The Vision Plan

Effective 1/1/25

The JPMorgan Chase Vision Plan ("Vision Plan" or "Plan") helps you and your family pay for covered vision expenses, such as eye exams, prescription glasses (lenses and frames), and contact lenses.

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

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

Questions?

For questions or concerns regarding this Vision Plan, please contact the Plan's claims administrator:

EyeMed Vision Care
(833) 279-4363

Representatives are available Monday through Friday, from 7:30 a.m. to 11 p.m. Eastern Time, Saturday from 8 a.m. to 11 p.m. and Sunday, from 11 a.m. to 8 p.m. Eastern Time.

About This Summary Plan Description

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

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

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

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Vision Coverage Highlights

My Health	**My Health** is your central online resource for our health care plans. From **My Health** you can easily connect to the EyeMed website to find in-network providers, check claims status, and much more.
Your Choices	The JPMorgan Chase Vision Plan lets you choose between an EyeMed network provider and a non-EyeMed network provider each time you need vision services. You will generally pay less for your eye care when you use an EyeMed network provider for two reasons: ▪ EyeMed network provider eye care is generally covered at a higher benefit level than care received through a non-EyeMed network provider; and ▪ EyeMed network providers have agreed to charge negotiated fees for their services and/or eyewear when treating JPMorgan Chase Vision Plan participants.
Your Coverage Level	Your coverage level is based on the dependents you enroll, as shown below: ▪ Yourself only; ▪ Yourself and your spouse/domestic partner, or yourself and your child(ren); or ▪ Your family (yourself, your spouse/domestic partner, and your children).
Disabled Dependents Over Age 26	If you are not enrolled in one of the Medical plans but want to continue coverage for your dependent child over age 26 for the Dental and/or Vision plan, please contact your Medical plan carrier (Aetna or Cigna) to see if they qualify for continued coverage under these plans.
Covered Services	Covered services include all of the following: ▪ Eye exams; ▪ Lenses; ▪ Frames; or ▪ Contact lenses.
Vision Exams Not Covered by JPMC Medical Coverage	Because routine eye exams are not covered under the JPMorgan Chase Medical Plan options, you will need to enroll in the Vision Plan to be covered for routine vision benefits.

Cost of Coverage

You pay the full cost of coverage under the Vision Plan — JPMorganChase does not pay any share of the cost. You pay for coverage in equal installments through payroll contributions with before-tax dollars.

The amount you pay via payroll contributions depends on the “coverage level” you choose (described under “Coverage Levels” in the *Health Care Participation* section).

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

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

Your Cost Is the Full Cost

Unlike medical and dental coverage, with vision coverage, JPMorganChase does not pay for part of the cost of your vision coverage. If you choose to enroll for vision coverage, the cost you pay is the full cost of that coverage.

How Vision Coverage Works

The Vision Plan covers a variety of services. The benefits the Plan provides depend on three things:

- What services or items are covered;
- When you last received benefits for the same service or item; and
- Whether you receive your eye care from an EyeMed network provider or a non-network provider.

What Is Covered

Your out-of-pocket cost depends on how much the Plan will cover for a specific item or service.

- The costs are different, depending on whether you receive your eye care from an EyeMed network provider or a non-EyeMed network provider.
- For non-network care, there may be a dollar reimbursement amount the Plan will pay for that item or service, or no coverage may be allowed. You are responsible for paying:
  - Any amount over the stated reimbursement amount or
  - The full amount if there is no coverage.

When You Last Received Care

For most care, the Plan provides benefits once per item per person per calendar year. For example, the Plan will cover one pair of eyeglasses (lenses and frames) or prescription contacts for you each calendar year, and will provide the same for each of your covered dependents. Some services are subject to different limits, and for some items, discounts are available for same-year items when the full Plan benefit is not available.

Selecting an EyeMed Provider

If you decide to enroll in the Vision Plan and want to use an EyeMed network provider, you can choose a different provider for yourself and for each covered dependent. EyeMed network providers include private practitioners, regional retail locations, online options, as well as the nation's premier retailers, LensCrafters®, Target Optical, and most Pearle Vision locations.

You can easily check which providers participate in the EyeMed network by accessing the Benefits Web Center via **My Health** or the EyeMed website (if you are enrolled in the Vision Plan).

You can also call EyeMed if you need help finding an EyeMed network provider. See the box titled "Questions" at the start of this *The Vision Plan* section on page 1 for contact information.

What the Plan Provides

Exams

For the following exams, each covered individual is limited to one service per calendar year.

Care and Service	In-Network Cost	Non-Network Reimbursement
WellVision Exam® A complete initial vision analysis, which includes a comprehensive visual exam, including the prescription for corrective eyewear and dilation, if necessary	$0 copayment	Reimbursed up to $45
Retinal Imaging Screening An enhancement to the WellVision Exam®.	Up to $39 copayment	No coverage
Standard Contact Lens Fit & Follow-Up Exam* Fitting and evaluation	Copayment of up to $40	No coverage
Premium Contact Lens Fit & Follow-Up	Copayment of up to $55	No coverage

Standard Plastic Lenses

For the following lenses, each covered individual is limited to one set of lenses per calendar year.

Care and Service	In-Network Cost	Non-Network Reimbursement
Standard Plastic Single Vision Lenses Lenses having one part that corrects for either near vision or distant vision	$10 copayment	Reimbursed up to $35
Standard Plastic Lined Bifocal Lenses Lined lenses having one part that corrects for near vision, one for distant vision	$10 copayment	Reimbursed up to $50
Standard Plastic Lined Trifocal Lenses Lined lenses having one part that corrects for near vision, one for intermediate vision, and one for distant vision	$10 copayment	Reimbursed up to $65
Standard Plastic Lenticular Lenses Lenses used to assist post-cataract surgery	$10 copayment	Reimbursed up to $100
Lens Options		
• Standard Progressive Lenses	$65	Reimbursed up to $50
• Premium Progressive Lenses	$95-$185	Reimbursed up to $50
• Standard Polycarbonate Lenses	$0 copayment	Reimbursed up to $21
• Tints (Solid or Gradient)	$0 copayment	Reimbursed up to $11
• Standard Plastic Scratch Coating	$0 copayment	Reimbursed up to $11
• UV Coating	$15 copayment	No coverage

Care and Service	In-Network Cost	Non-Network Reimbursement
• Standard Anti-Reflective Coating	$45 copayment	Reimbursed up to $5
• Premium Anti-Reflective Coating	$57-$85 copayment	Reimbursed up to $5

Frames

For frames, each covered individual is limited to one set per calendar year.

In-Network Cost	Non-Network Cost
$0 copayment; $150 allowance, 20% discount over $150	Reimbursed up to $75

Contact Lenses

Contact lens benefits are limited to one set per calendar year (whether the contacts are conventional, disposable, or medically necessary).

Please Note: Members are not eligible to receive contact **and** eyeglass lenses as covered benefits during the same **calendar year**. Therefore, if you choose contact lenses, you won't be eligible to receive eyeglass lenses as a covered benefit until the following calendar year.

For information on lens fittings and follow-up, please see the Contact Lens Fit & Follow-Up benefits, under "Exams" on page 5.

Care and Service	In-Network Cost	Non-Network Reimbursement
Conventional Contact Lenses	$0 copayment; $150 allowance, member pays 15% of any charge over $150	Reimbursed up to $120
Disposable Contact Lenses	$0 copayment; $150 allowance, member pays 100% of the cost above $150	Reimbursed up to $120
Medically Necessary Contacts (see details, below)	$0 copayment; paid in full	Reimbursed up to $300

Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding — 10D or +10D in meridian powers
- **Keratoconus** mild/moderate — when keratoconus is present and the member's vision is not correctable to $^{20}/_{25}$ in either or both eyes using standard spectacle lenses
- **Keratoconus advanced/ectasia —** when keratoconus is present and one or more specified conditions are met
- **Vision Improvement**: when the member's best correctable distance vision using a standard visual acuity chart can be improved by at least two lines by the use of contact lenses compared to spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers determine that contact lenses are necessary for other eye conditions or visual improvement.

Laser Vision Correction

In-Network Cost	Non-Network Reimbursement
15% off retail price or 5% off promotional prices	Not covered

Low Vision Benefits

When you visit an EyeMed network provider, the Plan may provide certain benefits if you have severe vision problems that are not correctable with regular lenses. To receive benefits, your provider must complete and submit a Low Vision Authorization Form to EyeMed.

The following chart shows how the Vision Plan pays benefits for low vision (in-network only):

Care and Service	Benefits Paid
Low vision aids approved by the claims administrator	Preferred or Non-Preferred Provider: 25% copayment, up to a $1,000 maximum allowance every two years
Supplementary testing approved by the claims administrator (a complete low vision analysis and diagnosis which provides a comprehensive vision exam, including prescription corrective eyewear or other vision aids)	• Preferred Provider: Covered in Full • Non-Preferred Provider: Reimbursed up to $125

Diabetic Eye Care Benefit

Members who have Type 1 or Type 2 diabetes are eligible to receive supplemental coverage for additional services from their vision provider. With this benefit, you can obtain a vision evaluation every six months to monitor for signs of diabetic complications. Subject to provider determination and benefit frequency limitations, you may also receive the following diagnostic testing: Retinal imaging, extended ophthalmoscopy, gonioscopy and laser scanning. If you have questions, please contact EyeMed's Customer Care Center.

Availability of diagnostic equipment and services varies by location. Members are encouraged to call their provider to confirm availability of services.

The following chart shows how the Vision Plan pays benefits for **both** Type 1 and Type 2 diabetes.

Care and Service	In-Network Cost	Non-Network Reimbursement
Office Service Visit (Medical Follow-up Exam)	$20 copayment	$77
Retinal Imaging*	$0 copayment	$50
Extended Opthalmoscopy**	$0 copayment	$15
Gonioscopy	$0 copayment	$15
Scanning Laser	$0 copayment	$33

* Not covered if extended opthalmoscopy is provided within six months.

** Not covered if retinal imaging is provided within six months.

Additional Discounts

Under the Plan, you may receive benefits for eyeglasses (frame and lenses) or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been exhausted. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers
- View additional discounts under Special Offers through EyeMed's website

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

What Is Not *Covered*

While the JPMorgan Chase Vision Plan covers a variety of vision expenses, not all expenses are covered. Benefits paid are subject to certain limitations and maximums set by the claims administrator.

You are responsible for paying the cost of any optional items or services not covered by the Vision Plan.

You are also responsible for payment of any applicable sales tax.

The expenses listed below are not covered. This list of excluded expenses may change at any time.

General Limitations and Exclusions

- Any costs that exceed the allowance;
- Special lens coatings or laminations; and
- Special or designer frames or oversized lenses.

Specific Limitations and Exclusions

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes, or supporting structures*;
- Any eye or vision examination, or any corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Plan;
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Non-prescription lenses and non-prescription sunglasses (except for 20% discount);
- Two pairs of glasses in place of bifocals;
- Refraction, when not provided as part of the comprehensive eye exam;
- Services rendered after the date an Insured Person ceases to be covered under the Plan, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;

- Safety eyewear;
- Solutions, cleaning products or frame cases;
- Services or materials provided by any other group benefit plan providing vision care;
- Certain frames in which the manufacturer imposes a no discount policy; and
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next plan year, when vision benefits would again become available.

* **Please Note:** These expenses may be covered by the JPMorgan Chase Medical Plan. Refer to the *Medical Plan* section for additional information.

Contact Lens Limitation on Prescription Lenses

If you choose contact lenses, you will not be eligible to receive prescription lenses as a covered benefit during the same calendar year.

Claiming Benefits

The following explains when and how to file claims for vision expenses. For more information on your rights with respect to claims, please see the *Plan Administration* section.

How to File Claims

Rules regarding claims depend on whether you receive your eye care from an EyeMed network provider or a non-network provider, as shown below:

Provider	Claims Process
EyeMed Network Provider Benefits	When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).
Out-of-Network Provider Benefits	You must file a claim. You may file electronically through EyeMed's website or you may mail in a claim form. Claim forms are available on **My Health** or through EyeMed's website. You can receive reimbursement up to specific dollar amounts for annual exams and eyewear if you use a non-network provider. You first pay the provider the full cost for services rendered and/or eyewear purchased, and then submit a claim to EyeMed. Please see "Where to Submit Claims" on page 10 for your claim administrator's phone and address information.

To have your claim considered for benefits, you need to file your claim by December 31 of the year following the year in which the services were provided. If you fail to meet this deadline, your claim will be denied. Be sure to attach itemized bills or receipts to your claim form, and keep copies for your records.

Your claim must include your receipts showing:

- An itemized listing of the services received;
- The covered member's name, address, and phone number;
- The covered member's Member ID number;
- The group name (JPMorganChase);

- The patient's name, date of birth, address, and phone number; and
- The patient's relationship to the covered member (such as self, spouse, child, etc.).

Separate claim forms must be submitted for each family member for whom a claim is made. After you submit a claim, you will receive an Explanation of Benefits (EOB) detailing how the benefit was paid.

Where to Submit Claims

First American Administrators (FAA) is the Vision Plan's claims administrator:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

(833) 279-4363

Representatives are available Monday through Friday from 7:30 a.m. to 11 p.m. Eastern time, Saturday from 8 a.m. to 11 p.m. and Sunday, from 11 a.m. to 8 p.m. Eastern time.

Time Frames for Processing Claims

FAA will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Appealing a Claim

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

Help Pursuing Claims

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

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

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

Defined Terms

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

Before-Tax Contributions	Before-tax contributions are contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. Your Medical, Dental, Vision and Spending Accounts Plans' payroll contributions are generally taken on a before-tax basis.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the 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 certain health plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. The *Health Care Participation* section provides details on COBRA coverage.
Coordination of Benefits	Coordination of benefits rules that determine how benefits are paid when a patient is covered by more than one group plan. If you are enrolled in the Vision Plan, EyeMed does not coordinate benefits and always acts as the primary coverage for you and your covered dependents.
Copayment	A copayment (also known as a copay) is the fixed dollar amount you pay toward certain services under the Plan when you receive your care from a network provider.
Covered Services	Covered services are services and procedures that are generally reimbursable by the Plan. While the Plan provides coverage for numerous services and supplies, there are limitations on what's covered. While a service or supply may be necessary, it may not be covered under the Plan. Please see the sections that explain what the Plan covers and what is not covered for more details.
Eligible Dependents	Under the Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see "Your Eligible Dependents" in the *Health Care Participation* section for more information.
Network Provider/Non-Network Provider	"In-network" and "out-of-network" are terms referring to whether a provider is part of the network associated with the Plan (network provider) or is not part of the network (non-network provider). When a service is performed through a network provider, benefits are paid at a higher level than they are when a service is performed through a non-network provider.