening numbers, wellness assessment responses, and/or claims data, a health care company representative (not JPMorganChase) may contact you directly. If you live in Florida, Louisiana, Georgia, and Oklahoma, Included Health may contact you directly.

**Please Note:** Your health care company has access to your medical, prescription drug, and lab claims. So even if you do not get a wellness screening or complete a wellness assessment, you may still be contacted by your health care company to inform you of health programs available to you.

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

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

- Emphysema and chronic bronchitis;
- Depression and anxiety;

- Diabetes/pre-diabetes;
- Healthy eating;
- High blood pressure;
- High cholesterol;
- Physical activity;
- Stress management; and
- Weight management.

### *Maternity Support Program*

The Maternity Support Program provides expectant mothers with help throughout their pregnancy. If you or a covered spouse/domestic partner are pregnant, you can enroll in the program anytime throughout your pregnancy to receive support from a health coach. This is a confidential program and JPMorganChase will not be notified of your individual enrollment. This program is available only if you are enrolled in the Medical Plan.

Contact your health care company to learn more. Employees and their covered dependents living in Florida, Georgia, Louisiana, and Oklahoma, should contact Included Health.

### *Condition Management*

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

Contact your health care company to learn more. Employees and their covered dependents living in Florida, Georgia, Louisiana, and Oklahoma, should contact Included Health.

### *Expert Medical Advice*

An expert second medical opinion through Included Health allows you to receive medical guidance from a national leading expert on a documented diagnosis — without leaving your home. Leading experts are available to review documentation on treatment plans, complex medical conditions, scheduled surgeries or major procedures and medications you are taking. This program is available to all U.S. employees and covered family members enrolled in the Medical Plan.

Additionally, Included Health can also help you find a highly rated, in-network doctor or specialist, assist you with scheduling office appointments and advise you on how to prepare for the office visit. And if you're in the hospital, a Care Coordinator can help answer your questions and connect with your care team. Visit Includedhealth.com or call (888) 868-4693.

### *Treatment Decision Support*

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

- **Aetna:** Treatment Decision Support offers support for a variety of medical and surgical conditions including but not limited to angina, benign prostate disease, breast cancer, dysfunctional uterine bleeding, endometriosis, fibroids, hip replacement, knee replacement, low back pain, and prostate cancer.
- **Cigna:** Treatment Decision Support offers support for benign uterine conditions, breast cancer, coronary artery disease, hip osteoarthritis/replacement, knee osteoarthritis/replacement, low back pain, and prostate cancer.

- **Included Health:** Treatment Decision Support offers support for coronary artery disease/heart disease, hyperlipidemia, metabolic disease, hypertension, obesity, low back pain, shoulder pain, knee pain, hip pain, other chronic joint pain, migraines, anxiety, depression, benign uterine conditions, prostate cancer, and breast cancer. Please note, Treatment Decision Support through Included Health is available to all U.S. employees and covered family members enrolled in the Medical Plan.

Contact your health care company or Included Health to learn more. Employees and their covered dependents living in Florida, Georgia, Louisiana, and Oklahoma, should contact Included Health for Treatment Decision Support, not Aetna or Cigna.

## Other Wellness Programs

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

### Employee Assistance Program (EAP)

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

Employees and their dependents (age 6+) receive up to 8 counseling sessions and 6 free coaching session each year through Spring Health. All services provided by the EAP are free, confidential, and can be scheduled 24 hours a day, seven days a week. If you so choose you can continue with the same therapist/counselor, after your free sessions have been exhausted, covered according to the in-network cost share through the JPMC Medical Plan (if you are enrolled). If a referral to some other professional is made and fees are involved, the counselor will help you determine whether your Medical Plan benefits will offset some of the costs.

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

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

For additional information about the EAP, see EAP > U.S. within the JPMC Intranet or call (877) 576-2007.

### Tobacco Cessation Program

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

The program provides, at no cost:

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

Upon completion of the program, you may be eligible for lower “non-tobacco user” rates for certain benefits, including the Medical Plan (see “Tobacco User Status” on page 11 for more information).

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

## Onsite Health & Wellness Centers

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

- Basic medical services;
- Wellness screenings (see “The Wellness Incentive Program and Medical Reimbursement Account (MRA)” on page 38 for more information) and other health evaluations; and
- Help understanding health information and guidance on resources available to you.

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

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

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

# *Using Your MRA and HCSA to Pay for Services*

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

## If You See an In-Network Provider

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

### *Using the Automatic Claim Payment Method*

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

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

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

### *Using the Debit Card Payment Method*

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

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

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

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

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

If this happens, you should show your provider your ID card and explain that your health care company needs to review the claim first to see what you owe. If you are still required to pay at the time of service, you should do so and get a receipt from your provider. For instructions on how to file for reimbursement, see the "Filing a Claim for Benefits" on page 48.

## If You See an Out-of-Network Provider

When you visit an out-of-network provider, you should always show the provider your ID card and ask if they will submit the claim for you. If they agree to do so, your claim will be processed as explained in "If You See an In-Network Provider" on page 46 (your health care company will see if funds are available — first from your MRA and then from your HCSA, if applicable).

If an out-of-network provider will not file a claim for you, you will need to pay for the service at the time of your visit and submit a Medical Claim Form to your health care company to be reimbursed for the Plan's share of the expense. You can file a claim online with your health care company or medical claim forms can be found on **My Health** or on your health care company's website. You can also be reimbursed from your MRA/HCSA, if applicable, for your out-of-pocket share of the expense. Please see "Filing a Claim for Benefits" on page 48 for instructions.

## The MRA/HCSA and Your Prescription Drug Expenses

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

| If You Elected Automatic Claim Payment | If You Elected or Were Assigned the Debit Card |
|---|---|
| Your network pharmacy will submit the claim through your prescription plan with CVS Caremark. After CVS Caremark pays its share of the cost, your health care company will pay your share of the expense first from your MRA and then from your HCSA, if applicable.<br>Your MRA balance will be used first to cover your share of the cost; you won't need to pay anything.<br>If your MRA has been exhausted, your health care company will use your HCSA balance, if any, to pay the pharmacy; you won't need to pay anything if the HCSA covers your remaining amount due.<br>If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost, you will need to pay the amount you owe out-of-pocket at the time of your pharmacy visit. | Your network pharmacy will submit the claim through your prescription plan with CVS Caremark. After CVS Caremark pays its share of the cost, you can decide whether to use your debit card to pay your share of the cost or pay out-of-pocket at the pharmacy.<br>If you use your debit card, the card would first use funds from your MRA and then from your HCSA, if applicable, to pay the pharmacy. You should keep your receipt in case you are asked to substantiate your expense.<br>If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost, you will need to pay the remaining balance out-of-pocket.<br>If you choose not to use your debit card and instead pay out-of-pocket, you may request reimbursement for your share of the expense from your MRA/HCSA, if applicable, later. You will need to provide a receipt if you file for reimbursement from your MRA/HCSA (see "If You Paid Out-of-Pocket for a Prescription Drug" under "Filing a Claim for Benefits" on page 48). |

# *Filing a Claim for Benefits*

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

How to file a claim and determine which claim form to use depends on the services you received and whether you paid out-of-pocket, as detailed in the following sections. Always keep your receipt for any out-of-pocket expense for which you intend to file for reimbursement. Instructions for accessing claim forms, if necessary, and mailing addresses are in "How to Submit a Claim" on page 50.

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

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

- If you elected automatic claim payment, you will typically be reimbursed automatically by your health care provider. However, if reimbursement is not made automatically, you will need to call your provider when you receive your Explanation of Benefits (EOB). The EOB will show that your health care company made payment to your provider. You should explain to the provider's billing office that they have been paid twice: once by you at the time of service, and again when the Plan paid them from your MRA/HCSA. (On the Cigna EOB, the "What My Accounts Paid" section shows the amount paid; on the Aetna EOB, this information is in the "You may owe" section.) If you need additional assistance, you can call the number on the back of your ID card or Health Advocate for help in getting reimbursed for amounts paid out-of-pocket (see "If You Have Questions About a Claim" on page 51).
- If you elected the debit card, use the MRA and/or HCSA Claim Form to request reimbursement from your accounts (see "How to Submit a Claim" on page 50).

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

Out-of-network providers may require payment at the point of service. In these circumstances, you should submit a Medical Claim Form to your health care company (see "How to Submit a Claim" on page 50) to be reimbursed for the Plan's share of the expense. Be sure **not** to sign the box on the Medical Claim Form or check the box when submitting the claim online on aetna.com or mycigna.com that authorizes your health care company to make payment directly to your provider, as the payment should be made to you.

Your health care company will process your claim to determine your and the Plan's responsibility.

- If you elected automatic claim payment, in addition to processing the claim to determine the amount the Plan should have paid, your health care company will determine what amount can be paid directly to you by available MRA funds first, and then from your HCSA, if applicable.
- If you elected or were defaulted to the debit card, you will receive an EOB showing the amount paid by the Plan. You can then submit an MRA and/or HCSA Claim Form to request reimbursement if you paid with your personal funds (see "How to Submit a Claim" on page 50).

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

If you paid out-of-pocket for a prescription drug at a network pharmacy because you have a debit card but chose not to use it, use the MRA/HCSA Claim Form to be reimbursed for your share of the expense (see "How to Submit a Claim" on page 50).

If you paid out-of-pocket for a prescription drug because you purchased your drugs through a non-network pharmacy or did not show your ID card at a network pharmacy, use the CVS Caremark Claim Form to be reimbursed for the amount owed by the Prescription Drug Plan (see "How to Submit a Claim" on page 50). If you have funds in your MRA/HCSA, you can be reimbursed for your out-of-pocket costs by filing a MRA and/or HCSA Claim Form (see "How to Submit a Claim" on page 50).

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

If you paid out-of-pocket for an expense because you had no funds left in your MRA/HCSA, but you have since earned MRA funds, use the MRA and/or HCSA Claim Form to be reimbursed (see "How to Submit a Claim," on page 50).

## How to Submit a Claim

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

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

You need to file your Medical and MRA reimbursement claims by December 31 of the year after the one in which you received the service or purchased the prescription. For example, if you incur an expense on July 1, 2025, you must file your claim for reimbursement by December 31, 2026. If you fail to meet this deadline, your claim will be denied.

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

You can submit an MRA/HCSA reimbursement request online or via the App (Cigna or Inspira Financial).

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

### Medical Claim Forms

**Aetna:**

Aetna
PO Box 14079
Lexington, KY 40512- 4079

(800) 468-1266

**Cigna:**

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

Customer Service: (800) 790-3086

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

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

### MRA and/or HCSA Claim Forms

**Inspira Financial (if enrolled with Aetna):**

Inspira Financial
P.O. Box 14879
Lexington, KY 40512-4879

Fax: 1-888-238-3539

Phone: 1-800- 468-1266

**Cigna:**

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

Customer Service: (800) 790-3086

## CVS Caremark Claim Forms

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

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

Member Services: (866) 209-6093

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

You can also submit your prescription claim through the CVS Caremark website or mobile app. Your prescription information and receipt are required for claim submission with CVS Caremark.

## If You Change Health Care Companies During Annual Benefits Enrollment

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

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

* Any balance of up to $640 remaining in your Health Care Spending Account (HCSA) at the end of the 2024 calendar year will be automatically carried over to the next year. Any amount over $640 in your HCSA, after processing claims for the 2024 year, will be forfeited. If you were previously enrolled in the HCSA and decide not to participate in 2025, any unused amounts under $25 will be forfeited. If you do not choose to contribute to the HCSA in a given plan year, any balance you carried over from a prior year will be forfeited at the end of the year that they elected not to contribute if you do not use it. If you do not enroll in the JPMorgan Chase Medical Plan your balance will be managed by Cigna.

## If You Have Questions About a Claim

You can check the status of your claim by accessing your health care company's website, or you can call your health care company at the number on the back of your ID card. If you live in Florida, Louisiana, Georgia, and Oklahoma, you can contact Included Health with questions about your claims or if you are experiencing difficulty with a claim.

The JPMorgan Chase Health Advocate program, available at **My Health**, can also help you resolve benefit claim issues.

## Appealing a Claim

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

### Designating an Authorized Representative

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. If you have any questions on how to designate an authorized representative, please contact your health care company.

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.

# What Is Covered

Each of the Medical Plan options cover a wide variety of services, as long as the services are medically necessary and their costs do not exceed reasonable and customary (R&C) charges. (Please see "Defined Terms" on page 65 for the definitions of "Medically Necessary " and "Reasonable and Customary Charges.") Covered services and frequency limits may vary slightly across the health care companies — Aetna and Cigna. The lists on the pages that follow include examples of covered services, but the lists are not exhaustive and coverage remains subject to any Plan requirements or limitations and clinical policies. For specific information on the Medical Plan's covered services and frequency limits, please contact the appropriate claims administrator (Aetna or Cigna) directly, using the telephone numbers provided under "Where to Submit Claims." The list of covered services may change at any time.

**Important Note**

While the services listed in this section are covered by the Medical Plan, they must be "medically necessary." Please see the definition of "Medically Necessary" under "Defined Terms" on page 65.

## Quality Providers

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

## Preventive Care Services

The preventive care services covered at 100% in-network are determined by your health care company based on guidelines and clinical recommendations developed for the general population by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorganChase does not make this determination. For a list of preventive services that are covered at 100%, go to your health care company's website. Age and frequency limits apply. Please contact your health care company for further information.

These services generally include:

- Routine care including:
  - PAP tests (one per year, includes related laboratory fees);
  - Prostate exams (based on provider's recommendation)
  - Flexible sigmoidoscopy (one baseline screening, and one follow-up screening every five years);
  - Screening colonoscopy (one baseline screening and one follow-up screening every five years);
  - Fecal occult blood test (one test per year);

- Routine physical exams (one per year office visit with appropriate laboratory and radiology services);
- Mammography screenings and breast ultrasounds (one mammogram per year);
- Routine screenings during pregnancy (for example for gestational diabetes and bacteriuria);
- Breast pumps (please contact your health care company for details about which breast pumps are fully covered);
- Travel immunizations; and
- Well-child/adult care office visits (plus immunization and labs):
  - Birth to age 12 months: seven exams
  - Age 13-24 months: three exams
  - Age 25-36 months: three exams
  - Age 3 and over: one exam per year

This list is subject to change at any time without notice.

**Please Note:** An in-network medical service will only be covered at 100% if it is coded as preventive. Before receiving any services, you should check with your physician to be sure a procedure is considered, and will be submitted to the claims administrator, as preventive medical care rather than as a diagnostic service.

## Outpatient Services

Outpatient services under the Medical Plan include, but are not limited to, the following services, subject to any limitations or requirements of the Plan and based on medical necessity. Please refer to your health care company's clinical guidelines or call your health care company to discuss coverage of any specific services listed below:

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

  Treatment must be performed by a licensed provider (check with your claims administrator).
- Allergy testing and treatment;
- Chemotherapy and radiation treatments;
- Chiropractic care when medically necessary as determined by the claims administrator to diagnose or treat illness, injury, or disease. Coverage is limited to 20 visits per year and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
- Diagnostic services, including:
  - EEG, EKG, and other medical electronic procedures;
  - Laboratory and pathology tests; and
  - Radiology services.
- Education therapy, but only for participants with a diagnosis of diabetes mellitus;
- Eye exams for patients with diabetes (covered as a specialist office visit);
- Hemodialysis provided at a free-standing facility such as a dialysis center or your home, when ordered by a licensed provider;
- Home health care, which may require precertification; limited to a maximum of 200 visits/calendar year; one visit = four hours.
  - Medical supplies and laboratory services prescribed by a physician;
  - Nutrition counseling provided by or under the supervision of a registered dietitian;
  - Part-time or intermittent nursing care provided or supervised by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);

  - Part-time or intermittent home health services, primarily for the patient's medical care; and
  - Physical, occupational, speech, or respiratory therapy by a licensed qualified therapist.
- Licensed, general hospital emergency room use for treatment of an injury or sudden illness, including:
  - Emergency treatment rooms;
  - Laboratory and pathology tests;
  - Licensed providers' services;
  - Supplies and medicines administered during the visit; and
  - Radiology services.
- Licensed provider-prescribed respiratory therapy approved by the claims administrator;
- Mental health care/substance abuse care;
- Cognitive rehabilitation therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis). Please see "Mental Health Benefits" on page 25 for more information.
- Occupational therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis). Please see "Mental Health Benefits" on page 25 for more information.
- Outpatient surgery and related follow-up care;
- Physical therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis). Please see "Mental Health Benefits" on page 25 for more information.
- Podiatric care when medically necessary as determined by the claims administrator to diagnose or treat illness, injury, or disease. Coverage ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
- Prenatal care;
- Speech therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year. (There is no visit limitation for those with an underlying mental health diagnosis). Please see "Mental Health Benefits" on page 25 for more information.
- Temporomandibular joint syndrome (TMJ) medical treatment only; including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery up to $1,000 combined in-network and out-of-network maximum per year (appliances are not covered); and
- Virtual doctor.

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

## Inpatient Hospital and Related Services

The Medical Plan covers medically necessary inpatient hospital admissions for an unlimited number of days.

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

- Allergy testing and treatment, when provided as part of inpatient care for another covered condition;
- Anesthetics and their administration;
- Bariatric surgery, subject to claims administrator guidelines. **Please Note:** To receive benefits for bariatric surgery, you must contact your health care company before obtaining services; you will be informed of any required precertification. If you and/or your covered dependent use a Center of Excellence (COE) for your treatment you may be eligible for reimbursement of travel and lodging expenses. To learn more about the travel and lodging benefit including reimbursement see the bullet in the list below starting with "Travel Benefit" for further details.
- Basic metabolic examinations;
- Cosmetic surgery when needed to:
  - Reconstruct or treat a functional defect of a congenital disorder or malfunction;
  - Treat an infection or disease;
  - Treat an injury or accident; or
  - Reconstruct a breast after mastectomy. Coverage for the following services is available under the Medical Plan in a manner determined in consultation with you and your physician:
    - Reconstruction of the breast on which the mastectomy was performed;
    - Surgery and reconstruction for the other breast to produce a symmetrical appearance; and
    - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.
- Diagnostic services, including:
  - EEG, EKG, and other diagnostic medical procedures;
  - Laboratory and pathology tests; and
  - Radiology services.
- Electrocardiographic and physiotherapeutic equipment usage;
- Hemodialysis for kidney failure;
- Intensive care unit service;
- Maternity care, including:
  - Any required care for an illness or injury that the newborn develops either before or after birth, as long as you and your newborn are enrolled in the appropriate coverage level within prescribed enrollment time frames;
  - Newborns will have a separate in-network copay and out-of-pocket maximum applied. If the provider or facility is out-of-network, then a separate out-of-network deductible, copay and out-of-pocket maximum will apply.

### Multiple Surgical Procedure Reduction Policy

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

- 100% of the negotiated charges are reimbursable for the primary major procedure;
- 50% of the negotiated charges are reimbursable for the secondary procedure; and
- If more than two procedures are performed, please check with your claims administrator for coverage details. Please see contact information in the *Contacts* section.

- Care required because of miscarriage or ectopic pregnancy;
- Coverage of eligible expenses if your covered child has a baby, but not including nursery or other expenses incurred by the newborn child;
- Delivery by a certified, registered nurse or midwife in a birthing center;
- Drugs, medications, and anesthesia;
- Normal or cesarean section delivery;
- Routine medical and hospital nursery care for your covered newborn child, as long as you and your newborn are enrolled in the appropriate coverage level within prescribed enrollment time frames;
- Circumcision by a licensed provider (for your covered newborn child), as long as you and your newborn are enrolled in the appropriate coverage level within prescribed enrollment time frames; and
- A semi-private room. The period of hospitalization for childbirth (for either the mother or the covered newborn child) is up to 48 hours after a vaginal delivery or 96 hours after a cesarean section. (However, your attending physician — after consulting with the mother — may decide to discharge the mother or newborn child earlier.)

**Please Note**

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

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

### Newborns' and Mothers' Health Protection Act

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

### Women's Health and Cancer Rights Act of 1998

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

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

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

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

## Other Covered Services

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

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

| Benefits Provision | Plan Option 1 and 2 |
|---|---|
| Treatment for an emergency, for example, sudden serious chest pain | Emergency Room Copay |
| Treatment for an urgent situation | Urgent Care INN Copay and any other applicable cost share based on type of service |
| All other treatment; for example, elective surgery scheduled several months in advance | Out-of-network coinsurance applies after deductible based on type of service |

If you receive treatment while traveling outside the United States, you will have to pay for the services up front and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, please see "Filing a Claim for Benefits" on page 48. If you have any questions about benefits while traveling abroad, please call your health care company.

- Dental procedures resulting from a congenital or medical disorder or accidental injury (treatment must be received within 12 months of the accident). Includes surgical removal of wisdom teeth only if procedure is done in a medical setting. **Please Note:** The charges must not be covered by the JPMorgan Chase Dental Plan or any other dental plan that you might be enrolled in.
- Diabetes services, diabetes self-management and training, and diabetic eye examinations/foot care — outpatient self-management training for the treatment of diabetes, education, and medical nutrition therapy services. Services must be ordered by a physician and provided by appropriately licensed or registered health care professionals. Covered services also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
- Diabetic self-management items — Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under durable medical equipment (DME), and Prosthetics. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets, and lancet devices are described under the separate prescription drug plan. Please note: Specific insulin pumps may also be covered under the Prescription Drug benefit. Contact CVS Caremark for additional information on which insulin pumps are covered under the Prescription Drug Plan and to see if obtaining your insulin pump via CVS Caremark would result in less cost share for you.
- External cochlear devices and systems;
- Gender Affirmation Treatment
  - Please refer to your health care company's clinical policies or call your health care company to discuss coverage of any specific procedure under the Plan. You may also contact Include Health (LGBTQ+ Health Concierge Service) a care navigation service for the LGBTQ+ community. They specialize in connecting the LGBTQ+ community and their loved ones with quality, affirming care.

    In-network surgery preauthorization is the responsibility of the in-network provider. For out-of-network surgery, you are responsible for preauthorization.
- Hearing aids: $3,000 limit every 36 months.
  - Hearing aids do not need to be prescribed by or obtained from an in-network provider or from an in-network Durable Medical Equipment (DME) provider in order to be considered a covered, eligible charge. You will be subject to out-of-network pricing if you obtain your hearing aid from an out-of-network provider/DME equipment provider. Hearing aid evaluations and hearing tests (not included in the hearing aid maximum benefit).
- Intensive behavior therapy, such as applied behavior analysis for autism spectrum disorder.
- Local emergency ambulance service or air ambulance to the nearest hospital qualified to treat the condition if medically necessary and confirmed by a licensed provider.
- Medical equipment and supplies ordered or provided by a physician including:
  - artificial eyes and larynx (including fitting);
  - artificial limbs (excluding replacements);
  - Apnea monitor;
  - blood and blood plasma (unless donated on behalf of the patient);
  - cane;
  - casts;
  - crutches;
  - custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot;
  - heart pacemaker;
  - hospital bed;
  - insulin pump;
  - manual pump-operated enema systems;
  - orthopedic braces;

- ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers and bags;
- splints;
- surgical dressings;
- trusses;
- ventilator;
- walker;
- wheelchair; and
- other items necessary to the treatment of an illness or injury that are not excluded under the plans.

Prior authorization or pre-certification may be required for coverage of some medical equipment and supplies. The claims administrator may authorize purchase of an item if more cost-effective than rental.

- Medically necessary visits to licensed physicians, surgeons, and chiropractors, whether in the office or in your home;
- Non-emergency transportation is covered if it is provided by a licensed professional ambulance (either ground or air ambulance as determined appropriate) when the transport is:
  - from an out-of-network hospital to the closest in-network hospital with capabilities to care for the condition;
  - to a hospital that provides a higher level of care that was not available at the original hospital (when medically necessary for the patient's care);
  - to a more cost-effective acute care facility (as authorized by the plan) from an acute facility to the nearest sub-acute facility.
- Nutritional support, including nutritional counseling (limited to six visits) and durable medical equipment, to treat inborn errors of metabolism and/or to function as the majority source of nutrition,* as long as each of the following conditions are met:
  - Without enteral (feeding tube) feedings, the individual is unable to obtain sufficient nutrients to maintain appropriate weight by dietary and/or oral supplements;
  - The administration of enteral nutrition requires ongoing evaluation and management by a physician; and
  - The individual has one of the following conditions that is expected to be permanent or of indefinite duration:
    - An anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel;
    - Disease of the small bowel that impairs absorption of an oral diet; or
    - A central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.
  - The limits noted above do not apply for nutritional counseling for behavioral disorders (eating disorders).

  * When assessing the "majority source of nutrition," the following considerations apply:
    - Enteral feeding constitutes over 50% of caloric nutritional intake as determined by clinical information submitted by the provider for review;
    - Calories from parenteral (intravenous) nutrition should not be considered when assessing for the sole source of nutrition; that is, transitioning to enteral feedings; and
    - Parenteral feedings are covered when considered "medically necessary" and used when oral or enteral alone are not possible.
- Oxygen and supplies for its administration;

- Prosthetic devices and related supplies, including fitting, adjustments, and repairs, and biomechanical devices, if ordered by a licensed provider. Please check with the claims administrator for frequency or other limitations. **Please Note**: Dentures, bridges, etc. are not considered medical prosthetic devices.
- Radiation, chemotherapy, and kidney dialysis;
- Rental or purchase of durable medical equipment — includes cranial orthotics (helmets) custom molded, when prescribed by physician — as determined by the claims administrator and if ordered by a licensed provider. Frequency and other limitations may apply. At the claims administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear when repair costs exceed new purchase price, or when a change in the medical condition occurs sooner than the end of a three-year time frame. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouthpieces, etc., for necessary durable medical equipment are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.
- Services and supplies that are part of an alternate care proposal. This is a course of treatment developed and authorized by the claims administrator as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless specified otherwise, the provisions of the Plan related to benefits, maximum amounts, and copayments will apply to these services.
- Skilled nursing facility for up to 365 days per lifetime (combined in-network and out-of-network). The lifetime maximums reflect services received across all JPMorgan Chase Medical Plans.
- Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to sickness or injury.
- Termination of pregnancy:
  - Voluntary (i.e., abortion)
  - Involuntary (i.e., miscarriage)
- Travel Benefit:
  - The plan offers travel benefits for some conditions/surgery, for example organ transplant up to a maximum of $10,000 per covered person per surgery/condition for transportation and lodging expenses (subject to certain limitations imposed by the IRS) incurred by you and reimbursed under the Plan in connection with all certified and approved procedures. To qualify for this benefit the procedure/treatment needs to take place more than 50 miles from your home. Employees and their covered dependents are encouraged to contact their health care company for further details on the services covered.
  - The claims administrator must receive valid receipts for such charges before you will be reimbursed. The items/services listed above may change at any time so check with your health care company to see if your condition or surgery qualifies for this benefit and for additional details on this benefit.
- Urgent care;
- Voluntary sterilization; and
- Wigs up to a $500 per year limit, for burns, chemotherapy or radiation, accidental injury, after a diagnosis of alopecia, or for other medically necessary reasons.

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

## Family Building Benefits

Employees and covered dependents who are enrolled in the Medical Plan have access to Family Building Benefits which includes the guidance and support of WINFertility.

Family Building Benefits can provide up to $35,000 for medical procedures and $15,000 for prescription drugs. These are lifetime limits, meaning once this limit is reached, no additional benefits will be available under the Plan. To unlock access to the higher Family Building Benefits medical lifetime limit of $35,000, you must enroll with WINFertility and complete a nurse consultation. If these steps are not completed with WINFertility, a reduced medical lifetime limit of $10,000 applies (rather than $35,000).

Covered treatment includes but is not limited to:

- Fertility treatments such as in vitro fertilization (IVF) and intrauterine insemination (IUI), whether or not you have a medical diagnosis of infertility
- Elective fertility preservation (egg, sperm, or embryo freezing with 12 months of storage)
- Associated prescription medications (There is a separate $15,000/lifetime prescription drug benefit).

Contact WINFertility at (833) 439-1517. Monday - Friday 9:00 a.m. - 9:00 p.m. Eastern time. Medical benefits (e.g., provider network, claims administration) will continue to be managed by your health care company — Aetna or Cigna. Prescription drug benefits are managed by CVS Caremark.

This lifetime limit does not apply to the services used to determine the initial diagnosis of infertility and/or its cause. All procedures and access will be governed by the health care company's clinical policies for determining appropriateness of care. Please also see the "Infertility Drugs" information under "What's Covered and Not Covered" on page 33 for information on a $15,000* lifetime maximum on prescription drugs related to infertility treatment. Please contact your health care company for specific details.

**Please Note:**

- To receive benefits for Family Building services, you must contact your health care company and receive precertification before obtaining services.
- To have access to the $35,000 medical lifetime maximum you must enroll with WINFertility and complete a nurse consultation

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

## Planning Treatments That May Cause Infertility

Planned cancer treatments include bilateral orchiectomy, bilateral oophorectomy, hysterectomy, and chemotherapy or radiation therapy that is established in the medical literature to result in infertility. To use Family Building Benefits covered under the Plan, you must contact your health care company and work with them and your doctor to determine your appropriate course of treatment. Coverage services include:

- Collection of sperm;
- Cryopreservation of sperm, eggs and reproductive tissue;
- Ovulation induction and retrieval of eggs;
- In vitro fertilization; and
- Embryo cryopreservation.

There is one Lifetime maximum for Family Building Benefits regardless of the reason you utilize these type of services (i.e., to preserve fertility, infertility, etc.)

## 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.

## Hospice Care

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

To be eligible for reimbursement, a hospice facility must offer a hospice program approved by the claims administrator. It must be either a hospital or a freestanding hospice facility that provides inpatient care or an organization that provides health care services in your own home.

Hospice services include:

- Hospice room and board while the terminally ill person is an inpatient in a hospice;
- Outpatient and other customary hospice services provided by a hospice or hospice team; and
- Counseling services provided by a member of the hospice team.

These services and supplies are eligible only if the hospice operates as an integral part of a hospice care program, and the hospice team includes at least a doctor and a registered graduate nurse. Each service or supply must be ordered by the doctor directing the hospice care program and be:

- Provided under a hospice care program that meets standards set by the claims administrator. If such a program is required by federal or state law to be licensed, certified, or registered, it must meet that requirement; and
- Provided while the terminally ill person is in a hospice care program.

Hospice benefits also include eligible expenses for counseling services for the family unit, if ordered and received under the hospice care program. Benefits will be paid if:

- On the day before the terminally ill person passed away, he or she was:
  - In a hospice care program;
  - A member of the family unit; and
  - A covered participant.
- The charges are incurred within three months after the death of the terminally ill person.

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

## Coverage Limitations

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

These limitations are included in the coverage charts earlier in this section. Please see “Mental Health Benefits” on page 25 for more information.

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

# What Is Not Covered

While the Medical Plan covers a wide variety of medically necessary services, some expenses are not covered. Some of these are listed below. To get an up to date list of excluded services, please contact your health care company.

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

- Care from a person who is a member of your family or your spouse's/domestic partner's family;
- Charges for the difference between a private and semi-private hospital room;
- Correction of weak, unstable, or flat feet; arch supports (unless prescribed by a physician); corrective shoes (unless prescribed by a physician); shoe orthotics (except for custom-molded shoe inserts prescribed to treat a condition, disease, or illness affecting the function of the foot); or treatment of corns, calluses, or chronic foot strain;
- Cosmetic surgery treatment, except to repair damage from accident or injury; treat a functional birth defect; reconstruct a breast after mastectomy and/or reconstruction of the non-affected breast to produce a symmetrical appearance; or treat an infection or disease;
- Custodial services, including custodial nursing care and group homes;
- Donor expenses with regard to infertility treatment;
- Educational therapy (except for members with a diagnosis of diabetes) and social or marital counseling;
- Embryo adoption
- Expenses for which you're not obligated to pay (for example, if a licensed provider or hospital waives an expense, the Plan will not pay any benefit to you or a licensed provider);
  - If you enter into an agreement with a provider regarding the waiver of an expense, you are required to inform your health care company of the agreement.
- Expenses in excess of reasonable and customary charges for out-of-network services;
- Expenses submitted later than December 31 of the year after the year in which services were provided;
- Experimental, investigational, or unproven services, devices, or supplies (see the definition of "Experimental, Investigational, or Unproven Services" under "Defined Terms" on page 65);
- Extended benefit coverage after termination from JPMorganChase (other than coverage elected through COBRA). If you are hospitalized on the date your JPMorgan Chase Medical Plan coverage terminates, Medical Plan coverage will end at midnight that day.
- Hospital admissions and other services that began before the participant's effective date of coverage under the Medical Plan;
- Inpatient private duty nursing;
- Non-medical charges for care in a nursing or convalescent home or long-term custodial care, even if prescribed by a licensed provider;
- Non-prescription contraceptive devices, unless medically necessary (prescription oral contraceptives are covered under the JPMorgan Chase Prescription Drug Plan);
- Non-surgical correction of temporomandibular joint (TMJ) syndrome, such as appliances or devices;
- Nutritional support expenses including but not limited to:
  - Regular grocery products (including over-the-counter infant formulas such as Similac and Enfamil) that meet the nutritional needs of the patient;

  - Infant formula that is not specifically made to treat inborn errors of metabolism;
  - Medical food products that:
    - Are prescribed without a diagnosis requiring such food;
    - Are used for convenience purposes;
    - Have no proven therapeutic benefit without an underlying disease, condition, or disorder;
    - Are used as a substitute for acceptable standard dietary interventions;
    - Are used exclusively for nutritional supplementation; and
    - Are required because of food allergies.
  - Nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals.
    - Food supplements, specialized infant formulas (e.g., Alimentum, Elecare, and Neocate, ), lactose-free foods, vitamins and/or minerals may be used to replace intolerable foods, for lactose intolerance, to supplement a deficient diet, or to provide alternative nutrition in the presence of such conditions as allergies, gastrointestinal disorders, hypoglycemia, and obesity. Food supplements, lactose-free foods, specialized infant formulas, vitamins and/or minerals taken orally are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.

- Personal services for comfort or convenience while in the hospital, such as television, telephone, etc.;
- Physical, psychiatric, or psychological exams, testing, vaccinations, or treatments if required solely for purposes of school, sports or camp, career or employment, insurance, marriage, or adoption;
- Refractive eye examinations for new lenses or the cost of eyeglasses or contacts. This does not apply to the first pair of contact lenses or the first pair of eyeglasses after cataract surgery;
- Refractive eye surgery including, but not limited to, LASIK or radial keratotomy;
- Reproductive education and conception prevention classes;
- Reversals of sterilization;
- Routine dental care (please see the Dental Plan Summary Plan Description on **My Health** for information about services covered under the JPMorgan Chase Dental Plan);
- Routine eye exams (please see the Vision Plan Summary Plan Description on **My Health** for information about services covered under the JPMorgan Chase Vision Plan);
- Services, supplies, or treatment for weight loss, nutritional supplements, or dietary therapy; please note: medications for weight loss are covered under the Prescription Drug Plan subject to Prior Authorization;
- Services that were not incurred for the purpose of affecting any structure or function of the participants own body
- Sickness or loss covered by state workers' compensation law or automobile insurance;
- Sickness or loss that is later determined to be the legal responsibility of another person or company;
- Treatments, services, or supplies that are not medically necessary or not approved by a licensed provider or services provided outside the scope of a provider's license;
- Treatments, services, medicines or supplies that are illegal in the State where performed or prescribed.

- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias (sexual behavior that is considered deviant or abnormal);
- Unbundled medical expenses — charges billed separately when considered by the claims administrator in its sole discretion to be part of a global procedure; and
- Vision therapy.

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

# Defined Terms

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

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| **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.<br>Your Medical Plan payroll contributions are taken on a before-tax basis. |
| **Claims Administrator** | The claims administrator is the company that provides certain claims administration services for the Medical Plan. If you elect Medical Plan coverage, your claims administrator is your health care company (Aetna or Cigna, depending on your election). CVS Caremark administers the Prescription Drug Plan. |
| **COBRA** | The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that allows you and/or your covered dependents to continue Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise end. The *Health Care Participation* section provides details on COBRA coverage. |
| **Coinsurance** | Coinsurance is the way you and the Medical Plan share costs for certain covered health care services, generally after you pay any applicable deductible under the Medical Plan. For certain medically necessary covered in-network services, the Medical Plan pays a percentage of providers' negotiated fees and you pay the remainder. For medically necessary covered out-of-network services, the Medical Plan pays a percentage of the reasonable and customary (R&C) charges for services and you pay the remainder (you are responsible for paying any additional amount above R&C charges). The coinsurance percentage you pay depends on the type of covered service. |

**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 children covered as dependents under two plans, the primary plan is the plan of the parent whose birthday falls earlier in the year (based on month and day only, not year).

Specific rules may vary, depending on whether the patient is:

- An employee in active status (or the dependent of an employee).
- Covered by Medicare.

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

**Copayment**

A copayment (also known as a copay) is the fixed dollar amount you pay for certain services or medications under the Medical and/or Prescription Drug Plan.

**Covered Services**

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

**Custodial Care**

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

**Deductible**

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

**Domestic Partner**

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

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

OR

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

You must certify that your domestic partner meets the eligibility rules as defined under the Plan before coverage can begin. You may also be asked to certify that your domestic partner and/or your domestic partner's children qualify as tax dependent(s) as determined by the Internal Revenue Code (IRC) to avoid any applicable imputed income. Please see "Domestic Partners" in the *Health Care Participation* section for more information.

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| **Eligible Dependents** | Under the Medical Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see the above definition of "Domestic Partner" and see "Eligible Dependents" in the *Health Care Participation* section for more information. |
| **Experimental, Investigational, or Unproven Services** | Experimental, investigational, or unproven services are medical, surgical, diagnostic, psychiatric, mental health, substance abuse and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the claims administrator makes a determination about coverage in a particular case, are determined to be:<br>▪ 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<br>▪ Subject to review and approval by any institutional review board for the proposed use; or<br>▪ 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<br>▪ 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.<br>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:<br>▪ Is safe with promising effectiveness;<br>▪ Is provided in a clinically controlled research setting; and<br>▪ Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.<br>**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.<br>If services are denied because they are deemed to be experimental, investigational, or unproven, and the service is then considered an approved service by the claims administrator within six months of the date of service, you may resubmit your claim for payment. |
| **Explanation of Benefits** | An explanation of benefits (EOB) is a statement that the claims administrator prepares, which documents your claims and provides a description of benefits paid and not paid under the Medical Plan. |
| **Home Health Care** | Home health care is an alternative to inpatient hospitalization during a patient's recovery period. If the attending physician believes that part-time care will suffice in treating the sickness or injury, the physician can prescribe a schedule of services to be provided by a state-licensed home health care agency. This schedule may include administration of medication, a regimen of physical therapy, suctioning or cleansing of a surgical incision, the supervision of intravenous therapy or other skilled nursing care. |
| **Hospice Care Program** | A hospice care program is a program that tends to the needs of a terminally ill patient as an alternative to traditional health care, while meeting medically necessary and acceptable standards of quality and sound principles of health care administration. The program must be a written plan of hospice care for a covered person, and it must be approved by the appropriate claims administrator. |
| **Hospital** | A hospital is an institution legally licensed as a hospital — other than a facility owned or operated by the United States government — that's engaged primarily in providing bed patients with diagnosis and treatment under the supervision of licensed physicians. The hospital must have 24-hour-a-day registered graduate nursing services and facilities for major surgery. Institutions that don't meet this definition don't qualify as hospitals. |
| **Hospital Notification** | Hospital notification refers to the requirement under the Medical Plan that you should notify the claims administrator in advance of a non-emergency hospital admission or if a maternity stay exceeds the guidelines. However, you will not be penalized under the Medical Plan if you do not notify the claims administrator. |

**In-Network**

"In-network" describes a covered service that is performed by a physician, hospital, lab, or other health care professional who is part of a health care company's network and who has agreed to pre-negotiated fees. When a service is performed in-network, benefits are generally paid at a higher level than they are when a service is performed out-of-network.

**Medical Reimbursement Account**

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

**Medically Necessary**

Medically necessary (also referred to as "medical necessity") 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.

**Multiple Surgical Procedure Reduction Policy**

The multiple surgical procedure reduction policy applies under the Medical Plan. Surgical procedures that are performed on the same date of service are subject to the multiple surgical procedure reduction policy. On an in-network basis, 100% of the negotiated charges are reimbursable for the primary/major procedure, 50% of negotiated charges are reimbursable for the secondary procedure, and 25% 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.

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| **Non-Duplication of Benefits** | Non-duplication of benefits is a provision that requires that the Medical Plan does not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. You are entitled to receive benefits up to what you would have received under the Medical Plan if it were your only source of coverage, but not in excess of that amount. If you have other coverage that is primary to the Medical Plan, the claims administrator will reduce the amount of coverage that you would otherwise receive under this plan by any amount you receive from your primary coverage. Please see the definition of "Coordination of Benefits" in this section. |
| **Out-of-Network** | "Out-of-network" describes a covered service that is performed by a physician, hospital, lab, or other health care professional who is not part of a health care company's network and who has not agreed to pre-negotiated fees. When a service is performed out-of-network, benefits are generally paid at a lower level than they are when a service is performed in-network and are generally limited to reasonable and customary charges. |
| **Out-of-Pocket Expense** | An out-of-pocket expense is the amount you pay for eligible expenses when you receive treatment. This includes your deductible, your share of the 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 out-of-network services) for medically necessary covered services under the Medical Plan. There are separate in-network and out-of-network out-of-pocket maximums.<br>Once the out-of-pocket maximum is reached, the Medical Plan will pay 100% of negotiated rates for medically necessary covered in-network care and 100% of reasonable and customary (R&C) charges for medically necessary covered out-of-network services for the rest of the year. Under the Medical Plan, amounts above R&C charges for out-of-network care do not count toward your medical out-of-network, out-of-pocket maximum.<br>Please see "Right of Recovery" in the *Plan Administration* section for information on circumstances when you may be required to repay the benefits you've received under the Plan. |
| **Primary Care Physician** | A primary care physician ("PCP") is the network physician who provides or coordinates all the care you receive.<br>Primary care physicians include doctors who practice family medicine, internal medicine*, obstetrics/gynecology, and pediatrics. Care provided by an in-network primary care physician is covered at 100% with a $15 copayment.<br>*Internists must be contracted with Aetna or Cigna as Primary Care Physicians. (A list of doctors who are designated as Primary Care Physicians is available on Aetna or Cigna's websites.) |
| **Primary Plan** | The primary plan is the plan that provides initial coverage to the participant. If the participant is covered under both a JPMorgan Chase Medical Plan option and another plan, the rules of the primary plan govern when determining the coordination of benefits between the two plans.<br>Specific rules may vary, depending on whether the patient is:<br>▪ An employee in active status (or the dependent of an employee); or<br>▪ Covered by Medicare.<br>These rules do not apply to any private insurance you may have. Please see "If You Are Covered by More Than One Health Care Plan" in the *Plan Administration* section for more information. |

**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.)

Any changes you make during the year must be consistent with your QSC. Please see "Changing Your Coverage Midyear," in the *Health Care Participation* section for more information.

**Please Note:** Regardless of whether you experience a QSC, you cannot change your health care company during the year.

**Reasonable and Customary Charges**

Reasonable and customary charges ("R&C charges," also known as "eligible expenses") are the actual charges that are considered for payment when you receive medically necessary care for covered services from an out-of-network provider. R&C means the prevailing charge for most providers in the same or a similar geographic area for the same or similar service or supply. These charges are subject to change at any time without notice.

Reimbursement is based on the lower of this amount and the provider's actual charge.

If your provider charges more than the R&C charges considered under the Plan, you'll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered covered expenses.

Therefore, they don't count toward your deductible, benefit limits, or out-of-pocket maximums.

The reasonable and customary charge does not apply to specific services per the Consolidated Appropriations Act of 2021 (CAA). These include:

- Services provided by certain out-of-network providers at an in-network facility
- Out-of-network air ambulance services
- Out-of-network emergency services

**Regional Cost Category**

The regional cost category is the category that is assigned to a state or region based on the cost of health care for that region in relation to the national average. The Regional Cost Category is used to determine your Medical Plan contributions and is based on your home address.

**Self-Insured**

A self-insured plan is a plan where the sponsor (in the case of the Medical Plan, JPMorganChase) is responsible for the payment of medical claims under the Medical Plan, including the Prescription Drug Plan. This makes the Plan self-insured.

**Skilled Nursing Facility**

A skilled nursing facility is an institution that primarily provides skilled nursing care and related services for people who require medical or nursing care, and that rehabilitates injured, disabled, or sick people.

**Spouse**

Your spouse is the person to whom you are legally married as recognized by U.S. federal law.

If 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 through **My Health**.

**Tobacco-User Surcharge**

The tobacco-user surcharge refers to additional Medical Plan contribution costs for employees and covered spouses/domestic partners who use tobacco products. Eligible employees and covered spouses/domestic partners who do not use tobacco products pay less for coverage under the Medical Plan than those who use tobacco products.

A "tobacco user" (for a plan year), as defined in the Medical Plan, is any person who has used any type of tobacco products (for example, cigarettes, cigars, pipes, chewing tobacco, snuff, or a pipe) regardless of the frequency or location (this includes daily, occasionally, socially, at-home only, etc.) in the 12 months preceding January 1 of the plan year. Tobacco users may be able to qualify for lower non-tobacco user rates by completing a tobacco cessation program (see "Tobacco Cessation Program" on page 45).

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| **Total Annual Cash Compensation** | Total Annual Cash Compensation (“TACC”) is your annual rate of base salary/regular pay plus any applicable job differential pay (e.g., shift pay) as of each August 1, plus any cash earnings from any incentive plans (e.g., annual incentive, commissions, draws, overrides and special recognition payments or incentives) that are paid to or deferred by you for the previous 12-month period ending each July 31. Overtime is not included. It is recalculated as of each August 1 to take effect the following January 1 and will remain unchanged throughout the year. For most employees hired on or after August 1, it will be equal to your annual rate of base salary/regular pay plus applicable job differentials.<br><br>Total Annual Cash Compensation is used for purposes of determining your Medical Plan contribution pay tier, deductible and in-network out-of-pocket maximum. |
| **Visit** | A visit is an encounter with a provider involving direct patient contact. Some benefit provisions limit the number of covered visits. Unless a visit is defined for a particular benefit provision (such as home health care), each procedure code billed counts as a visit toward the limit. The length of a visit may vary by procedure code. |