The Core Medical Plan

Effective 1/1/21

In addition to providing coverage in the event of illness, the Core Medical Plan (also referred to Medical Plan throughout this document) offers full coverage for eligible preventive care and eligible preventive generic prescription drugs, along with 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 costs. You can earn funds for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in wellness 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 Core Medical Plan. Please retain this section for your records. Other sections may also constitute the complete SPD/plan document, including the *Plan Administration* and the *Health Care Participation* 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.

Two Options

The Medical Plan offers two “Consumer Driven Health Plan” options, and you choose whether your coverage is provided through Aetna or Cigna. Both options offer the same coverage for medically necessary services and supplies, including prescription drugs. The key difference between the two options is the level of payroll contributions versus deductibles and coinsurance maximums.

Here’s how the two Medical Plan options compare:

- Option 1 — Higher medical payroll contributions; lower annual deductibles and annual coinsurance maximums.
- Option 2 — Lower medical payroll contributions; higher annual deductibles and annual coinsurance maximums.

Both Aetna and Cigna have networks of selected health care providers, and you are strongly encouraged to go to in-network providers, as this saves both you and the Medical Plan 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.

The Medical Reimbursement Account

When you enroll in Option 1 or 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 eligible out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments). You can earn Wellness Rewards for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in certain wellness activities.

For Eligible U.S. Employees in Arizona and Ohio, the Simplified Medical Plan

If you are an eligible U.S. employee living in Arizona or Ohio, your JPMorgan Chase medical coverage is available via the Simplified Medical Plan, not the Core Medical Plan. For details, see the Simplified Medical Plan overview.

Our Health Care Companies

JPMorgan Chase 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 one of these health care companies administer your Medical Plan, regardless of whether you choose Option 1 or Option 2.

Provider Directories

You can easily check which health care providers participate in the various JPMorgan Chase Medical Plan options by accessing your health care company's website at **My Health**.

Please Note: You should always check with your health care provider to ensure that he or she plans 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.**

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:

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

Cigna
(800) 790-3086
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. JPMorgan Chase & Co. 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 JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

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Medical 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 carriers' 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

Option 1 and Option 2 of the Medical Plan, each offered through Aetna and Cigna, are "Consumer Driven Health Plan" options. Both options cover the same medically necessary services and supplies, including prescription drugs and pre-existing conditions.

However, Option 1 has higher payroll contributions but generally lower annual deductibles and annual coinsurance maximums, while Option 2 has lower payroll contributions but generally higher annual deductibles and annual coinsurance maximums.

Option 1 and 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 it's not in the network. However, the most cost-effective care will always be available through in-network providers who have agreed to accept pre-negotiated rates.

- Eligible in-network preventive care (including physical exams and recommended preventive screenings) and eligible preventive generic drugs are covered at 100% with no deductible, coinsurance, or copayments.
- **Important**: In-network primary care office visits are covered at 90% with no deductible. 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.
- Virtual doctor visits provide on-demand 24/7/365 access to non-urgent primary care services at 90% with no deductible through a national network of licensed, board-certified, U.S.-based doctors, including pediatricians. Virtual doctor visits with mental health providers are covered at 80% after the deductible.
- When you receive non-primary care medical services, you'll need to satisfy an annual deductible — a set amount that you pay out-of-pocket — before the Plan shares in the cost for care. There are separate deductibles for in- and out-of-network care and for prescription drugs.
- After you satisfy the deductible, the Plan pays a percentage (generally 80% in-network and 50% out-of-network) of the cost. Your share — called coinsurance, the amount you and the Plan pay for certain expenses — after the deductible is typically 20% of the cost of in-network care and 50% of the cost for out-of-network care. The amount of coinsurance you have to pay each year is limited by separate annual in-network and out-of-network coinsurance maximums, which act as a financial "safety net." In-network charges do not apply toward the out-of-network deductible or coinsurance maximum — and vice versa. Benefits for out-of-network care are limited 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. Out-of-network charges are typically higher than the pre-negotiated rates for in-network care. You are responsible for paying any amount above R&C charges.
- If you see an in-network provider, you will generally not have to pay anything at the point of service, and you will not have to file a claim. Your provider will typically submit your claim electronically to your health care company using the information on your ID card.
- Prescription drug benefits are part of your coverage. The Prescription Drug Plan has a different plan design than other Medical Plan features and is subject to a separate deductible and a separate safety net in the form of per-prescription maximums and an annual out-of-pocket maximum.

Your Coverage Level	You can choose to cover: ▪ Yourself only; ▪ Yourself and your spouse/domestic partner; or Yourself and your child(ren); or ▪ Your family (yourself, your spouse/domestic partner, and your children).
Contribution Rates	Contribution rates vary by the types of dependent whom you choose to cover — for example, a spouse/domestic partner vs. a child. You will be charged for up to a maximum of four 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, the 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 Initial Wellness completion status. 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: ▪ Hospitalization; ▪ Surgical procedures; ▪ Physician's office visits; ▪ Lab services/X-rays; ▪ Emergency room services; ▪ Maternity care; ▪ Mental health and substance abuse care; and ▪ Prescription drugs. The Medical Plan also covers various preventive care services. Services and procedures must be considered medically necessary to be covered.
Resources	Resources to help you make health care decisions include: ▪ NurseLine; ▪ Expert Medical Advice; ▪ Health Advocate; ▪ Condition Management; ▪ Treatment Decision Support; and ▪ Maternity Support Program.

Medical Plan Options

The Medical Plan, a "consumer driven health plan" provides two options — Option 1 and Option 2 — offered through Aetna and Cigna. Both options cover the same medically necessary services and supplies, including prescription drugs.

Here's how the two Medical Plan options compare:

- Option 1 — Higher medical payroll contributions; lower annual deductibles and annual coinsurance maximums.
- Option 2 — Lower medical payroll contributions; higher annual deductibles and annual coinsurance maximums.

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

Cost of Coverage

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

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

- The Medical Plan option you choose (described under "Medical Plan Option" on page 54);
- 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 56);
- You and your covered spouse's/domestic partner's Initial Wellness Activity completion status (see "Initial Wellness Activity (New Activity for 2021; Applies to Wellness Activity Completed in 2020)" on page 61);
- Your and/or your covered spouse's/domestic partner's tobacco user status (see "Tobacco User Status" on page 57), and
- Your regional cost category (geographic location) (see "Regional Cost Categories" on page 57).

If you cover your children, you will be charged for up to a maximum of four 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 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 Initial Wellness Activity and/or costs in your geographic area are higher than average.

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.

JPMorgan Chase 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 JPMorgan Chase 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 HR Answers 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 and the annual coinsurance maximum.

Your TACC is:

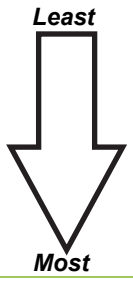
- Your annual rate of base salary plus applicable job differential pay (for example, shift pay) as of each August 1, plus
- Any cash earnings from any incentive plans (for example, annual incentive compensation, commissions, draws, overrides, and special recognition payments or incentives) that are paid 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 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 coinsurance maximum for the next calendar year.

Tier	Total Annual Cash Compensation	Employee Pays
1	< $45,000	
2	$45,000–$59,999	
3	$60,000–$79,999	
4	$80,000–$149,999	
5	$150,000–$249,999	
6	$250,000–$349,999	
7	$350,000 and above	

Initial Wellness Activity

By completing the Initial Wellness Activity during the annual specified time frame, you can save $500 in your annual medical payroll contributions. If you cover your spouse/domestic partner, you can save an additional $500 if your spouse/domestic partner also completes their Initial Wellness Activity during the annual specified time frame. In addition to savings on medical payroll contributions, timely completion of this activity will also earn employees Wellness Rewards in their Medical Reimbursement Account (MRA). There are special provisions for newly eligible members or employees on a leave of absence. For the 2021 plan year, the Initial Wellness Activity is the online Wellness Assessment only. Please see “Initial Wellness Activity (New Activity for 2021; Applies to Wellness Activity Completed in 2020)” on page 61 for more information about the 2021 Initial Wellness Activity and other ways to earn Wellness Rewards for your MRA.

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 JPMorgan Chase 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. 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 course to qualify for the lower non-tobacco user rates. In subsequent 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 on or 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, go to **My Health**.

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. To ensure equity in how the Medical Plan options are priced, JPMorgan Chase 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 55.

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

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)

The Medical Reimbursement Account (MRA) and Wellness

The Medical Plan includes a health reimbursement account, which we call the Medical Reimbursement Account (MRA). This tax-free account will automatically be established on your behalf at your health care company — Aetna or Cigna. Your MRA is completely company-funded; you are not permitted to contribute.

To Check Your MRA Balance

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

You can earn funds, called Wellness Rewards, for your MRA when you take action for your health by completing certain wellness activities. You can also earn Wellness Rewards for your MRA when your covered spouse/domestic partner also completes certain wellness activities.

Wellness Rewards are available through the Wellness Program, which gives you and your covered spouse/domestic partner ways to get and stay healthy. The program provides tailored, personal support to help you make educated health care decisions when you need treatment. In addition to earning Wellness Rewards, you can also save money on your medical payroll contributions by completing the Initial Wellness Activity See “Wellness Activities within the MRA” on page 59 for more information.

You can access all the Wellness Program offerings easily through **My Health > Wellness Activities & Services** or by calling your health care company.

The MRA

You can use the MRA to help pay for covered out-of-pocket medical and prescription drug expenses, such as deductibles, coinsurance, and copayments incurred by you and your covered dependents. **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 JPMorgan Chase employee enrolled in the Medical Plan*; or
- You leave JPMorgan Chase 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 JPMorgan Chase Ends" on page 66).

* If you are an active employee who previously enrolled in the Medical Plan and had an MRA balance but you currently choose not 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.

You can earn up to $1,000 ($1,400 if your covered spouse/domestic partner also participates) in Wellness Rewards for your MRA by completing certain wellness activities in a given year. The following sections summarize the opportunities for 2021 to earn Wellness Rewards.

See "MRA Payment Elections" on page 65 and "Using Your MRA and HCSA to Pay for Services" on page 90 for more information.

Your MRA and/or Spending Accounts (HCSA, DCSA) are administered by your health care company (PayFlex, an Aetna Company or Cigna), or Cigna if you are not enrolled in the JPMC Medical Plan. 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 the April timeframe).

However, if you change health care companies (from Aetna to Cigna or vice versa) because you are a late hire, late year COBRA enrollee or in certain other limited circumstances on or before January 31, of any given year, your associated MRA, HCSA and/or DCSA accounts may 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 automatically. Your new health care company will also create an MRA for you to store 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 health care company.

Wellness Activities within the MRA

This is a summary of the wellness activities that are eligible for Wellness Rewards. Be sure to review the more detailed information about each activity to understand it better, especially when to complete the Initial Wellness Activity to save money on your medical payroll contributions. See the following table for list of activities and amount of MRA funds you can earn.

2021 Wellness Activity	Amount of MRA Funds That Can Be Earned* for Employee's MRA by:		Earn funds up to this many times for each activity in 2021
	You	Your Covered Spouse/ Domestic Partner	
Initial Wellness Activity(see "Initial Wellness Activity (New Activity for 2021; Applies to Wellness Activity Completed in 2020)" on page 61) Complete online Wellness Assessment between Nov 23, 2019 and Nov. 20, 2020 in order to earn MRA funds, see **My Health** for details.			
Online Wellness Assessment	$200 **AND** $500 savings on your medical payroll contributions	$100 **AND** an additional $500 savings on your medical payroll contributions	Once

2021 Wellness Activity	Amount of MRA Funds That Can Be Earned* for Employee's MRA by:		Earn funds up to this many times for each activity in 2021
	You	Your Covered Spouse/ Domestic Partner	
Additional Wellness Activities (between Jan. 1 and Dec. 31)			
	Receive up to a maximum of $800	Receive up to a maximum of $300	
Preventive Care (see page 62)	$200	$100	Once
Achieve a Healthy Body Mass Index (BMI) < 25 OR make progress toward a healthy BMI** (see "Healthy BMI/Progress Toward Healthy BMI*" on page 62)	$200	$100	Once
Achieve a Healthy Blood Pressure of 120/80 or less OR complete an alternative activity** (see "Healthy Blood Pressure or Alternative Activity" on page 62)	$200	$100	Once
Personal Action Call (see page 62)	$50	$50	Once
Health Coaching Programs (telephonic or online) (see page 62)			
Online coaching	$100	$50	Once
Telephonic Coaching	$200	$100	Twice
Maternity Support (see "Maternity Support Program" on page 63)	$200	$100	Once
Condition Management (see page 63)	$300	$150	Twice
Expert Medical Advice (see page 64) Receive funds for completing an expert second medical opinion on a documented diagnosis	$300	$150	Once
Treatment Decision Support (see page 64)	$200	$100	Once
Online Learning Programs			
Choosing Care Wisely (see "Online Learning Programs" on page 64)	$50	$50	Once
Planning Your Finances Wisely (see "Online Learning Programs" on page 64)	$50	$50	Once
meQuilibrium (see page 64)	$100	Not Applicable	Once
Maximum MRA Funds $1,400 if employee and covered spouse/domestic partner complete Initial + Additional Wellness Activities within required timeframes.	$1,000 ($200*** + $800)	$400 ($100*** + $300)	

* Assumes that Wellness Activities are completed as noted above and you are actively employed when MRA funds are distributed

** If it is unreasonably difficult because of a medical condition for you and/or your covered spouse/domestic partner to achieve the standards for the reward under this program, contact your health care company to work with you (and, if you wish, with your doctor) on an alternative.

*** The $200 and $100 amounts shown assumes the online Wellness Assessment was completed between Nov. 23, 2019 and Nov. 20, 2020.

Initial Wellness Activity (New Activity for 2021; Applies to Wellness Activity Completed in 2020)

Online Wellness Assessment

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).

You and your covered spouse/domestic partner (if applicable) must complete the Wellness Assessment between November 23, 2019 and November 20, 2020 at 11:59 pm Eastern time in order to:

- Earn Wellness Rewards in your MRA for 2021 ($200 for you and $100 if covering a spouse/domestic partner); and
- Save $500 in medical payroll contributions ($1,000 if covering a spouse/domestic partner) in 2021.

Employees who become eligible for benefits coverage — and/or add a spouse/domestic partner to medical coverage — after September 1, 2020 will automatically save $500 (or $1,000 if covering a spouse/domestic partner) on both 2020 and 2021 medical payroll contributions without completing the Initial Wellness Activity in 2020. They will have until the 2021 Initial Wellness Activity deadline (to be communicated in 2021) to earn 2021 MRA dollars for completing the Initial Wellness Activity; however, if they complete the Initial Wellness Activity by November 20, 2020, they not only earn Wellness Rewards for their 2020 MRA, but for their 2021 MRA, too.

The **2021** 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 Assessment between November 23, 2019 and November 20, 2020. This means the $500 savings (or $1,000 if you cover a spouse/domestic partner) will be reflected in your 2021 medical payroll contributions. If you and/or your covered spouse/domestic partner didn't complete the Wellness Assessment by the deadline, your medical payroll contributions will increase in February 2021. The $500 or $1,000 increase will be applied in equal installments to each pay from the first effective pay in February 2021 through December 2021.

Note: You have until June 30, 2021, to open a case with your health care company if you believe your online Wellness Assessment was completed by the deadline and not reflected in your medical payroll contributions.

For employees currently on an approved Leave of Absence: You and your covered spouse/domestic partner are encouraged to participate in the Initial Wellness activity. However, if you are on an approved Leave of Absence for at least 45 consecutive days between September 1 and November 20, 2020, and do not complete your online Wellness Assessment during that period, you will not lose the $500 in 2021 medical payroll contribution savings ($1,000 if covering a spouse/domestic partner). Other provisions of the Medical Plan and Wellness Program will continue to apply, including the opportunity to earn MRA funds by completing Additional Wellness Activities.

Additional Wellness Activities

Complete Additional Wellness Activities between January 1 – December 31 and earn up to $800 in your MRA. Your covered spouse/domestic partner can complete Additional Wellness Activities during the same time period, and you will receive up to an additional $300 in your MRA.

Preventive Care

The Medical Plan covers eligible in-network preventive care at 100% with no deductible, coinsurance, or copayments. Out-of-network preventive care is also covered but generally at a higher cost. You and/or your covered spouse/domestic partner can earn Additional Wellness Rewards for completing any of the following age and gender appropriate preventive care services:

- Wellness physical;
- Cervical or prostate screening;
- Mammogram; and
- Colonoscopy.

Healthy BMI/Progress Toward Healthy BMI*

Body mass index (BMI) is one of the numbers that is measured in the Wellness Screening. BMI can be an indicator of overall health. Achieve a BMI under 25 or a weight loss of at least 5% since your last screening and earn $200 in Wellness Rewards.

* If it is unreasonably difficult because of a medical condition for you and/or your covered spouse/domestic partner to achieve the standards for the reward under this program, contact your health care company to work with you (and, if you wish, with your doctor) on an alternative.

Healthy Blood Pressure or Alternative Activity

A Healthy blood pressure is a reading of 120/80 or less.

If your blood pressure is 120/80 or less, you earn $200 in Wellness Rewards.

If your blood pressure is greater than 120/80 but less than 160/100, you can earn $200 in Wellness Rewards in one of two ways:

- You can make an appointment at an onsite JPMC Health & Wellness Center for in-person health coaching regarding your risks for high blood pressure. After completion of your coaching session, the JPMC nurse will notify your health care company that the coaching took place and the health care company will authorize Wellness Rewards for Blood Pressure.
- You can call your health care company (Aetna/Cigna) and complete a Telephonic Health Coaching that will be focused on your blood pressure or a related topic, such as Heart Health. Your health care company will authorize your Wellness Rewards. **Note:** The incentive for completing this Blood Pressure activity will be recorded under Telephonic 'Health Coaching', not Blood Pressure

If your blood pressure is 160/100 or greater, you can still earn $200 in Wellness Rewards by calling your health care company (Aetna/Cigna) to obtain the “Wellness Screening Outcomes Exemption Form” and taking it to your personal health care provider. Your health care provider can determine if medication adjustment or information regarding your blood pressure risks is appropriate for you. They can then complete the form and fax it to your health care company as evidence that you are currently under medical care for your blood pressure. Your health care company will then award Wellness Rewards for Blood Pressure.

Personal Action Call

After you complete a Biometric Wellness Screening (even though not a part of 2021 Initial Wellness Activities), and/or an Online Wellness Assessment you can call your health care company to discuss the results and to learn what tools and resources are available to improve your results.

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, navigate the Wellness Program, 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 (Aetna or Cigna) 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 JPMorgan Chase) may contact you directly.

Please Note: Aetna and Cigna have 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. Keep in mind that you do not have to participate in these programs, but if you don't, you'll miss earning Additional Wellness Rewards.

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 at Aetna and Cigna. 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.

Please see the mycigna.com website through **My Health** (even if you are with Aetna) for a more comprehensive list of the topics that Aetna and Cigna can address through their telephonic and online programs.

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 and enroll in the program within the first trimester of a pregnancy, or within 31 days of the effective date of your Medical Plan coverage, you and your covered spouse/domestic partner can earn Additional Wellness Rewards. **Please Note:** You can enroll in the program anytime throughout your pregnancy to receive support from a health coach, however you will not be incented upon completion of the program if your enrollment is after your first trimester or after 31 days of your enrollment into the Medical Plan. This is a confidential program and JPMorgan Chase will not be notified of your individual enrollment. This program is available only if you are enrolled in the Medical Plan. You will not receive your incentive reward until after you complete your post-partum call.

Contact your health care company to learn more.

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.

Expert Medical Advice

An expert second medical opinion through Grand Rounds 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 only if you are enrolled in the Medical Plan. You or your covered spouse/domestic partner must complete the entire expert second medical opinion process — from medical collection to a written report by the expert — to be eligible for Wellness Rewards in your MRA. Visit www.grandrounds.com/jpmc or call (888) 868-4693.

Treatment Decision Support

The Treatment Decision Support program offers access to registered nurses, or in the case of Grand Rounds, staff clinicians who can help you deal with conditions that have multiple treatment options, such as breast cancer and prostate cancer. 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.

- **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.
- **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.
- **Grand Rounds:** 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.

Contact your health care company or Grand Rounds to learn more.

Online Learning Programs

You can take advantage of health and financial Online Learning Programs:

- Choosing Care Wisely — learn how to become a good health care purchaser. Go to www.mycigna.com (even if you are enrolled with Aetna)
- Planning Your Finances Wisely — learn more about how to be financially well by using tools and resources that JPMorgan Chase provides. Go to www.mycigna.com (even if you are enrolled with Aetna)

meQuilibrium

meQuilibrium is an online and mobile program designed to help you manage stress, feel your best, and become more resilient. It targets your individual stress triggers based on your personalized stress profile. In addition, the program provides a specific set of skills to help you practice behavior changes to stay calm and focused, boost self-confidence, sleep better, work well under pressure, better handle life's competing demands and more. Go to www.mymeQ.com/jpmc. Only employees are eligible to participate in the meQuilibrium program.

Wellness Program If You Do Not Enroll in JPMC Medical Coverage

Employees who do not enroll in the Medical Plan have access to a Wellness Program designed to provide ways to get and stay healthy. The program, which is administered by Cigna, provides tailored, personalized support.

The Wellness Rewards component of the program allows you to earn up to $600 per year by completing certain wellness activities. The Wellness Rewards are paid to you in cash through JPMorgan Chase payroll (this is considered taxable income and will be reported as such).

If you completed an online Wellness Assessment during the annual required time frame, you will earn $200, payable in January if you are actively employed at that time. If you completed the Wellness Assessment but your employment subsequently terminates before the January payroll deposit, you will forfeit the funds.

The Additional Wellness Activities you can complete are:

- Personal Action Call;
- Biometric Guidelines for Body Mass Index and Blood Pressure;
- Preventive Care;
- Telephonic Health Coaching;
- Online Health Coaching;
- Planning Your Finances Wisely
- meQuilibrium.

Wellness Rewards are not available to spouse/domestic partners of employees who do not enroll in the JPMorgan Chase Medical Plan.

Special Rules for Company Couples

If you are covering a spouse/domestic partner who is also a JPMorgan Chase employee (i.e., company couple), they will be incented as a covered spouse/domestic partner and the Wellness Rewards they earn for completing Wellness Activities will be deposited into your MRA. They will not be incented as a waiver (i.e., an employee who chooses not to enroll in the JPMorgan Chase Core Medical Plan).

MRA Payment Elections

During Annual Benefits Enrollment or when you first enroll in Option 1 or 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 default option for new Medical Plan enrollees or
- With a debit card.

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 automatic claim payment method. Your election will remain in effect for future plan years, unless you make a change during a subsequent Annual Benefits Enrollment. (Annual Benefits Enrollment is the only time during the year that you can change your MRA payment election*.) **Please Note:** During 2020, all Aetna enrollees were defaulted to the debit card option and those enrollees will remain in the debit card option unless they elect automatic claim payment during Annual Benefits Enrollment.

* You are eligible for a mid-year payment method change (from automatic claim payment to debit card) if you or your dependent is eligible for a prescription drug co-payment or discount program.

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. 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 90, 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**. Also see the "Automatic Claim Payment vs. Debit Card" tip sheet on **My Health**.)

What Happens to Your MRA If Your Employment with JPMorgan Chase Ends

If your employment with JPMorgan Chase ends and you do not enroll in COBRA or retiree medical coverage you:

- Cannot earn additional Wellness Rewards beyond your termination of employment;
- Can use your remaining MRA balance for covered 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, 2021, you would have until December 31, 2022, to submit an MRA claim for covered expenses incurred during 2021. You will forfeit any remaining MRA funds.
- Will also forfeit any rewards for completing an online Wellness Assessment during the annual required time frame if you don't elect COBRA and remain on COBRA through the January award cycle or enroll in Retiree Medical coverage.

If your employment with JPMorgan Chase 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 Rewards for your MRA as if you were an active employee up to the full annual amount of $1,000 (or $1,400 if you are covering a spouse/domestic partner).
- You qualify as "retired" from JPMorgan Chase (that is, at the time your employment ends with JPMorgan Chase, 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 JPMorgan Chase, 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 Rewards to increase your MRA balance.
- If you are enrolled in COBRA or in the JPMorgan Chase Retiree Medical Plan, the MRA can be used to pay for eligible out-of-pocket medical and prescription drug expenses. You will have to submit your claims for reimbursement.

- If you are covered by another plan, the covered 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 92).
- 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.
- 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 **me@jpmc** or **My Rewards**.

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 (out-of-network deductibles, coinsurance, and copayments) under the Medical Plan. Please see “What Is Covered” on page 96 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 107 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 can be reimbursed for these expenses from a Health Care Spending Account, if you choose to participate in that Plan. Please see the *Spending Accounts* Summary Plan Description on **My Health** for more information.

Other Wellness Programs

In addition to the Wellness Activities and Programs that are associated with the MRA, JPMorgan Chase offers other wellness related benefits to give you and your family more ways to stay healthy. These programs are provided to 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) and Work-Life Program

The Employee Assistance and Work-Life Program (EAP) is available to provide professional, confidential counseling, consultation 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 counseling for topics related to stress, anxiety, depression, marriage, family, relationship issues and more.

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

Employees can receive up to five counseling sessions a year per issue. All services provided by the EAP are free, confidential, and available 24 hours a day, seven days a week. If 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.

Use of the Employee Assistance Program is voluntary and completely confidential as required by law and JPMorgan Chase policy.

When Employee Assistance Program coverage ends for you 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 and Work-Life Program, go to me@jpmc > Health, Life & Parenting > Employee Assistance and Work Life Program > U.S. or call (877) 576-2007 or access the Employee Assistance Program on **My Health >** Wellness Activities & Services.

Tobacco Cessation Program

JPMorgan Chase 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 57 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, JPMorgan Chase provides fully staffed Health & Wellness Centers. These Centers provide:

- Basic medical services;
- Wellness Screenings (see "Wellness Activities within the MRA" on page 59 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 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 JPMorgan Chase Health & Wellness Centers, visit **My Health**.

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

How Your Medical Plan Works

Option 1 and Option 2 pay the same percentage for the same covered expenses (the Plan's "coinsurance" rate). What differs between the two options are the payroll contributions required for each option and the annual deductible and coinsurance maximum values, as explained in the following sections.

The prescription drug plan is the same, regardless of whether you choose Medical Plan Option 1 or Option 2. For a description of coverage for prescription drugs, please see "The Prescription Drug Plan" on page 81.

The Annual Deductible

Under Options 1 and 2, 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 most covered expenses.

Under Options 1 and 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 without having to satisfy the deductible;
- In-network primary care is covered at 90% without having to satisfy the deductible; and
- Virtual doctor visits are covered for approximately $5, before the deductible for primary care services. Mental health virtual visits are covered at 80% after the deductible.
- For more information on what is considered "eligible preventive care" and "primary care," please see the chart under "Coinsurance Paid for Covered Benefits" beginning on page 74.

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 and has separate deductibles from those 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.

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

In- and Out-of-Network Deductibles (Medical Only)				
Coverage Level	**Option 1**		**Option 2**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Total Annual Cash Compensation: less than $60,000				
Employee*	$1,000	$2,750	$2,000	$4,750
Employee + spouse/domestic partner or Employee + child(ren)	$1,875	$4,125	$3,375	$7,125
Family (employee + spouse/domestic partner + child(ren))	$2,750	$5,500	$4,750	$9,500
Total Annual Cash Compensation: $60,000 or more				
Employee*	$1,750	$2,750	$2,750	$4,750
Employee + spouse/domestic partner or Employee + child(ren)	$2,625	$4,125	$4,125	$7,125
Family (employee + spouse/domestic partner + child(ren))	$3,500	$5,500	$5,500	$9,500

* Also functions as a "per person" deductible under the other coverage levels.

If you elect coverage for yourself, you must pay up front for all eligible expenses (except for preventive care and primary care) 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 (please see chart under "Coinsurance Paid for Covered Benefits" beginning on page 74 for the Plan's coinsurance for various expenses).

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. Please see "The Per-Person Deductible and Coinsurance Maximum Provision" on page 71.

The Annual Coinsurance Maximum

Under Options 1 and 2, the annual coinsurance maximum is the maximum amount you must pay in coinsurance in a plan year toward eligible covered expenses.

The coinsurance maximum does not include the deductible, and there are separate coinsurance maximums for in-network and out-of-network charges.

The coinsurance maximum varies based on coverage level and TACC (see definition under "Defined Terms" on page 109), which provides greater financial protection for lower-paid employees, as shown in the following table.

The coinsurance 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 coinsurance maximum is reached, the Medical Plan will pay 100% of negotiated fees for covered in-network care and 100% of the reasonable and customary charges for covered out-of-network services for the rest of the year.

Amounts that you pay toward your medical deductible and amounts above reasonable and customary charges for out-of-network care do not count toward your coinsurance maximum. In addition, prescription drug benefits are subject to a separate out-of-pocket maximum, as explained under "How the Prescription Drug Plan Works" on page 82.

In- and Out-of-Network Coinsurance Maximums (Medical Only, Excludes Deductible and Prescription Drugs)				
	Option 1		Option 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Total Annual Cash Compensation: less than $60,000				
Employee*	$1,000	$6,000	$2,750	$6,000
Employee + spouse/domestic partner or Employee + child(ren)	$1,500	$8,000	$4,125	$8,000
Family (employee + spouse/domestic partner + child(ren))	$2,000	$12,000	$5,500	$12,000

In- and Out-of-Network Coinsurance Maximums (Medical Only, Excludes Deductible and Prescription Drugs)				
	Option 1		Option 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Total Annual Cash Compensation: $60,000-$149,999				
Employee*	$1,500	$6,000	$3,050	$6,000
Employee + spouse/domestic partner or Employee+ child(ren)	$2,250	$8,000	$4,575	$8,000
Family (employee + spouse/domestic partner + child(ren))	$3,000	$12,000	$6,100	$12,000
Total Annual Cash Compensation: $150,000+				
Employee*	$2,250	$6,000	$3,050	$6,000
Employee + spouse/domestic partner or Employee + child(ren)	$3,375	$8,000	$4,575	$8,000
Family (employee + spouse/domestic partner + child(ren))	$4,500	$12,000	$6,100	$12,000

* Also functions as a “per person” coinsurance maximum under the other coverage levels.

The Per-Person Deductible and Coinsurance Maximum Provision

The prior sections describe the deductible and coinsurance maximums — outlining services that are and are not subject to the deductible, as well as the portion the Plan pays in coinsurance and coinsurance maximums established within the Medical Plan.

If you have elected Employee Only coverage, then the deductible and coinsurance descriptions and amounts shown in the chart will apply.

If you cover dependents, the charts under “The Annual Deductible” on page 70 and “The Annual Coinsurance Maximum” on page 70 depict the deductible level and coinsurance maximum levels that apply for that coverage level (i.e., employee plus adult, or family coverage).However, there is also a “per person” rule that allows any single individual (for example, the employee or a covered spouse/domestic partner or child) within a coverage level to reach the individual deductible or coinsurance maximum, after which the deductible or coinsurance maximum is satisfied for the year for that individual.

Covered family members who have not met the deductible or coinsurance maximum may then combine to meet the remainder of the deductible or coinsurance maximum for that coverage level. If no one individual has met the individual deductible or coinsurance maximum, the expenses of all covered members can combine to meet the deductible or coinsurance maximum for that coverage level.

An Example: Amounts Applied Toward In-Network Family Coinsurance Maximum for Medical Plan Option 1 After Deductibles Were Met (Total Annual Cash Compensation < $60,000)	
On behalf of you	$1,000
On behalf of your spouse/domestic partner	$100
On behalf of one child	$50
On behalf of a second child	$50
TOTAL	**$1,200**
In this example, one person has met the $1,000 per-person coinsurance maximum (the employee), and combined coinsurance costs for the family have reached $1,200. Any charges for eligible medically necessary covered services for the employee's care would therefore be reimbursable at 100% for the remainder of the year, even though the family as a whole has not yet met the family coinsurance maximum for the Total Annual Cash Compensation < $60,000 tier ($2,000).	

Note: If your coverage level changes during a calendar year as a result of Qualified Status Change, your annual deductible and/or annual coinsurance 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 Qualified Status Change.

Maximum Lifetime Benefits

There is no dollar limit on the amount Options 1 and 2 would pay for essential benefits while you and your covered dependents are enrolled in the Medical Plan.

However, there is a $10,000 lifetime infertility services maximum provided by the Medical Plan ($30,000 if you and/or your covered spouse/domestic partner receive your care in a Center of Excellence, as explained under "Centers of Excellence (COEs)" on page 80). These amounts do not include the infertility benefit provided by the Prescription Drug Plan.

There is also a lifetime limit of 365 days for in- or out-of-network care in a skilled nursing facility. The infertility services and skilled nursing facility lifetime maximum benefits apply to both in-network and out-of-network care.

An Important Note on the Option 1 and Option 2 Benefit Maximums

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

- Medical Plan Option 1.
- Medical Plan Option 2.

You do not gain a new benefit maximum if you switch your coverage between options or health care companies.

Choosing Between In- and Out-of-Network Care

Under Options 1 and 2 of the Medical Plan, you can choose to see any provider, but 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, the Plan pays a higher rate of coinsurance for in-network care, so your share of charges, if any, is less for in-network care. Lastly, the deductible is lower for in-network care than it is for out-of-network care, so you have to incur less expense before the Medical Plan begins to pay coinsurance for covered expenses.

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 network provider will usually file claims for you.
- 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 fees that are on average lower than the fees charged by doctors outside the network. You cannot be billed for any amounts above those pre-negotiated fees.

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 92 for more information.
- Your out-of-pocket costs for medically necessary covered services generally will be higher than if you received in-network care.

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 by your out-of-network provider 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 deductible or coinsurance maximum.

The Shared Savings Program is a program in which Aetna and Cigna may obtain a discount to an out-of-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 (i.e., coinsurance and deductible) are determined using the reduced charge. In addition, the out-of-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 for either Aetna or Cigna. In some instances, Aetna or Cigna may not obtain a discount. In this case the out-of-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. Out-of-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 JPMorgan Chase 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 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.

Coinsurance Paid for Covered Benefits

The following table shows the coinsurance percentage paid by the Medical Plan on an in-network and out-of-network basis for covered expenses. Please also see "What Is Covered" on page 96 for a more detailed list of covered expenses under the Medical Plan.

Please Note

When you visit an in-network facility for a scheduled surgery, Options 1 and 2 will cover care provided by radiologists, anesthesiologists, and/or pathologists (RAPs) at the in-network percentage of the billed charges, even if the provider is considered an out-of-network provider.

For example, assume you visit an in-network facility for surgery and are treated by an out-of-network anesthesiologist whose charge is $500. The Plan will reimburse you 80% of the reasonable and customary (R&C) amount; if the R&C amount is $500 you would be reimbursed $400; you will be responsible for payment of the remaining $100. Fees for services provided by any other out-of-network specialists who attend to you while you are confined in an in-network facility will be paid at the out-of-network level of benefits. Services performed in an out-of-network facility will be paid at the out-of-network level of benefits.

Covered Benefits: Eligible Preventive Care

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Eligible Preventive Care**		
Please Note: A medical service will only be covered at 100% if it is coded as preventive. Before receiving any service, you should check with your physician to be sure the procedure is considered, and will be submitted to 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 covered at 100% with no deductible.		
Fecal Occult Blood Test	• 100% before deductible • One test per year	• 50% coverage after deductible • One test per year
Immunizations (routine adult and child) (includes immunizations related to travel)	• 100% before deductible	• 50% coverage after deductible
Preventive Sigmoidoscopy/Colonoscopy	• 100% before deductible • One baseline screening and one follow-up screening every five years	• 50% coverage after deductible • One baseline screening and one follow-up screening every five years
Routine Gynecological Exams and Pap Smears	• 100% before deductible • One exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines	• 50% coverage after deductible • One exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Routine Mammography, Prostate Specific Antigen (PSA) Test, and Digital Rectal Exam	• 100% before deductible • Age 40 and over: one exam per year based on age and gender	• 50% coverage after deductible • Age 40 and over: one exam per year based on age and gender
Routine Physical Exams	100% before deductible**	50% coverage after deductible**
Routine Screenings Provided During Pregnancy (For example, gestational diabetes and bacteriuria screenings, as well as items such as certain breast pumps)	100% before 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 the preventive care services covered at 100% under the Plan 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. JPMorgan Chase does not make this determination. For a list of preventive services that are covered at 100%, go to your health care company's website accessible via **My Health > My Medical Plan Website.**

Covered Benefits: Outpatient Services

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Outpatient Services		
Acupuncture Services	80% coverage after deductible	50% coverage after deductible
Cognitive Rehabilitation Therapy (combined in-network and out-of-network limit of 60 visits/calendar year)	80% coverage after deductible	50% coverage after deductible
Convenience Care Clinics	90% coverage before deductible	50% coverage after deductible
Home Health Care (may require precertification; limited to maximum of 200 visits/calendar year; one visit = four hours) See "Mental Health Benefits" on page 80 for more information.	80% coverage after deductible	50% coverage after deductible

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Infertility Services (available to covered members with a medical diagnosis of infertility, as defined by your health care company) Limited to combined in-network and out-of-network maximum of $10,000/lifetime for each covered member** ($30,000 lifetime maximum if a Center of Excellence is used for your treatment, as described under "Infertility Treatment Procedures" on page 105) Separate $10,000 prescription drug benefit; see "What's Covered and Not Covered" on page 86.	80% coverage after deductible; coverage requires you to contact your health care company and receive precertification before obtaining services	50% coverage after deductible; coverage requires you to contact your health care company and receive precertification before obtaining services
Mental Health Care	80% coverage after deductible	50% coverage after deductible
Primary Care Office Visits (to family practitioners, internists, pediatricians, OB/GYNs, and convenience care clinics). Internists must be contracted with Aetna or Cigna as a Primary Care Physician (PCP). Go to Aetna or Cigna's websites through **My Health** to search for PCPs/primary care. (includes tests, injection drugs, supplies, and other services authorized by the Plan and provided during the visit and billed by the Primary Care Physician)	90% coverage before deductible	50% coverage after deductible
Routine eye exams	Not covered	Not covered
Specialist's Office Visits (includes tests, injection drugs, supplies, and other services authorized by the Plan and provided during the visit, consultations, specialist referrals, and second surgical opinions)	80% coverage after deductible	50% coverage after deductible

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Speech, Physical, or Occupational Therapy (combined in-network and out-of-network limit of 60 visits/calendar year per therapy type**; unlimited for those with a mental health diagnosis) See "Mental Health Benefits" on page 80 for more information.	80% coverage after deductible	50% coverage after deductible
Spinal Treatment/Chiropractic Care (coverage ends when medical recovery is achieved, and treatment is for maintenance or managing pain; limited to 20 visits/calendar year including initial consultation**	80% coverage after deductible	50% coverage after deductible
Substance Use Disorder Services	80% coverage after deductible	50% coverage after deductible
Urgent Care Center	80% coverage after deductible	80% coverage after the ***in-network deductible***
Virtual Doctor Visit for medical (non-mental health) services delivered through Teladoc (Aetna) and MDLive (Cigna)	Approximately $5 (90% coverage) before deductible for primary care services. Mental health services are covered at 80% after the deductible.	Not covered

* 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.

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

Covered Benefits: Inpatient Services

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Inpatient Services (precertification recommended, please see "Prior Authorization" on page 79)		
Acute Hospital Care (based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases)	80% coverage after deductible	50% coverage after deductible
Hospice Care	80% coverage after deductible	50% coverage after deductible
Mental Health Care	80% coverage after deductible	50% coverage after deductible

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Skilled Nursing Facility (includes charges for services and supplies provided while patient is under continuous care and requires 24-hour skilled nursing care and room and board; limited to combined in-network and out-of-network maximum of 365 days/lifetime for each covered individual**)	80% coverage after deductible	50% coverage after deductible
Substance Use Disorder Services	80% coverage 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.

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

Covered Benefits: Other Services

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Other Services		
Ambulance Services (for sudden and serious medical conditions approved by your health care company as required for emergency care — also see "If You Need Emergency Care" on page 80)	80% coverage after deductible	80% coverage after the ***in-network deductible***
Emergency Room (for sudden and serious medical conditions approved by your health care company as required for emergency care — also see "If You Need Emergency Care" on page 80) In accordance with applicable regulations, true emergency is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors.	• 80% coverage after deductible for true emergencies**; • 50% coverage after deductible for non-emergencies	• 80% coverage after in-network deductible for true emergencies; • 50% coverage after in-network deductible for non-emergencies; • **Note:** the in-network deductible applies for true emergencies**, rather than the out-of-network deductible

	Plan's Coinsurance Percentage for In-Network Care	Plan's Coinsurance Percentage for Out-of-Network Care*
Durable Medical Equipment and Prosthetics (includes certain*** glucose monitors, insulin pumps and related pump supplies)	80% coverage after deductible	50% coverage after deductible
Prescription Drugs	Please see "The Prescription Drug Plan" on page 81.	
X-rays and Labs (when performed to diagnose a medical problem or treat an illness or injury)	80% coverage 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.

** True emergency as determined based on what a prudent person would consider an emergency, not on the final diagnosis reached by doctors.

*** 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)

Additional Plan Provisions

Prior Authorization

Prior authorization is required for many services and procedures, such as hospital stays and some surgical procedures.

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:** You must obtain prior authorization when an out-of-network provider intends to admit you to an in-network facility or refers you to other in-network providers.

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 claims administrator.

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. 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. Your emergency care will be covered at 80% (assuming you have met the in-network annual deductible) under both Option 1 and Option 2 as long as your health care company approves the care as being required for a true emergency.

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.

If your health care company determines that you did not have a true emergency, the Plan will pay benefits at 50% rather than 80% after meeting the in-network deductible. 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 nearest 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; or
- to a more cost-effective acute care facility (as authorized by the Plan) from an acute facility to the nearest most appropriate sub-acute facility.

Note: The determination of whether the visit was a true emergency and thus whether coverage is at the 50% or 80% level is determined based on what a prudent layperson would consider an emergency, not on the final diagnosis reached by doctors. True emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Centers of Excellence (COEs)

Organ transplants, bariatric surgery, and infertility treatment 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, bariatric surgery or receiving infertility treatment to receive instruction on any required precertification. This applies whether or not you choose a Center of Excellence.

The Medical Plan contains incentives designed to encourage use of COEs for infertility services. Your infertility medical benefit maximum will be increased from $10,000 to $30,000 if you choose a COE for treatment. (**Please Note**: There is a separate $10,000 prescription drug benefit for infertility services.)

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

NurseLine

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 NurseLine. 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, "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, for approximately $5 per virtual visit (before the deductible) for primary care services. Mental health services are covered at 80% after the deductible. Doctors can make diagnoses, provide advice and call in prescriptions to your local pharmacy. Register before you need care: Go to **My Health**.

The Prescription Drug Plan

The Prescription Drug Plan is the same under Option 1 and Option 2 of the Medical Plan and is administered by CVS Caremark. Prescription drug coverage has a separate plan design from the other Medical Plan features, with a separate deductible, copayments, and coinsurance, and a separate "safety net" in the form of per-prescription maximums and an annual prescription drug out-of-pocket maximum. You will receive a separate prescription drug identification (ID) card from CVS Caremark in addition to your Medical Plan ID card.

For Help with the Prescription Drug Plan

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;
- Set up personal email reminders for refills; and
- Print temporary CVS Caremark ID cards.

How the Prescription Drug Plan Works

Highlights of the Prescription Drug Plan are listed below; detailed information follows.

- Free preventive generic drugs. Eligible preventive generic medications are covered at 100% with no deductible, copayments or coinsurance at network pharmacies.
- Separate deductibles and coinsurance maximums than the Medical Plan;
- MRA funds can be used to pay for covered out-of-pocket prescription drug costs;
- Discounted prices that 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;
- Option of having maintenance prescriptions filled through a convenient mail-order program or at a pharmacy;
- 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; and
- 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.

Here is how the Plan generally pays for different types of drugs:

- Free preventive generic drugs. Eligible preventive generic medications are covered at 100% with no deductible, copayments, or coinsurance at network pharmacies.
- Preventive drugs are medications that can help prevent the onset of a condition if you are at risk or help you manage your health if you have a condition. CVS Caremark determines which drugs are considered "preventive generic" drugs. To see a list of drugs in this category, visit CVS Caremark's website accessible via **My Health**.

Please Note: Generic prescription contraceptives are also fully covered with no deductible (as are brand-name, contraceptive drugs for which a generic is not available)

- $10 copayment for non-specialty generic drugs (up to 30-day supply). You pay $10 for non-specialty generic drugs not considered preventive purchased at a network pharmacy. Non-specialty generic drugs are not subject to a deductible. If the cost of a generic drug is less than the $10 copayment, you'll pay the lower amount.
- Annual retail deductible for brand-name and specialty generic drugs. An annual deductible of $100 per individual (with a maximum of $300 per family) applies to brand-name and specialty generic prescriptions filled at retail pharmacies. There is no deductible for non-specialty generic drugs or for 90-day supplies purchased at a CVS retail pharmacy or by mail.
- Coinsurance for brand-name and specialty generic drugs. After you satisfy the retail deductible, you and the Plan share the cost of brand-name and specialty generic drugs through coinsurance.

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.

- Per-prescription maximum. The amount you pay for brand-name and specialty generic drugs each time you fill a prescription is capped by a per-prescription maximum, a safety net that protects against the cost of very expensive drugs. If the coinsurance amount is greater than the per-prescription maximum, you will pay only the amount of the maximum.
- Cost savings for long-term maintenance medications. Maintenance Choice® offers advantageous pricing when you receive 90-day supplies of maintenance medication by mail or pick up your prescription at CVS retail pharmacies, where the same discounts are available. There is no deductible for maintenance medications received through Maintenance Choice®.
- Annual out-of-pocket maximum. The annual out-of-pocket maximum is the overall "safety net" of your prescription drug coverage. The maximum caps your annual cost for covered prescriptions at $1,150 per individual (with a maximum of $2,300 per family), not including the deductible. Once an individual reaches this limit (or once the family meets the family limit), that individual (or family) does not have to pay anything further for covered drugs for the calendar year, regardless of coverage level.
- The out-of-pocket maximum covers all copayments and coinsurance for covered drugs. It does not include the annual deductible for retail prescriptions or costs for non-covered drugs. **Please Note:** The prescription drug out-of-pocket maximum is separate from the Medical Plan's out-of-pocket maximum.
- If you have money in your Medical Reimbursement Account (MRA), those funds are available to offset your share of the cost of your eligible covered medication.
- If you have elected or were assigned 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 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.
  - If you elected autopay during enrollment and subsequently receive a prescription drug coupon or prescription drug copay assistance card, you have the option to switch to debit card mid-year.
- 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.

A Note about Generic vs. Brand-Name Drugs

Many popular brand-name drugs are expected to have a generic version available. Shortly after generic equivalents are introduced, the equivalent brand-name drug will move from preferred to non-preferred status. If you choose to continue to take the brand name drug when the generic is available, you may be subject to a significantly higher cost. Please see "Mandatory Generic Drug Program" on page 88 for more information. You should talk to your doctor to determine whether a generic equivalent is suitable.

How Prescription Drug Benefits Are Paid Under the Medical Plan

Prescription drug coverage has a separate plan design from the other Medical Plan features, with a separate deductible, copayments, and coinsurance, and a separate "safety net" in the form of per-prescription maximums and an annual prescription drug out-of-pocket maximum.

Category	Provisions
Preventive Generic Drugs	100% coverage (deductible does not apply)
Non-preventive Generic Drugs (non-specialty)	30-day supply: $10 or the actual cost of the drug if less than $10; not subject to the deductible 90-day supply: You pay $20 or actual cost of the drug if less than $20; not subject to the deductible

Category	Provisions	
Annual Retail Deductible (retail pharmacy only; waived for non-specialty generic drugs)	Employee only (also serves as a per-person maximum**)	$100
	Employee + spouse/domestic partner or Employee + child(ren)	$200
	Family (employee + spouse/domestic partner + child(ren))	$300
Retail Pharmacy Benefit (up to a 30-day supply) The Retail Pharmacy benefit covers up to a 30-day supply of medication purchased from a network pharmacy.		
• Preferred brand-name and specialty generic coinsurance/per-prescription maximum*	You pay 30% after the deductible, up to a $200 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $200 maximum)	
• Non-preferred brand-name coinsurance/per-prescription maximum*	You pay 45% after the deductible, up to a $250 maximum per-prescription payment (the Plan pays 55% coinsurance plus costs above the $250 maximum)	
Mail Order Pharmacy or CVS Retail Pharmacy/ Maintenance Choice® (up to a 90-day supply; opt-out available)* The deductible does not apply if you fill maintenance medications through Maintenance Choice®. Please see “Details about Maintenance Choice®” on page 85 for more information.		
• Preferred brand-name and specialty generic coinsurance/per-prescription maximum**	You pay 30% up to a $500 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $500 maximum)	
• Non-preferred brand-name coinsurance/per-prescription maximum**	You pay 45% up to a $625 maximum per-prescription payment (the Plan pays 55%coinsurance plus costs above the $625 maximum)	
Annual Out-of-Pocket Maximum (covers copayment/coinsurance expenses for covered eligible prescription drugs; does not include the deductible)	Employee only (also serves as a per-person maximum**)	$1,150
	Employee + spouse/domestic partner or Employee + child(ren)	$1,750
	Family (employee + spouse/domestic partner + child(ren))	$2,300
• **CVS Caremark Excluded Drugs** (Traditional and Specialty)	Not covered; you will pay the full cost for these drugs.	
• **Non-Sedating Antihistamines** (also known as NSAs)	Not covered; you will pay the full cost for these drugs.	

* The Maintenance Choice® program covers 90-day supplies of maintenance medication. There is no deductible for maintenance medications. 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 any CVS retail pharmacy. If you “opt out” out of Maintenance Choice®, your prescription will be subject to the deductible and your costs will generally be higher. Please see “Details about Maintenance Choice®” on page 85.

** 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 continue to take a noncovered 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**.

*** For both the retail deductible and the annual out-of-pocket maximum, the “per person” rule allows the employee or any covered dependent(s) [for example, spouse/domestic partner or child(ren)] to reach an individual deductible or out-of-pocket maximum, after which the deductible or out-of-pocket maximum is satisfied for the year for that person. Covered individuals who have not met the deductible or out-of-pocket maximum may combine to meet the remainder of the deductible or out-of-pocket maximum for that particular coverage level. If no one person has met the individual deductible or out-of-pocket maximum, the expenses of all covered individuals can combine to meet the deductible or out-of-pocket maximum for that coverage level.

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-CVS retail network 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 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 participating network pharmacy (see "Opting Out of Maintenance Choice®" on page 85).

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.

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 CVS retail pharmacy. However, you may "opt out" of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy. You will be subject to the annual retail deductible, and, for 90-day supplies of medication, your per-prescription maximum will be higher, as shown in the following table.

Comparing Per-prescription Maximums Under Maintenance Choice® to Opting Out of Maintenance Choice®

	Maximum per-prescription charge	
	Maintenance Choice® (obtain through mail or at a CVS retail pharmacy)	***Opt Out (obtain prescription at a non-CVS retail in-network pharmacy*)***
Annual Deductible	Not Applicable	$100
Generic non-specialty 90-day supply	$20	$30, after satisfying annual deductible
Preferred brand-name and specialty generic 90-day supply	$500	$600, after satisfying annual deductible
Non-preferred brand-name 90-day supply	$625	$750, after satisfying annual deductible

* Or picking 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-CVS retail in-network pharmacy, visit CVS Caremark's website.

To continue to fill your maintenance medication prescription at a non-CVS 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-CVS 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" under "Filing a Claim for Benefits" on page 92.) 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 common prescription drugs and their coverage status. **Please Note:** This list does not show every drug covered 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 caremark.com.

Prescription Drugs Covered by the Prescription Drug Plan

Drug	Coverage Status
Allergy Serums (oral immunotherapy drugs)	Covered but requires prior authorization
Aspirin	Covered — generic aspirin (81mg only) is fully covered without a deductible as prevention medication 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); 2) for primary prevention of cardiovascular disease and colorectal cancer (Age limit: 50 to 59 years, quantity limit: 100 units per fill) OTC products require prescription
Breast Cancer Drugs	Covered — generic anastrozole, exemestane, raloxifene, and tamoxifen are fully covered without a deductible as part of a treatment therapy for women at risk for breast cancer and/or diagnosed with breast cancer for age 35 or older

Drug	Coverage Status
Contraceptives	Covered — generic prescription contraceptives are fully covered without a deductible, as are brand-name prescription contraceptives for which a generic is not available, such as Lo Loestrin® 24 Fe.* * **Please Note:** If a generic prescription becomes available for a brand-name contraceptive, the generic form of the contraceptive will be fully covered without a deductible, while the brand-name version of the contraceptive would be covered according to the provisions for other brand-name medications (see chart under "How Prescription Drug Benefits Are Paid Under the Medical Plan" on page 83).
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 without a deductible for children age 5 or younger
Infertility Drugs (exclusive of treatment)	Covered up to a $10,000 lifetime maximum (combined Retail Pharmacy Benefit and Maintenance Choice® program) per person
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
Proton Pump Inhibitors (PPIs) (such as Prilosec, Tagamet, and Nexium)	Covered subject to preauthorization, as described under "Coverage for Proton Pump Inhibitors" on page 88
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

Drug	Coverage Status
Mifeprex	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-guostomy and irrigation supplies, other Rx devices)	Not covered
Select Medical Devices and Artificial Saliva products	Not Covered
Vaccines/Toxoids	Not covered (except seasonal flu and COVID-19 vaccines, which 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, 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 per-prescription maximums 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 spouses/domestic partners) 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 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 or coinsurance 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 7 a.m. to 7 p.m. Central time, Monday – Friday, 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.

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, 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 JPMorgan Chase 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 "How to Submit a Claim," on page 94, under "Filing a Claim for Benefits" on page 92.

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 90 (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 at mycigna.com or medical claim forms can be found on **My Health** or on your health care provider's website. You can also be reimbursed from your MRA/HCSA, if applicable, for your out-of-pocket share of the expense. Please see "How to Submit a Claim," on page 94, under "Filing a Claim for Benefits" on page 92 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 or were assigned automatic claim payment or whether you elected the debit card method of payment for your MRA/HCSA. Your health care company manages both your MRA and HCSA accounts.

If You Elected or Were Assigned Automatic Claim Payment	If You Elected 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. Your MRA balance will be used first to cover your share of the cost; you won't need to pay anything. 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. If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost, your health care company will inform your pharmacy. 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. 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. 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. 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 92).

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 94.

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 JPMorgan Chase 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 or were defaulted to 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 your health care company at the number on the back of your ID card or the JPMorgan Chase Health Advocate for help in getting reimbursed for amounts paid out-of-pocket (see "If You Have Questions about a Claim" on page 95).
- 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 94).

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 94) 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, based on whether you have satisfied your deductible and the amount of coinsurance applicable.

- If you elected or were defaulted to 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 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 94).

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 94).

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 94). 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 94).

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 94).

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, 2021, you must file your claim for reimbursement by December 31, 2022. 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 PayFlex, an Aetna Company).

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

Medical Claim Forms

Aetna:

Aetna
P.O. 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

Aetna (PayFlex is an Aetna company):

PayFlex Systems USA, Inc.
P.O. Box 14879
Lexington, KY 40512-4879

Fax: (888) 238-3539

Phone: (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. To do so, please visit the CVS Caremark website and click on “Submit Prescription Claim” on the Plan & Benefits tab. On the mobile app, click “Submit Claims” on the main screen. 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 four 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 $550 remaining in your Health Care Spending Account (HCSA) at the end of the 2020 calendar year will be automatically carried over to the next year. Any amount over $550 in your HCSA, after processing claims for the 2020 year, will be forfeited. If you were previously enrolled in the HCSA and decide not to participate in 2020, any unused amounts under $25 will be forfeited. Even if you do not participate in 2020, amounts of $25 or more will remain available for future eligible health care expenses. 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 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.

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 HR Answers.

What Is Covered

Each of the Medical Plan options cover a wide variety of services, as long as the services are medically necessary (please see the definition of “Medically Necessary” under “Defined Terms” on page 109) and their costs do not exceed reasonable and customary (R&C) charges. (Please see “Defined Terms” on page 109 for the definitions of "Necessary Services" 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 109.

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. JPMorgan Chase 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 (one exam per year);
  - — 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 office visit per year with appropriate laboratory and radiology services);
- — Mammography screenings (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.

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:

- 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 (including initial consultation) 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. (Please see "Mental Health Benefits" on page 80 for more information.) The attending physician must submit a detailed description of the medical necessity and scope of services provided to the claims administrator. The following are covered if ordered by the physician under the home health care plan and provided in the patient's home:
  - 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;
- 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 80 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 80 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 80 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 spouse/domestic partner 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;

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 your medical option's coinsurance percentage amount for the primary or major surgical procedure; and
- 50% of your medical option's coinsurance percentage amount 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 spouse/domestic partner uses a Center of Excellence (COE) 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 the following conditions/surgery: bariatric surgery and organ transplant up to a maximum of $10,000 per covered person per surgery/condition for all transportation and lodging expenses 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.
  - — 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:

Benefit Provision	Coverage under Options 1 and 2
Treatment for a true emergency*; for example, sudden, serious chest pain	80% after in-network deductible
Treatment for an urgent situation that is not a true emergency	80% after in-network deductible
All other treatment; for example, elective surgery scheduled several months in advance	50% after out-of-network deductible

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 92. If you have any questions about benefits while traveling abroad, please call your health care company.

* True emergency as determined based on what a prudent person would consider an emergency, not on the final diagnosis reached by doctors.

- 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 Plan. Contact CVS Caremark for additional information on which insulin pumps are covered under the Prescription Drug Plan.
- External cochlear devices and systems;
- Gender Affirmation Surgery (may be referred to by our healthcare companies as Gender Reassignment Surgery or GRS). To be eligible, the participant must meet certain medically established guidelines that are outlined in your healthcare companies clinical polices (which may align with the WPATH Standards of Care v7), for obtaining the surgery which require the participant to, among other things:

  — Be at least 18 years old;

  — Have a gender identity disorder diagnosis;

  — Have been approved for hormone therapy;

  — Have at least one year's real life experience living in desired gender; and

  — Have two letters endorsing surgery, including one from a mental health provider at the master's degree level.

  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.

  In-network surgery preauthorization is the responsibility of the in-network provider. For out-of-network surgery, you are responsible for preauthorization.
- Hearing aids: reimbursement for up to $3,000 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);

- Athner 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;
- iron lung;
- 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, copayments, and deductible 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)

- 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.

Infertility Treatment Procedures

There are special covered procedures that induce pregnancy but do not treat the underlying medical condition. They include (but are not limited to) artificial insemination and in vitro fertilization. Infertility services are subject to a $10,000 ($30,000 if a Center of Excellence (COE) is used) combined lifetime maximum benefit for each covered individual. This limit applies to all benefits received under the Medical Plan regardless of whether the service was received in-network or out-of-network. Please note: amounts paid by the Plan (not your out-of-pocket expenses) apply to the Lifetime Infertility maximum. This limit does not apply to the services used to determine the initial diagnosis of infertility and/or its cause, which are not subject to the $10,000 ($30,000 if using a COE) benefit maximum. 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 86 for information on a $10,000* lifetime maximum on prescription drugs related to infertility treatment. Please contact your health care company for specific details.

Please Note:

- To receive benefits for infertility services, you must contact your health care company and receive precertification before obtaining services.
- If you use a COE for your treatment, your lifetime infertility benefit maximum will be increased to $30,000. You must complete all program requirements to earn the increase to the benefit maximum. To locate a COE, contact your health care company.

  * The lifetime maximum for prescription drugs under the infertility benefit includes the charges paid by the Plan. Your prescription drug out-of-pocket expenses (dollars you pay towards the deductible, coinsurance/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

Covered individuals with a diagnosis of cancer who are planning cancer treatment, or medical treatment for any condition that is demonstrated to result in infertility, are considered to meet the definition of infertility. Planned cancer treatments include bilateral orchiectomy, bilateral oophorectomy, hysterectomy, and chemotherapy or radiation therapy that is established in the medical literature to result in infertility. To use infertility 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 is limited to:

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

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

Infertility Diagnostic Services

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

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. However, for those individuals with a mental health diagnosis, associated medical treatments subject to visit limits (such as physical, occupational, and speech therapy and home health care services) will not be subject to an annual visit limitation.

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 deductibles and coinsurance.

These limitations are included in the coverage charts earlier in this section. Please see “Mental Health Benefits” on page 80 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.

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;
- 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 109);
- Extended benefit coverage after termination from JPMorgan Chase (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;
- 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 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 Core 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.

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 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) and CVS Caremark for prescription drug coverage.
Coinsurance	Coinsurance is the way you and the Plan share costs for certain covered health care services, generally after you pay any applicable deductible under the Medical and/or Prescription Drug Plan. For 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.
Coinsurance Maximum	The coinsurance maximum is a "safety net" that protects you from having to pay high expenses in the event of a serious medical situation. The coinsurance maximum is the most you would need to pay in a calendar year in addition to the deductible for medically necessary covered services under the Medical Plan. There are separate in-network and out-of-network coinsurance maximums. Once the coinsurance 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 that you pay toward your medical deductible, amounts above R&C charges for out-of-network care, and your deductible, copayments, and coinsurance for prescription drugs do not count toward your medical coinsurance maximum. There is a separate coinsurance maximum for the Prescription Drug Plan. 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.
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.

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 JPMorgan Chase employee, your JPMorgan Chase 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 medications under the Prescription Drug Plan. For example, copayments apply for generic drugs.

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 JPMorgan Chase 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 many expenses. There are separate in-network and out-of-network deductibles. Amounts in excess of reasonable and customary (R&C) charges and ineligible charges do not count toward the deductible. A separate deductible applies for the Prescription Drug Plan.

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.

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: ▪ Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or ▪ Subject to review and approval by any institutional review board for the proposed use; or ▪ The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or ▪ Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed. The claims administrator, in its judgment, may determine an experimental, investigational or unproven service to be covered under the Medical Plan for treating a "life-threatening" sickness or condition if the claims administrator determines that a service: ▪ Is safe with promising effectiveness; ▪ Is provided in a clinically controlled research setting; and ▪ Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. **Please Note:** For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. If services are denied because they are deemed to be experimental, investigational, or unproven, and the service is then considered an approved service by the claims administrator within six months of the date of service, you may resubmit your claim for payment.
Explanation of Benefits	An explanation of benefits (EOB) is a statement that the claims administrator prepares, which documents your claims and provides a description of benefits paid and not paid under the Medical Plan and through any related Medical Reimbursement Account and/or Health Care Spending Account.
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 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 Rewards for your MRA by completing the Initial Wellness Activity and Additional 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 (deductibles, coinsurance, and copayments).

Medically Necessary

Medically necessary health care services and supplies are services or supplies that are determined by the claims administrator in its sole discretion 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 50% of negotiated charges are reimbursable for all subsequent procedures. On an out-of-network basis, 100% of the reasonable and customary (R&C) charges are reimbursable for the primary/major procedure, 50% of R&C charges are reimbursable for the secondary procedure, and 50% of R&C charges are reimbursable for all subsequent procedures. Participants undergoing surgery are urged to discuss this policy with their health care provider.

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, coinsurance, and copayments.
Out-of-Pocket Maximum	The out-of-pocket maximum, under the Prescription Drug Plan, is the maximum amount you would have to pay each year in copayments and coinsurance for prescription drugs. The annual out-of-pocket maximum does not include the deductible. After you reach the annual out-of-pocket maximum, the Prescription Drug Plan would pay 100% of the cost of covered prescription drugs for the remainder of the year. 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. 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 90% of the pre-negotiated fee and is not subject to the deductible. * 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. Specific rules may vary, depending on whether the patient is: ▪ An employee in active status (or the dependent of an employee); or ▪ Covered by Medicare. These rules do not apply to any private insurance you may have. Please see "If You Are Covered by More Than One Plan" in the *Plan Administration* section for more information.
Qualified Status Change	The JPMorgan Chase 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, as determined in the sole discretion of the claims administrator. These charges are subject to change at any time without notice. Reimbursement is based on the lower of this amount and the provider's actual charge. If your provider charges more than the R&C charges considered under the 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 coinsurance maximums.
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, JPMorgan Chase) 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 JPMorgan Chase 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 JPMorgan Chase 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 68).
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. Total Annual Cash Compensation is used for purposes of determining your Medical Plan contribution pay tier, deductible and in-network coinsurance 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.

Your JPMC Benefits Guide

Effective 1/1/21

JPMorgan Chase is committed to providing a comprehensive set of benefits choices to meet different employee needs and lifestyles. In return, we ask our employees to take an active role in designing a personal strategy to help meet their short-term and long-term health care and insurance and retirement savings objectives.

This Guide provides a detailed summary of the Health Care and Insurance Plans for Active Employees of the JPMorgan Chase U.S. Benefits Program. To access the Retirement Savings Plans, you must be on the website at www.jpmcbenefitsguide.com and click on the "Retirement Savings" item in the black horizontal menu bar at the top of the web page. For the plans that are subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), this Guide serves as the summary plan description for those plans. For most of these plans, this Guide is also the plan document.

Print and Web Versions

This Guide is available as a website, at www .jpmcbenefitsguide.com.

The website includes links to PDF versions of each section, through the "Print a Section" page, in case you want to download a section to read it offline.

How This Guide Is Organized

Most of the sections of this Guide describe the details of each benefit plan. Those sections include:

- *Health Care Benefits,* which includes the *Medical*, *Dental*, and *Vision* Plans;
- *Spending Accounts;*
- *Life and Accident Insurance*;
- *Disability Coverage*, which includes the *Short-Term* and *Long-Term Disability* Plans;
- *Other Benefits,* which includes the *Health & Wellness Centers Plan,* the *Fertility Benefits Program,* the *Group Legal Services Plan,* the *Group Personal Excess Liability Plan,* the *Back-Up Child Care Plan,* the *Expatriate Medical and Dental Plans* and the *Hawaii Medical Plan.*

Other sections of the Guide cover information that applies to all or most of the benefit plans. These sections are separated from the specific plan details to minimize repetition and to keep related information together. These sections include:

- *What Happens If …*, which describes how different life events and situations can affect your benefits or provide you with opportunities to adjust your benefits coverage;
- *Plan Administration*, which provides administrative details such as plan numbers and statements of your rights, including your right to appeal, which is required by law; and
- *Contacts*, with a full list of contact details for all of the plans.

The section *About This Guide* provides additional legal information, including information about the role this Guide serves as summary plan descriptions ("SPDs") of the benefit plans.

Retirement Savings

The 401(k) Savings Plan and the Retirement (Pension) Plan summary plan descriptions are available at www .jpmcbenefitsguide.com, as PDFs. The SPDs for those plans are complete in the PDFs, and do not rely on the any of the other sections of this Guide.

Questions?

If you still have questions after reviewing this Guide, there are a number of resources that can provide answers. As a first stop, 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. JPMorgan Chase & Co. 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 JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

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About This Guide

Effective 1/1/21

This Guide serves as the summary plan description (SPD) for the following plans of the JPMorgan Chase U.S. Benefits Program, effective as of January 1, 2021:

- *The JPMorgan Chase Core Medical Plan*
- *The JPMorgan Chase Simplified Medical Plan*
- *The JPMorgan Chase Dental Plan*
- *The JPMorgan Chase Vision Plan*
- *The JPMorgan Chase Spending Accounts*
- *The JPMorgan Chase Basic Life Insurance Plan*
- *The JPMorgan Chase Supplemental Term Life Insurance Plan*
- *The JPMorgan Chase Accidental Death and Dismemberment (AD&D) Insurance Plan*
- *The JPMorgan Chase Business Travel Accident Insurance Plan*
- *The JPMorgan Chase Short-Term Disability Plan*
- *The JPMorgan Chase Long-Term Disability Plan*
- *The JPMorgan Chase Health and Wellness Centers Plan*
- *The JPMorgan Chase U.S. Fertility Benefits Program*
- *The JPMorgan Chase Group Legal Services Plan*
- *The JPMorgan Chase Group Personal Excess Liability Insurance Plan*
- *The JPMorgan Chase Back-Up Child Care Plan*
- *The JPMorgan Chase Expatriate Medical and Dental Plans*
- *The JPMorgan Chase U.S. Retiree Benefits Program (this document does not include information related to the JPMorgan Chase U.S. Retiree Benefits Program; see the PDF available at www .jpmcbenefitsguide.com for the entire SPD for the JPMorgan Chase U.S. Retiree Benefits Program)*
- *The JPMorgan Chase 401(k) Savings Plan (this document does not include information related to the JPMorgan Chase 401(k) Savings Plan; see the PDF available at www.jpmcbenefitsguide.com for the entire SPD for the JPMorgan Chase 401(k) Savings Plan)*

About This Summary

This section summarizes certain information for the health care and insurance plans. Please retain this section for your records. Other sections may be needed in addition to this section to provide a complete summary plan description (SPD) and/or plan document for a plan, including the sections that describe the benefits the plan provides.

These summaries/SPDs/plan documents do not include all of the details contained in the applicable insurance contracts, if any. For plans with applicable insurance contracts, if there is a discrepancy between the insurance contract and the summary/SPD/plan document, the insurance contract will control.

An SPD is a legally required document that provides a comprehensive description of benefit plans and their provisions. The plans include:

- *Plan Administration*
- *What Happens If…*
- *Health Care Participation*
- *COVID-related legislative changes to the Health Care Spending Account and the Dependent Care Spending Account*

Additional Plan Information

Your primary contact for matters relating to plan benefits is each plan's claims administrator or service provider. Contact HR Answers for information about general administration issues such as enrollment and eligibility for the plans.

Your benefits as a participant in the plans are provided under the terms of this document and insurance contracts, if any, issued to JPMorgan Chase. If there is a discrepancy between the insurance contracts and this document, the insurance contracts will control.

Please Note: No person or group (other than the plan administrator for the JPMorgan Chase U.S. Benefits Program) has any authority to interpret the plans (or official plan documents) or to make any promises to you about them. The plan administrator for the JPMorgan Chase U.S. Benefits Program has complete authority in his or her absolute discretion to construe and interpret the terms of the plans and any underlying insurance policies and/or contracts, including the eligibility to participate in the plans, and to make factual determinations.

All decisions of the plan administrator for the JPMorgan Chase U.S. Benefits Program are final and binding upon all affected parties. The plan administrators delegate their discretion to interpret the plans to the claims administrators, and to decide claims and appeals, including making factual determinations, to:

- The claims administrators; and
- The Health and Income Protection Plans Appeals Committee.

No Assignment of Benefits

The plans are used exclusively to provide benefits to you and, in some cases, your survivors. Neither you nor JPMorgan Chase can assign, transfer, or attach your benefits, or use them as collateral for a loan. You may not assign your right to file actions under ERISA regarding the plans, or use power of attorney or similar arrangements for that purpose.

Please Note: You may assign certain employee life insurance benefits and may assign to a health care service provider the right to payment. Please contact HR Answers for more information.

Right to Amend

JPMorgan Chase & Co. expressly reserves the right to amend, modify (including cost of coverage), reduce or curtail benefits under, or terminate the benefit plans and programs at any time for any reason, by act of the Benefits Executive, other authorized officers, or the Board of Directors. In addition, the plans and benefits described in this Guide do not represent vested benefits.

JPMorgan Chase also reserves the right to amend any of the plans and policies, to change the method of providing benefits, to curtail or reduce future benefits, or to terminate at any time for any reason, any or all of the plans and policies described in this Guide.

If you have any questions about this plan, please contact HR Answers.

Not a Contract of Employment

Neither this Guide nor the benefits described in this Guide create a contract or a guarantee of employment between JPMorgan Chase and any employee. JPMorgan Chase or you may terminate the employment relationship at any time.

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. JPMorgan Chase & Co. 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 JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

What Happens If…

Effective 1/1/21

This section describes the impact of certain life changes and events on your JPMorgan Chase Health Care and Insurance Plans for Active Employees benefits. Generally, you make elections once a year during Annual Benefits Enrollment, unless you have a Qualified Status Change (QSC) or other event, such as a change in work status. QSC's are generally legally defined situations. See the following information for types of changes and implications to your benefits. For more information, see the Benefits Status Change Guide on ***My Health*** *> Learn about the JPMC Benefits Program.*

New Dependents Must Be Verified

Please Note: If a QSC results in the ability to add a dependent to your coverage, that dependent is subject to the dependent verification process from JPMorgan Chase or the plans' administrators, to confirm the dependent is eligible.

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. JPMorgan Chase & Co. 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 JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

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Qualified Status Changes (QSCs)

There are many changes in your situation that meet the requirements to be Qualified Status Changes (QSCs). While many of your benefits cannot be changed during the year, if you have a QSC, some benefit changes are allowed.

The following tables summarize the changes that you can make for each event. They are separated into:

- Health Benefits;
- Spending Accounts;
- Life Insurance Benefits; and
- Accident Insurance Benefits.

If You Have an Event…

If you have a QSC, or if you are unclear whether your situation is a QSC, contact HR Answers to get answers on what you can do in your situation.

31-Day Deadline

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 Medical Plan coverage should that dependent pass away within this 90-day period.). Any changes you make during the year must be consistent with the status change. Be sure to take action promptly, so that you don't miss the deadline to make any benefit changes!

Retroactive Payroll Contribution Changes

If a QSC or other permitted plan change results in retroactive changes to payroll contributions, those changes will be reflected on your next administratively available pay.

QSCs for Health Benefits — Medical, Dental, Vision

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner Child
Marriage	Add	Add	Add
Domestic Partner Commitment	Add	Add	Add
Divorce, Legal Separation, or Termination of DP Commitment	Add	Drop	Drop
Death of Spouse/DP	N/A	Drop	Drop
Birth/Adoption/Legal Guardianship	Add	Add	Add
Child Gains Eligibility	Add	Add	Add
DP's Child Becomes Eligible	Add	Add	Add

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner Child
Child Gains Eligibility due to QMCSO	Add	N/A	Add
Child/DP Child no Longer Eligible	N/A	N/A	Drop
Death of Child/DP Child	N/A	N/A	Drop
You or Covered Dependent Gains Other Coverage	Drop/reduce # of dependents	Drop/reduce # of dependents	Drop/reduce # of dependents
You or Covered Dependent Loses Other Coverage	Add	Add	Add
Change in Dependent Care Provider or Fees	N/A	N/A	N/A
Move out of Provider Service Area	Change option	change option	change option

*QSCs for Spending Accounts**

QSC	Health Care Spending Account	Dependent Care Spending Account
Marriage	Begin, increase	Begin, increase, decrease, or stop
Domestic Partner Commitment	Begin, increase	Begin, increase, decrease, or stop
Divorce, Legal Separation, or Termination of DP commitment	Decrease, stop	Begin, increase, decrease, or stop
Death of Spouse/DP	Decrease, stop	Begin, increase, decrease, or stop
Birth/Adoption/Legal Guardianship	Begin, increase	Begin, increase
Child Gains Eligibility	Begin, increase	Begin, increase
DP's Child Becomes Eligible	Begin, increase	Begin, increase
Child Gains Eligibility due to QMCSO	Begin, increase	N/A
Child/DP Child no Longer Eligible	Decrease, stop	Decrease, stop
Death of Child/DP Child	Decrease, stop	Decrease, stop
You or Covered Dependent Gains Other Coverage	N/A	Decrease, stop

QSC	Health Care Spending Account	Dependent Care Spending Account
You or Covered Dependent Loses Other Coverage	Begin, increase	Begin, increase
Change in Dependent Care Provider or Fees	N/A	Begin, increase, decrease, or stop
Move out of Provider Service Area	N/A	N/A

*You can change your Transportation Spending Accounts elections at any time.

QSCs for Supplemental Term Life Insurance Benefits

QSC	Employee	Adult Dependent	Dependent Child/Domestic Partner Child
Marriage	Begin, increase, decrease, or stop	Begin, increase	Begin, increase, decrease, or stop
Domestic Partner Commitment	Begin, increase, decrease, or stop	Begin	Begin, increase, decrease, or stop
Divorce, Legal Separation, or Termination of DP Commitment	Begin, increase, decrease, or stop	Drop	Begin, increase, decrease, or stop
Death of Spouse/DP	Begin, increase, decrease, or stop	Drop	Begin, increase, decrease, or stop
Birth/Adoption/Legal Guardianship	Begin, increase	Begin, increase	Begin, increase
Child Gains Eligibility	Begin, increase	Begin, increase	Begin, increase
DP's Child Becomes Eligible	Begin, increase	Begin, increase	Begin, increase
Child Gains Eligibility due to QMCSO	Begin, increase	N/A	Begin, increase
Child/DP Child no Longer Eligible	Decrease, stop	Decrease, stop	Decrease, stop
Death of Child/DP Child	Decrease, stop	Decrease, stop	Decrease, stop
You or Covered Dependent Gains Other Coverage	Decrease, stop	Decrease, stop	Decrease, stop
You or Covered Dependent Loses Other Coverage	Begin, increase	Begin, increase	Begin, increase
Change in Dependent Care Provider or Fees	N/A	N/A	N/A
Move out of Provider Service Area	N/A	N/A	N/A

QSCs for Accidental Death and Dismemberment (AD&D) Benefits

QSC	Employee	Adult	Child
Marriage	Begin, increase, decrease, or stop	Begin, increase	Begin, increase, decrease, or stop
Domestic Partner Commitment	Begin, increase, decrease, or stop	Begin	Begin, increase, decrease, or stop
Divorce, Legal Separation, or Termination of DP Commitment	Begin, increase, decrease, or stop	Drop	Begin, increase, decrease, or stop
Death of Spouse/DP	Begin, increase, decrease, or stop	Drop	Begin, increase, decrease, or stop
Birth/Adoption/Legal Guardianship	Begin, increase	Begin, increase	Begin, increase
Child Gains Eligibility	Begin, increase	Begin, increase	Begin, increase
DP's Child Becomes Eligible	Begin, increase	Begin, increase	Begin, increase
Child Gains Eligibility due to QMCSO	Begin, increase	N/A	Begin, increase
Child/DP Child no Longer Eligible	Decrease, stop	Decrease, stop	Decrease, stop
Death of Child/DP Child	Decrease, stop	Decrease, stop	Decrease, stop
You or Covered Dependent Gains Other Coverage	Decrease, stop	Decrease, stop	Decrease, stop
You or Covered Dependent Loses Other Coverage	Begin, increase	Begin, increase	Begin, increase
Change in Dependent Care Provider or Fees	N/A	N/A	N/A
Move out of Provider Service Area	N/A	N/A	N/A

You Get Married

Getting married is a Qualified Status Change (QSC) that gives you the opportunity to adjust your coverage in ways consistent with your change in status. For example, you could enroll yourself and/or your new spouse for coverage.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections titled "Changing Your Coverage Midyear" in the plan descriptions

If you are using the change to add a new dependent, you will be required to provide documentation of the new dependent's eligibility for coverage.

You Have or Adopt a Child or Become a Legal Guardian

Having or adopting a child or becoming a legal guardian of a child is a Qualified Status Change (QSC) that gives you the opportunity to adjust your company coverage in ways consistent with your change in status. For example, you could enroll your new child for coverage.

Any changes based on a QSC must be submitted within 31 days of the change in status, but the time available is 90 days when the qualifying event is the birth or adoption of a child. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear." You will be required to provide documentation of the new dependent's eligibility for coverage.

(You will have 90 days from the QSC to add any newly eligible dependents to the JPMC Medical Plan should that dependent pass away within this 90-day period; please contact HR Answers if this situation applies to you.)

If you are using the change to add a new dependent, you will be required to provide documentation of the new dependent's eligibility for coverage.

A Covered Dependent Becomes Ineligible

If your dependent becomes ineligible (such as when a dependent child reaches age 26, for health care coverage), the dependent's coverage will end on the last day of the month in which he or she no longer meets the eligibility requirements. For Supplemental Term Life and AD&D, once your dependent is no longer eligible, it is your responsibility to remove the dependent from your coverage.

When coverage ends, the dependent may have a right to elect COBRA for up to 36 months. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

A covered dependent becoming ineligible is a Qualified Status Change (QSC) that gives you the opportunity to adjust your coverage in ways consistent with your change in status. This means you could cancel company coverage or stop contributions to spending accounts.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear."

You and/or Your Dependents Lose Other Coverage

If you declined company coverage because you had coverage from another source and you lose that coverage, you may be eligible to enroll for company coverage because of your HIPAA Special Enrollment rights. Similarly, if you declined company coverage for an eligible dependent because he or she had coverage from another source and he or she loses that coverage, you may be eligible to enroll your eligible dependent for company coverage because of your HIPAA Special Enrollment rights. See "HIPAA Special Enrollment Rights" in the *Health Care Participation* section for more details.

Both of these situations are Qualified Status Changes (QSCs) that give you the opportunity to adjust your company coverage in ways consistent with your change in status.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear." You will be required to provide documentation of the new dependent's eligibility for coverage.

If you are using the change to add a new dependent, you will be required to provide documentation of the new dependent's eligibility for coverage.

You and/or Your Dependents Gain Other Coverage

Gaining access to other coverage is a Qualified Status Change (QSC) that gives you the opportunity to adjust your coverage in ways consistent with your change in status. This means you could decline company coverage and enroll for the newly available coverage, instead.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled “Changing Your Coverage Midyear.”

You Move

If you move out of your Medical or Dental Plan option service area and your current option is no longer available, you can change Medical and/or Dental Plan option for yourself and your covered dependents. (**Please Note:** In this situation, you will be assigned new coverage by JPMorgan Chase based on your new service area. However, you will have the ability to change this assigned coverage within 31 days of the qualifying event.)

You Divorce, Separate or Terminate a Domestic Partner Relationship

Getting divorced, separated, or terminating a domestic partner relationship is a Qualified Status Change (QSC) that gives you the opportunity to adjust your coverage in ways consistent with your change in status. This means you could decline company coverage or enroll yourself and/or your dependents for coverage if you declined it in the past.

Any changes based on a QSC must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled “Changing Your Coverage Midyear.”

If you are using the change to add a new dependent, you will be required to provide documentation of the new dependent’s eligibility for coverage.

For medical, dental, and vision coverage: If your spouse and/or child(ren) lose medical, dental, or vision coverage because of divorce/separation, they may have a right to elect COBRA for up to 36 months. (Please see “Continuing Coverage Under COBRA” in the *Health Care Participation* section for more information on COBRA.)

If you divorce or become legally separated, certain court orders could require you to provide health care benefits to covered child(ren). JPMorgan Chase is legally required to recognize qualified medical child support orders within the limits of the JPMorgan Chase plans. If you’re a party in a divorce settlement that involves the JPMorgan Chase plans, you should have your attorney contact HR Answers to make sure the appropriate documents are filed and that the court order in question is actually a qualified medical child support order that complies with governing legislation. Please see “Qualified Medical Child Support Orders” in the *Health Care Participation* section for more information.

For the spending accounts: In case of divorce or separation, you can decrease or stop contributions to the Health Care Spending Account and can start, change, or stop contributions to the Dependent Care Spending Account.

For the Life and Accident Insurance Plans: If you divorce or become legally separated, your covered spouse/domestic partner would be ineligible to continue coverage under the JPMorgan Chase Life and Accident Insurance Plans, and coverage would end as of the date of the status change. Your formerly covered spouse/domestic partner can port or convert their dependent Supplemental Term Life Insurance. Accidental Death & Dismemberment insurance may be ported. For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

For the Group Legal Services Plan: If you divorce or become legally separated, coverage for your spouse will end on the date of your divorce or legal separation.

For the Group Personal Excess Liability Plan: If you divorce or become legally separated, coverage for your spouse will end on the date of your divorce or legal separation.

You Pass Away

For medical, dental, and vision coverage, including expatriate coverage: If you pass away while actively employed at JPMorgan Chase, any dependents who were covered under your JPMorgan Chase health care coverage before your death will continue to be covered until the last day of the month in which you pass away. Covered dependents can then elect to continue coverage under COBRA and pay the active employee rate for coverage for up to 36 months of the COBRA period. Dependents must be covered under the Medical Plan at the time of your death to be eligible for COBRA coverage at JPMorgan Chase-subsidized rates. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

In addition, your dependents may be eligible to continue coverage under the Retiree Medical, Dental and/or Vision Plans if, at the time of death:

- You have already met the general eligibility requirements for retirement. (For more information, please see the **As You Leave Guide,** available on **me@jpmc**); or
- You have already met the alternative eligibility requirements for retirement in the event of position elimination. (For more information, please see the **As You Leave Guide** as noted above.); or
- You have 25 years of total service with JPMorgan Chase.

Dependents may continue coverage under the Retiree Medical, Dental and/or Vision Plans as long as they meet the plans' requirements.

For the spending accounts: If you pass away, claims for spending accounts for expenses incurred on or before the date of death can be filed to the appropriate program administrator, please see the *Spending Accounts* section for more details and the appropriate deadlines.

For the Life and Accident Insurance Plans: If you pass away, benefits from the Life and Accident Insurance Plans are paid to the beneficiary named. If a beneficiary has not been named, then the benefits are paid according to the order listed under "Beneficiaries" in the *Life and Accident Insurance* section.

- If your dependents are enrolled for supplemental term life and accidental death and dismemberment (AD&D) insurance when you pass away, they may port their coverage by contacting MetLife, the claims administrator. Your dependents will be directly billed for this coverage. Dependents can also convert their supplemental term life insurance; however, they may not convert AD&D coverage. (Certain states have additional, specific requirements. Please refer to MetLife for state-specific rules.)

For the Group Legal Services Plan: In the event of your death while actively employed by JPMorgan Chase, your dependents have the option to continue their group legal coverage by contacting MetLife Legal Plans within 31 days of the date of your death to extend coverage for an additional 12 months with direct payment to MetLife Legal Plans. Any services in progress at the time of your death will be provided, even if your dependents don't elect to continue coverage.

For the Group Personal Excess Liability Plan: In the event of your death, covered surviving members of the household should contact Arthur J. Gallagher Risk Management Services for instructions on paying the balance due. If payment is not received within 31 days of the date of the letter sent by Arthur J. Gallagher Risk Management Services to the participant's survivor, the policy will be canceled as of the date of your death. The Plan will also cover any legal representative or person having proper temporary custody of the participant's property. Also, coverage will be provided until the end of the policy period or policy anniversary date, whichever occurs first, for any surviving member of your household who is a covered person at the time of death. Premium payments for this coverage apply.

Other Events or Changes

Change in Scheduled Work Hours

This section describes how your benefits are affected if your work status changes but you are still employed by the company. The focus is on changes to your scheduled work hours. A change in work status that changes your eligibility gives you the opportunity to adjust your coverage in ways consistent with your change in status. This means you could decline company coverage or enroll for coverage if you declined it in the past, and can enroll your eligible spouse for coverage. If your spouse has children and they become your eligible dependents, you can also enroll them for coverage.

Any changes must be submitted within 31 days of the change in status. For more information, see the subsections in the plan descriptions titled "Changing Your Coverage Midyear."

Here's how coverage is affected if your schedule changes and you are regularly scheduled to work fewer than 20 hours per week:

- **Your JPMorgan Chase medical, dental, and vision coverage** will end on the last day of the month in which your work status changes and you are then scheduled to work fewer than 20 hours per week. Even if your coverage ends, you may be able to continue medical, dental, and/or vision coverage for a certain period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

  For expatriate coverage, COBRA continuation applies if you are a U.S. home-based expatriate or an expatriate assigned to the United States. Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for COBRA continuation coverage.

- **Your contributions to the Health Care Spending Account** will end on the last day of the month in which your work status changes and you are then scheduled to work fewer than 20 hours per week. In this case, you may continue to make contributions to the Health Care Spending Account on an after-tax basis under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if elected. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

- **Your contributions to the Dependent Care and Transportation Spending Accounts** end on the date your work status changes and you are then scheduled to work fewer than 20 hours per week.

- **For the Basic Life Insurance Plan, Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan:** Your coverage and eligibility will end on the date of your status change and you are then scheduled to work less than 20 hours per week. For more information on when you increase work hours to more than 20 hours, please see the *Life and Accident Insurance* section.
  - — You can convert your basic life insurance to an individual policy within 31 days of your status change date by contacting MetLife, the claims administrator, for a conversion application.
  - — You can port or convert your employee supplemental term life insurance and/or port your AD&D — up to the lesser of five times your eligible compensation or $1 million — through a direct billing arrangement with MetLife. Contact MetLife, the claims administrator, within 31 days of your change in status. If you port your coverage, you may also port dependent coverage. For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

- **For the Business Travel Accident Insurance Plan,** you remain eligible for coverage regardless of your scheduled work hours, if you are otherwise eligible for coverage.

- **Your Health & Wellness Centers Plan coverage** will end on the last day of the month in which your work status changes and you are then scheduled to work fewer than 20 hours per week. Even if your coverage ends, you may be able to continue coverage for a certain period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

- **Your Group Legal Services Plan coverage** will end on the date your work status changes and you are then scheduled to work fewer than 20 hours per week. However, you can continue coverage for additional 12 months by contacting the MetLife Legal Group.
- **Your Group Personal Excess Liability Insurance Plan coverage** will end on the date your work status changes and you are then scheduled to work fewer than 20 hours per week. However, you may continue coverage through the end of year by contacting Arthur J. Gallagher Risk Management.

For information on becoming eligible for benefits due to a work status change, see each specific plan section (e.g., Medical).

You Go on Short-Term Disability Leave

Under the Short-Term Disability Plan, you may have the financial protection of full or partial pay for up to 25 weeks. While you are on a short-term disability leave you may continue many of your elected benefits provided you make the necessary contributions. Benefits that do not continue while you are on short-term disability leave include Business Travel Accident Insurance, the Dependent Care Spending Account, and the Transportation Spending Account.

- **For the Medical Plan, the Dental Plan, the Vision Plan, the Health & Wellness Centers Plan, the Group Legal Services Plan, and the Group Personal Excess Liability Insurance Plan:** For the approved period of your disability leave, you'll remain eligible to be covered under the Medical Plan, the Dental Plan, the Vision Plan, the Health & Wellness Centers Plan, the Group Legal Services Plan, and the Group Personal Excess Liability Insurance Plan, and you will remain eligible to participate in the Health Care Spending Account. JPMorgan Chase will deduct any required contributions for medical coverage from the pay you receive during this period on a before-tax basis for the health care plans and the Health Care Spending Account and on an after-tax basis for the Group Legal Services Plan and the Group Personal Excess Liability Insurance Plan.
  - This medical and dental coverage continuation includes expatriate medical and dental coverage. If you are not receiving pay via Expat Payroll during your leave, JPMorgan Chase will bill you directly for any required contributions.
- **For the Dependent Care Spending Account**, your participation is suspended during a period of paid or unpaid leave.
- **For the Transportation Spending Account**, your participation is terminated during a period of paid or unpaid leave and any unused credits in your account(s) will be forfeited if you do not return to work and reenroll in the Transportation Spending Account. If you know you will be going on a leave, you should change your contribution amount to zero approximately one month before your leave begins in order to avoid forfeiting any contributions. Expenses incurred after your leave begins will not be eligible for reimbursement or payment from your account(s). If you wish to continue participation after you return to active service, you must re-enroll. However if you participated in the "Pay Me Back" option, you have 180 days following the end of any particular benefit month you participated in the program to file claims for reimbursement from your "Pay Me Back" account.
- **For the Basic Life Insurance Plan, Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan:** For the approved period of your disability leave, you'll remain eligible to be covered under the Basic Life Insurance Plan (including Identity Theft (ID) Assistance Program, Travel Assistance and Emergency Evacuation services, funeral concierge services, and SurvivorSupport® financial counseling services), Supplemental Term Life Insurance Plan, and the AD&D Insurance Plan.
  - In the case of the Basic Life Insurance Plan, your eligible compensation is updated as changes occur throughout the year.
- **For the Business Travel Accident Insurance Plan:** While you are on disability leave, your business travel accident insurance will be suspended.

You Go on Long-Term Disability

If you receive long-term disability (LTD) benefits from the JPMorgan Chase Long-Term Disability Plan (LTD Plan), you will continue to be eligible to participate in the following benefits* as long as you continue to make timely premium payments:

- Medical
- Dental
- Vision
- Group Legal
- Group Personal Excess Liability Plan
- Basic Life Insurance (fully paid by JPMC)
- Supplemental Term Life Insurance
- Accidental Death and Dismemberment Insurance

* You can also continue participation in the Health & Wellness Centers Plan.

You'll be eligible to continue these benefit plans at active employee rates for the first 24 months after going on approved LTD (that is, 30 months from the date of disability). The premiums will be converted to a monthly rate, and you will be required to pay for this coverage monthly on an after-tax basis. You will pay for this coverage on a direct-bill basis with JPMorgan Chase's administrator.

If you are an expatriate and you qualify for long-term disability (LTD) benefits from a JPMorgan Chase long-term disability plan, your expatriate assignment will end and, coincidentally, so will your eligibility for the Expatriate Medical and Dental Plan options. You must then elect coverage under your home country Medical and/or Dental Plan options, if available. If you are a U.S. home-based expatriate employee, medical coverage under one of the U.S. domestic options may continue while you are receiving LTD benefits under the U.S. LTD Plan. Be sure to consider this carefully before you decline coverage under the LTD Plan.

In certain cases, you may be temporarily approved for additional leave under another JPMorgan Chase Policy, such as the Disability and Reasonable Accommodation Policy. (For details on medical plan coverage should you become eligible for Medicare during this timeframe, please see "You Are on LTD and Become Eligible for Medicare" on page 19.)

Absent any temporary leave accommodation, your employment with JPMorgan Chase will end immediately after you have received 24 months of payments under the LTD Plan. However, you will continue to be eligible for LTD benefits provided you meet all eligibility provisions of the LTD Plan. Even if your LTD benefits end, you may be able to continue medical, dental, vision, and Health & Wellness Centers coverage for a certain period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

Please Note: If you became disabled before January 1, 2011**,** your coverage will continue at active employee rates while you receive benefits under the Long-Term Disability Plan. If you do not make the required contributions to continue your coverage, your coverage will be canceled.

For the Health Care Spending Account, while you are receiving benefits under the JPMorgan Chase LTD Plan, you may continue to make monthly contributions to the Health Care Spending Account on an after-tax basis via direct bill. Participation in the Health Care Spending Account will cease at the end of the benefit plan year in which you start to receive LTD benefits.

For the Dependent Care Spending Account: For the Dependent Care Spending Account, you may use your account balance only for eligible expenses incurred prior to your LTD effective date and must file those claims by March 31 of the next calendar year.

For the Transportation Spending Account, your participation is suspended and any unused credits in your account(s) will be forfeited if you do not return from LTD. If you know you will be going on a leave, you should change your contribution amount to zero approximately one month before your leave begins in order to avoid forfeiting any contributions. Expenses incurred after your leave begins will not be eligible for reimbursement or payment from your account(s). If you wish to continue participation after you return to active service, you must re-enroll. However if you participated in the "Pay Me Back" option, you have 180 days following the end of any particular benefit month you participated in the program to file claims for reimbursement from your "Pay Me Back" account.

Your Business Travel Accident Insurance Plan coverage does not continue while you are receiving LTD benefits.

You Are on LTD and Become Eligible for Medicare

If you are receiving full long-term disability (LTD) benefits from the JPMorgan Chase Long-Term Disability Plan (LTD Plan), are not actively at work and become eligible for Medicare, Medicare becomes the primary source of your medical coverage. You will no longer be eligible for the active JPMorgan Chase medical coverage. Instead, Medicare-eligible participants have access to individual supplemental Medicare coverage available through Via Benefits, a private Medicare exchange, which is not coverage sponsored by JPMorgan Chase. For those Medicare-eligible individuals who enroll in coverage through Via Benefits and are eligible for a medical subsidy, JPMorgan Chase sponsors the Health Reimbursement Arrangement Plan associated with that coverage. For further details, contact HR Answers.

You Become Eligible for Medicare

If you are a JPMorgan Chase employee enrolled in an active JPMorgan Chase health care plan, such as the Medical Plan, Dental Plan, or Vision Plan, are actively working and you become entitled to Medicare because of your age or a qualifying disability, the JPMorgan Chase plans continue to be the primary source of your coverage. For further details on Medicare, see www.medicare.gov.

You Go on a Military Leave

Your benefits coverage may be affected if you take a military leave (paid or unpaid), as described below. For detailed information about the JPMorgan Chase Military Leave and Reserve Training Policy, please visit **me@jpmc**. In all cases, JPMorgan Chase will comply with legal requirements, including the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Paid Military Leave

If you qualify for a paid military leave, you will be provided with continuation of most benefits. **Please Note**: Certain benefits plans have exclusions for injury or illness that results from an act of war.

Benefits that do not continue while you are on a paid military leave include:

- Business Travel Accident Insurance Plan;
- Transportation Spending Account;
- Long-Term Disability Plan (after 16 weeks of paid military leave); and
- Short-Term Disability Plan.

You may resume your benefits coverage when you return to work. Some of your benefits are reinstated, but for others like the Transportation Spending Account, you must re-enroll. **Please Note:** Evidence of insurability may also be required for some plans.

Unpaid Military Leave

If you qualify for an unpaid military leave, you may continue many of your elected benefits, provided you make the necessary contributions in a timely manner. **Please Note**: Certain benefits plans have exclusions for injury or illness that results from an act of war.

Benefits that do not continue while you are on an unpaid military leave include:

- Business Travel Accident Insurance Plan;
- Dependent Care Spending Account;
- Transportation Spending Accounts;
- Long-Term Disability Plan (after 16 weeks of unpaid military leave); and
- Short-Term Disability Plan.

Making Contributions While on Unpaid Leave

If you wish to continue certain benefits while on any unpaid leave, you must make the necessary contributions on a timely basis, even if you do not receive a bill.

You may resume your benefits coverage when you return to work. Some of your benefits are reinstated, but for others like the Transportation Spending Account, you must re-enroll. **Please Note:** Evidence of insurability may also be required for some plans.

You Go on a Parental Leave

While you are on an approved parental leave, you may continue many of your elected benefits, provided you make the necessary contributions in a timely manner. Benefits that do not continue while you are on a parental leave include Business Travel Accident Insurance, the Dependent Care Spending Account, and the Transportation Spending Accounts.

Generally, if your benefits coverage ended during your leave, you may resume coverage when you return to work.

You Go on Approved Family and Medical Leave

You may continue many of your elected benefits while you are on an approved family and medical leave, provided you make the necessary contributions in a timely manner. Benefits that do not continue while you are on family leave include Business Travel Accident Insurance, the Dependent Care Spending Account, and the Transportation Spending Accounts.

Generally, if your benefits coverage ended during your leave, you may resume your benefits coverage when you return to work.

Special Rules for Health Care Spending Account

Special rules apply to your Health Care Spending Account. When you take a leave covered under the Family and Medical Leave Policy, the entire amount you elected under your Health Care Spending Account will be available to you during your leave period, less any prior reimbursements that you have received for that plan year, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on a leave and you may not receive reimbursement for any health care expenses you incur after your coverage terminated.

If your Health Care Spending Account participation terminates during your leave, your Health Care Spending Account contributions will begin again if you return to work during the same year in which your leave began. You will not be able to submit claims for reimbursement for expenses incurred during your leave, and your contributions will increase to “make up” for the contributions you missed during your leave. The amount available for reimbursement will be the same annual amount you elected before the leave.

You may not use your Health Care Spending Account for expenses incurred during the period you did not participate.

You Go on Unpaid Leave

For medical, dental, and vision coverage: For an approved unpaid leave of absence, the Medical, Dental, and Vision Plans will still cover you, as long as you make any required contributions. You will be directly billed for any required contributions on an after-tax basis. You will also still be covered by the Health & Wellness Centers Plan.

If you do not make the required contributions to continue your coverage in a timely manner, your coverage will be canceled. However, your coverage may be reinstated when you return to work.

For the Health Care Spending and Dependent Care Spending Accounts: During an approved unpaid leave of absence, you may continue to make monthly contributions to the Health Care Spending Account on an after-tax basis, via your benefits invoice. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on a leave and you may not receive reimbursement for any health care expenses you incur after your coverage terminated. You may not make contributions to a Dependent Care Spending Account during an unpaid leave. For the Dependent Care Spending Account, you may use your account balance only for eligible expenses incurred prior to the date of your approval to go on unpaid leave, and must files those claims by March 31 of the next calendar year.

For the Transportation Spending Account, you must disenroll and any unused credits in your account(s) will be forfeited. If you know you will be going on a leave, you should change your contribution amount to zero approximately one month before your leave begins in order to avoid forfeiting any contributions. Expenses incurred after your leave begins will not be eligible for reimbursement or payment from your account(s). If you wish to continue participation after you return to active service, you must re-enroll. However if you participated in the “Pay Me Back” option, you have 180 days following the end of any particular benefit month you participated in the program to file claims for reimbursement from your “Pay Me Back” account.

For life and accident coverage: While you are on an unpaid leave, you will continue to pay your premiums for supplemental term life and AD&D insurance to JPMorgan Chase. Your basic life insurance continues at no cost to you. Your business travel accident insurance will end.

For Group Legal Services Plan coverage, you will be billed monthly to continue coverage.

For Group Personal Excess Liability Insurance Plan coverage, you will be billed monthly to continue coverage.

You Return from a Leave of Absence

If you go on a leave of absence (such as a disability, long-term disability, or paid or unpaid leave) and you return to work in a work status that makes you eligible for benefits, then:

For medical, dental, and vision coverage: The coverage that you had before your leave of absence will be reinstated.

For the Health Care Spending Account (HCSA):

- If you return to work from an unpaid leave of absence in **the same** plan year in which your leave began, before-tax contributions from your pay will automatically continue, and your total remaining amount will be prorated over the remaining pay cycles. If you return to work from a paid leave of absence in the same plan year, there is no interruption to your HCSA contributions while you are on a paid leave.
- If you return to work from **a paid or unpaid leave of absence of absence or a paid or unpaid disability leave** in **a different** plan year than the one in which your leave began, or if **you return to work from a leave in which you were receiving benefits under the JPMorgan Chase Long-Term Disability Plan**, you may enroll in the HCSA within 31 days of the date you return to work.

For the Dependent Care Spending Account (DCSA):

- If you return to work from **a leave of absence (paid or unpaid) or a disability leave (paid or unpaid)** in **the same** plan year in which your leave began, and want to participate in the DCSA, you have 31 days from your return to work date to re-elect to participate in DCSA. Contributions automatically stop when you begin your leave (of any type) and will not start automatically.
- If you return to work from **a paid or unpaid disability leave or other leave of absence** in **a different** plan year than the one in which your leave began, or if **you return to work from a leave in which you were receiving benefits under the JPMorgan Chase Long-Term Disability Plan**, you may enroll in the DCSA within 31 days of when you return from your leave.

For the Transportation Spending Account (TSA): Contributions automatically stop when you begin your leave (of any type). If you return to work from a leave and wish to participate in TSA, you must enroll in this account when you return to work. The effective date of your participation depends on the date of your enrollment. Please wait approximately ten days for your return to work information to reach WageWorks. Changes to your TSA elections become effective as of the first of the month for the following month's expenses (i.e., April deductions for May expenses).

For LTD Benefits:

- If your Total Annual Cash Compensation (TACC) is less than $60,000, you will be reinstated in LTD coverage immediately.
- If your TACC is equal to or greater than $60,000, generally, you have to re-enroll for LTD coverage within 31 days of your return from your leave, and you may be required to provide evidence of insurability (EOI). Your coverage will resume on the first pay cycle after EOI is approved. If you don't re-enroll within 31-days, your next opportunity to enroll will be Annual Benefits Enrollment. Contact HR Answers for specific questions.
  - If you are on an approved medical leave, your LTD coverage remains in effect throughout your leave
  - If you are on a paid parental leave, your LTD coverage ends after 16 weeks
  - If you are on an unpaid leave, your LTD coverage ends after 16 weeks
  - If you are on any other type of nonmedical, paid or unpaid leave, coverage ends after 16 weeks

Total Annual Cash Compensation (TACC)

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.

You Leave JPMorgan Chase

For health care coverage: If your employment with JPMorgan Chase terminates, participation in the Medical, Dental, Vision, and Health & Wellness Centers Plans for you and your covered dependents ends on the last day of the month in which you end active employment. However, you generally will be eligible to continue participation for a certain period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.) The health care plans cannot reimburse expenses incurred after the end of the month in which you leave JPMorgan Chase unless you choose to continue your participation under COBRA or under JPMorgan Chase retiree coverage. For more information, please see the **As You Leave Guide** on **me@jpmc**.

- The provisions noted above for the health care plans also apply to the expatriate medical and dental options. If you are a U.S. home-based expatriate or an expatriate assignment to the U.S., under certain circumstances, you may be eligible to continue participation for a certain period of time under COBRA. Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for COBRA continuation coverage.

For the Health Care Spending Account, if you are participating in the Health Care Spending Account when your employment with JPMorgan Chase ends, you will be covered for eligible expenses incurred in the plan year up to the end of the month in which you terminate. You then have until March 31 of the year following your termination from JPMorgan Chase to submit claims for any eligible expenses incurred during the previous year, up to the end of the month in which you terminate. Expenses incurred after the end of the month in which you leave JPMorgan Chase cannot be reimbursed by the JPMorgan Chase Health Care Spending Account unless you choose to continue your Health Care Spending Account participation under COBRA. By electing continuation coverage under COBRA, you may continue your Health Care Spending Account participation through any month up until the end of the year in which your employment ends, if you make after-tax contributions to the account. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.)

For the Dependent Care Spending Account, if you have a balance remaining in the Dependent Care Spending Account when your employment with JPMorgan Chase ends, you may continue to submit claims against the balance in the account for eligible expenses incurred in the plan year up to your termination date. You then have until March 31 of the year following your termination from JPMorgan Chase to submit claims for any eligible expenses incurred during the previous year, up to your termination date. Expenses incurred after your termination date cannot be reimbursed by the JPMorgan Chase Dependent Care Spending Account. You may not continue to make contributions to the Dependent Care Spending Account after your termination.

For the Transportation Spending Accounts, if you have a balance remaining in the "Pay Me Back" option of the Parking Account when you leave, you may continue to submit claims against the balance in your account for up to 180 days following the end of the benefit month (for example, expenses incurred in January must be claimed by July); otherwise, your Parking Account balance will be forfeited. You may not continue to make contributions to the Transportation Spending Accounts after your termination. If you are planning to leave the company, you should change your contribution amount to zero approximately one month before your departure in order to avoid forfeiting any contributions. The Transportation Spending Accounts, under Section 132 of the Internal Revenue regulations, allow qualified transportation expenses to be excluded from an employee's gross income. Under these regulations, before-tax contributions are non-refundable to the employee under any circumstances including termination of employment.

For the Life and Accident Insurance Plans, if your employment with JPMorgan Chase terminates, active participation in the Business Travel Accident, Basic Life, Supplemental Term Life and AD&D Insurance Plans generally end on the date your employment ends. For more information, please see the *Life and Accident Insurance* section.

- **For Basic Life**, upon receipt of the MetLife conversion package at your home mailing address, and within 31 days of your termination date, you may convert any portion of your Basic Life Insurance to an individual policy by contacting Metropolitan Life Insurance Company (MetLife), the plan administrator. Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will be able to address any questions on how much to convert to an individual policy. MetLife will bill you directly.

If You Port or Convert

For any policies you port or convert, you must designate beneficiaries directly with MetLife.

- **For Supplemental Term Life**, within 31 days of your termination date, you have the option to convert your employee and/or dependent life insurance coverage to an individual life policy or port that coverage following your termination of employment as follows:

  — Employee Supplemental Life Insurance:

  - You may convert the coverage to an individual policy; OR
  - You may port the lesser of your total life insurance in effect at date of termination or up to $2 million (in increments of $25,000)
  - You must provide MetLife evidence of insurability for the additional coverage amount
  - If you are already at the $2 million maximum you may not increase your coverage.

— Dependent Spouse Supplemental Life Insurance:

- You may convert the coverage to an individual policy; OR
- You may port the minimum of $2,500 ($10,000 when porting Dependent Spouse life insurance alone) to a maximum of the lesser of your total dependent spouse life insurance in effect at date of termination, or $300,000.

— Dependent Child Supplemental Life Insurance:

- You may convert the coverage to an individual policy; OR
- You may port your dependent child supplemental life insurance coverage at a minimum of $1,000 to a maximum of the lesser of the total amount in effect at the date of termination or $20,000.

- **For Accidental Death and Dismemberment (AD&D) Insurance:**
  - — You may port up to $2 million of your employee AD&D coverage with Metropolitan Life Insurance Company (MetLife) within 31 days of your termination date.
  - — When you leave JPMorgan Chase, you may increase the amount of your portable AD&D coverage in increments of $25,000, up to a maximum of $2 million. Evidence of Insurability (EOI) may be required.
  - — You may also port any dependent AD&D coverage, but only if you elect to port your employee AD&D coverage.
  - — Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will also be able to address any questions on how much AD&D coverage to port for you and/or your dependents.
  - — When you port your coverage(s), MetLife will bill you directly.
- **For Business Travel Accident Insurance**, you may not convert or port this coverage to an individual policy.
- For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

Porting Versus Converting Insurance Policies

When leaving the company, you may be able to either “port” or “convert” the group insurance policy to an individual policy. Both typically result in higher rates than a group policy, but there are differences.

- When you convert an insurance policy, you are not required to provide proof of insurability to receive coverage. The premium you pay is based on your age at the time of policy conversion.
- When you port a policy, you must provide proof of insurability to receive preferred, or less expensive, premiums. Also, the premiums generally change as you age.

For the Group Legal Services Plan, if your employment with JPMorgan Chase terminates, participation for you and your covered dependents usually ends on your termination date. You have the option to continue coverage by contacting MetLife Legal Plans, the claims administrator, within 31 days of the date your coverage ends and electing to continue the Plan. Currently you can continue the Plan for an additional 12 months with direct payment to MetLife Legal Plans. Any services in progress before your termination date will be provided, even if you don’t continue coverage.

For the Group Personal Excess Liability Plan, if your employment with JPMorgan Chase terminates, participation for you and your covered dependents usually ends on your termination date. While you cannot convert or port your coverage, you may continue your current coverage through the end of the calendar year by paying the balance of the remaining premium in full directly to Arthur J. Gallagher Risk Management Services.

Your Expatriate Assignment Ends

If your expatriate assignment ends, your Expatriate Medical and/or Dental Plan coverage will end on the last day of the month in which your work status changes. If you remain an active JPMorgan Chase employee, you will need to elect coverage under your local/domestic, home-country medical plan and/or dental plan.

You Retire from JPMorgan Chase

For medical, dental, and vision coverage: You need to meet minimum age and service requirements at the time of retirement to be eligible for retiree medical and dental coverage. For vision coverage, you may enroll for retiree vision coverage even if you were not covered under the Vision Plan at the time of your retirement.

- **For expatriate medical and dental coverage**, you must be a U.S. home-based expatriate employee and meet minimum age and service requirements and have active medical coverage at the time of retirement to be eligible for U.S. retiree medical coverage.
- For more information, please see the **As You Leave Guide** on **me@jpmc**.

For the Health Care Spending Account, if you are participating in the Health Care Spending Account when your employment with JPMorgan Chase ends, you will be covered for eligible expenses incurred in the plan year up to the end of the month in which you terminate. You then have until March 31 of the year following your termination from JPMorgan Chase to submit claims for any eligible expenses incurred during the previous year, up to the end of the month in which you terminate. Expenses incurred after the end of the month in which you leave JPMorgan Chase cannot be reimbursed by the JPMorgan Chase Health Care Spending Account unless you choose to continue your Health Care Spending Account participation under COBRA. By electing continuation coverage under COBRA, you may continue your Health Care Spending Account participation through any month up until the end of the year in which your employment ends, if you make after-tax contributions to the account. (Please see “Continuing Coverage Under COBRA” in the *Health Care Participation* section for more information on COBRA.)

For the Dependent Care Spending Account, if you have a balance remaining in the Dependent Care Spending Account when your employment with JPMorgan Chase ends, you may continue to submit claims against the balance in the account for eligible expenses incurred in the plan year up to your termination date. You then have until March 31 of the year following your termination from JPMorgan Chase to submit claims for any eligible expenses incurred during the previous year, up to your termination date. Expenses incurred after your termination date cannot be reimbursed by the JPMorgan Chase Dependent Care Spending Account. You may not continue to make contributions to the Dependent Care Spending Account after your termination.

For the Transportation Spending Accounts, if you have a balance remaining in the “Pay Me Back” option of the Parking Account when you leave, you may continue to submit claims against the balance in your account for up to 180 days following the end of the benefit month (for example, expenses incurred in January must be claimed by July); otherwise, your Parking Account balance will be forfeited. You may not continue to make contributions to the Transportation Spending Accounts after your termination. If you are planning to leave the company, you should change your contribution amount to zero approximately one month before your departure in order to avoid forfeiting any contributions. The Transportation Spending Accounts, under Section 132 of the Internal Revenue regulations, allow qualified transportation expenses to be excluded from an employee’s gross income. Under these regulations, before-tax contributions are non-refundable to the employee under any circumstances including termination of employment.

For the Life and Accident Insurance Plans, if your employment with JPMorgan Chase terminates, active participation in the Business Travel Accident, Basic Life, Supplemental Term Life and AD&D Insurance Plans generally end on the date your employment ends. For more information, please see the *Life and Accident Insurance* section.

- **Retiree Life Insurance Coverage may be available.** You need to meet minimum age and service requirements at the time of retirement to be eligible for retiree medical and dental coverage. For details on the eligibility requirements, please see the **As You Leave Guide** on **me@jpmc**.

- **For Basic Life**, upon receipt of the MetLife conversion package at your home mailing address, and within 31 days of your retirement date, you may convert any portion of your Basic Life Insurance (over the first $10,000) to an individual policy by contacting Metropolitan Life Insurance Company (MetLife), the plan administrator. Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will be able to address any questions on how much to convert to an individual policy. MetLife will bill you directly after you retire.

If You Port or Convert

For any policies you port or convert, you must designate beneficiaries directly with MetLife.

- **For Supplemental Term Life**, within 31 days of your retirement date, you have the option to convert your employee and/or dependent life insurance coverage to an individual life policy or port that coverage following your retirement as follows:
  - Employee Supplemental Life Insurance: You may port up to $2 million of your employee Supplemental Term Life Insurance with MetLife within 31 days of your retirement date.
  - When you retire from JPMorgan Chase, you may increase the amount of your portable employee supplemental life insurance coverage in increments of $25,000, up to a maximum of $2 million. You must provide evidence of insurability for the additional coverage amount. If you are already carrying the maximum amount of coverage, you may not increase your coverage.
  - You have two options for Dependent Supplemental Life Insurance:
    1. If you elect to port your employee supplemental life insurance, you also have the opportunity to port your dependent supplemental life insurance
    2. If you do not elect to port your employee supplemental life coverage but want to continue coverage for your dependents, you must convert your dependent supplemental life insurance to an individual whole life policy
- **For Accidental Death and Dismemberment (AD&D) Insurance:**
  - When you retire from JPMorgan Chase, you may port up to $2 million of your employee AD&D coverage with Metropolitan Life Insurance Company (MetLife) within 31 days of your retirement date.
  - When you leave JPMorgan Chase, you may increase the amount of your portable AD&D coverage in increments of $25,000, up to a maximum of $2 million. You must provide evidence of insurability for the additional coverage amount.
    - If you're age 80 or older, your benefit will be limited to $100,000.
  - You may also port any dependent AD&D coverage, but only if you elect to port your employee AD&D coverage.
  - Financial advisors at Barnum Financial Group (acting on behalf of MetLife) will also be able to address any questions on how much AD&D coverage to port for you and/or your dependents.
  - When you port your coverage(s), MetLife will bill you directly.
- **For Business Travel Accident Insurance**, you may not convert or port this coverage to an individual policy.
- For more details, see the information in each plan description about continuing coverage in the *Life and Accident Insurance* section.

For the Health & Wellness Centers Plan, if you retire from JPMorgan Chase, your Health & Wellness Centers Plan coverage will end on the last day of the month in which you retire. However, you generally will be eligible to continue participation for a certain period of time under COBRA, if elected. (Please see "Continuing Coverage Under COBRA" in the *Health Care Participation* section for more information on COBRA.) For more information, please see the **As You Leave Guide** on **me@jpmc**.

For the Group Legal Services Plan, if you retire from JPMorgan Chase, coverage for you and your covered dependents ends on your retirement date. Any services in progress before your termination date will be provided, even if you don't continue coverage. For more information, please see the **As You Leave Guide** on **me@jpmc**.

For the Group Personal Excess Liability Insurance Plan, if you retire from JPMorgan Chase, coverage for you and your covered dependents ends on your retirement date. You are eligible to continue your participation through the end of the policy year in which you retire, provided you pay the balance of the policy in full. After your employment ends, Arthur J. Gallagher & Co., the plan administrator, will contact you with instructions for continuing your coverage and paying the balance. If your payment is not received within 31 days, your policy will be cancelled effective as of your retirement date. For more information, please see the **As You Leave Guide** on **me@jpmc**.

You Work Past Age 65

For the spending accounts: If you continue to work for JPMorgan Chase after you reach age 65, you can continue participating in the spending accounts, as long as you meet all the other eligibility requirements to participate.

For Life and Accident Insurance Plans: If you continue to work for JPMorgan Chase after you reach age 65, you may continue to participate in the Life and Accident Insurance Plans, as long as you are actively employed and meet all eligibility requirements.

- If you continue working after age 75, AD&D coverage is limited to no more than $200,000 beginning the January 1 after the year in which you reach age 75, and is reduced to a maximum of $100,000 beginning the January 1 after the year in which you reach age 80. This limitation also applies to your spouse/domestic partner.

For the Health & Wellness Centers Plan: If you continue to work for JPMorgan Chase after you reach age 65, you may continue to participate in the Health & Wellness Centers Plan, as long as you are actively employed and meet all eligibility requirements.

For the Group Legal Services Plan: If you continue to work for JPMorgan Chase after you reach age 65, you and your covered dependents can continue to be covered under the Group Legal Services Plan.

For the Group Personal Excess Liability Plan: If you continue to work for JPMorgan Chase after you reach age 65, you may continue to participate in the Plan, as long as you are actively employed and meet all eligibility requirements.

Health Care Benefits

Effective 1/1/21

Your health is important to you and to JPMorgan Chase . That's why the company provides you and your family with access to high-quality, cost-effective health care coverage and to the resources you need to stay healthy.

Our health benefit plans are built on the principle of a shared commitment to health.

- *JPMorgan Chase provides valuable benefits, funding, and a suite of features designed to help you get and pay for the care you need, manage your health care expenses, and, most importantly, take care of yourself and your family.*
- *Your role is to take responsibility for the controllable aspects of your health and your spending on health care. You can do this by staying informed about healthy lifestyle choices, getting preventive care, carefully selecting your doctors and hospitals, and understanding your treatment options and their costs before receiving services.*

How This Section Is Organized

This *Health Care Benefits* section has separate subsections for:

- The Medical Plan (including prescription drugs, the Medical Reimbursement Account (MRA), the U.S. Fertility Benefits Program, and wellness benefits);
  - For eligible employees in the United States, the plan has two options: the Simplified Medical Plan for employees in Arizona and Ohio and the Core Medical Plan for all other U.S. employees.
- The Dental Plan; and
- The Vision Plan.

Because these three plans have the same rules about who is eligible, how you enroll, what happens when coverage ends, and COBRA information there is a separate subsection called *Health Care Participation* that covers those rules.

COBRA Continuation

The health plans described in this section are subject to special rules that can offer you an opportunity to continue coverage under JPMorgan Chase 's plans even when coverage for you or a dependent would otherwise end. See "Continuing Coverage Under COBRA" in the *Health Care Participation* section for details.

Health Care Participation

Effective 1/1/21

This section describes the general guidelines for participating in the JPMorgan Chase Medical, Dental and Vision Plans (the "Plans"). Participating in the Plans and their programs is optional — the choice is yours!

Be Sure to See *What Happens If…*

This section covers information about topics such as who is eligible, how to enroll, when you can change your coverage, when coverage ends, and opportunities to continue your coverage after it ends.

Be sure to also see the *What Happens If …* section, which describes how a wide variety of life events and situations can affect your benefits and/or give you an opportunity to adjust your coverage.

About This Summary

This section summarizes eligibility, enrollment and other participation information for the Medical, Dental and Vision Plans. Please retain this section for your records. Other sections may be needed in addition to this section to provide a complete summary plan description (SPD) and/or plan document for a plan, including the sections that describe the benefits the plan provides and Plan Administration.

These summaries/SPDs/plan documents do not include all of the details contained in the applicable insurance contracts, if any. For plans with applicable insurance contracts, if there is a discrepancy between the insurance contract and the summary/SPD/plan document, the insurance contract will control.

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. JPMorgan Chase & Co. 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 JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

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Who's Eligible?

In general, you are eligible to participate in the Medical, Dental, and Vision Plans if you are:

- Employed by JPMorgan Chase & Co., or one of its subsidiaries that has adopted the Plan, on a U.S. payroll and you are subject to FICA taxes;
- Paid hourly, salary, draw, commissions, or production overrides; and
- Regularly scheduled to work 20 or more hours per week.

Who's Not Eligible

An individual who does not meet the criteria under "Who's Eligible?" as well as an individual classified or employed in a work status other than as a common law salaried employee by his or her employer is not eligible for the Medical, Dental and Vision Plans, regardless of whether an administrative or judicial proceeding subsequently determines this individual to have instead been a common law salaried employee.

Examples of such individuals include an:

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

When You Become Eligible

Employees are eligible to participate in the Medical, Dental and Vision Plans as follows:

- If you are a full-time employee (regularly scheduled to work 40 hours per week), you are eligible to join the Plans on the first of the month after your date of hire.
- If you are a part-time employee (regularly scheduled to work at least 20 but less than 40 hours per week), you are eligible to join the Plans on the first of the month after 60 days from your date of hire.

Eligible Dependents

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

Your eligible dependents under the Medical, Dental and Vision Plans — and under certain other plans as reference in those plan sections of this Guide — include:

- Your spouse or domestic partner (see "Domestic Partners" on page 33 for more information); and
- Your and/or your spouse's/domestic partner's children up to the last day of the month in which they reach age 26*, regardless of student or marital status, financial dependence on parents, residency with parents, or eligibility for coverage under another health plan. To cover your domestic partner's children, you must elect coverage for your domestic partner.

* Newly hired employees wishing to enroll their disabled dependent who is over the age of 26 in the medical plan can do so by contacting HR Answers for assistance in completing the disabled dependent enrollment process.

Please Note: You may continue coverage beyond age 26 for an unmarried child who is enrolled at the time of turning age 26 in that benefit and is deemed unable to support himself or herself because of a mental or physical disability that began before age 26 and who depends on you for financial support. Contact your health care company* for more information and specific requirements before your dependent turns 26. To continue coverage for a disabled dependent, that dependent must be enrolled in the Plan prior to turning age 26.

* 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 Aetna to see if they qualify for continued coverage under these plans.

Important Note on Dependent Eligibility

You are responsible for understanding the dependent eligibility rules applicable to each Plan and abiding by them. Each year during Annual Benefits Enrollment, you must review your covered dependents and confirm that they continue to meet the eligibility requirements. It is important that you review both the dependent eligibility rules and the status of your dependents on file, and make any necessary adjustments during your enrollment period or within 31 days of a Qualified Status Change (QSC), 90 days if the qualifying event is the birth or adoption of a child.

The benefits you elect will be effective the date of the event. (**Please Note:** You will have 90 days from the QSC date to add any newly eligible dependents to the Medical Plan, including add and then removing that dependent should that dependent pass away within this 90-day period.). For more information on QSCs, see "Changing Your Coverage Midyear" on page 38. JPMorgan Chase reserves the right to conduct eligibility verifications on existing dependents at any time. If you fail to provide satisfactory proof (when requested) that your covered dependents meet the current eligibility requirements, you could face penalties ranging from loss of coverage for your dependents to termination of employment.

Within 30 days of adding a new dependent, a mailing will be sent to your home address on file with JPMC requesting materials to verify your dependent's eligibility (that is, birth certificate, marriage license, etc.). You must supply acceptable supporting documents and sign and return the supplied Confirmation of Eligibility within 60 days. If you fail to provide satisfactory proof that your dependent(s) meet the current eligibility requirements, your dependent's coverage will be terminated and you will be responsible for any claims paid by the Medical, Dental and Vision Plans.

For a listing of acceptable documentation to establish proof of your dependents' eligibility for coverage under the JPMorgan Chase U.S. Benefits Program, please see **Dependent Eligibility Requirements** on **My Health**.

Spouse

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

If JPMorgan Chase employs your spouse, domestic partner, or child, he or she can enroll in coverage as an employee in their own eligible coverage 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 JPMorgan Chase 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**.

* Except for the Supplemental Term Life Insurance Plans. If your spouse is also a JPMorgan Chase employee, he or she can elect Employee Supplemental Term Life Insurance coverage as an employee and be also covered as your spouse under the Dependent Supplemental Term Life Insurance Plan.

Children

"Children" include the following:

- Your natural children;
- Your stepchildren (children of your current spouse);
- Children of your domestic partner (if your domestic partner is also enrolled in the Plan);
  - If you are covering the child of a domestic partner who is not your tax dependent, imputed income for that child will be applied.

- Your legally adopted children;
- Your foster children;
- Children under your legal guardianship (as established by a court order) whom you claim on your income tax return as dependents or for whom you provide more than 50% of their financial support;
- A child under age 18 who lives with you and 1) for whom adoption proceedings have already begun, and 2) whom you have the legal obligation to support (in whole or in part);
- Children who are alternate recipients under a Qualified Medical Child Support Order (QMCSO), as required by law; and
- A disabled child dependent who is over age 26 and meets the following criteria:
  - Is an unmarried, eligible child dependent
  - Is deemed not capable of supporting themselves due to a mental or physical disability that began prior to age 26
  - Is dependent on the employee for financial support
  - Is enrolled in the JPMC Medical plan prior to turning 26 or is the dependent of a newly hired employee who has enrolled in the Medical Plan during their new hire enrollment period

Domestic Partners

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

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

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

OR

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

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

Please Note: If you are covering a domestic partner who is not a tax dependent, imputed income for that domestic partner will be applied. Information about domestic partner coverage and the various tax consequences can be found on **My Health >Benefits Enrollment > 2021 U.S. Benefits Resources** > Covering a Domestic Partner Tip Sheet.

Qualified Medical Child Support Orders

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

Enrolling

Because participating in the Medical, Dental and Vision Plans is optional, you must enroll to have coverage. If you decide to participate, when you enroll you will choose:

1. The option you want for the Medical Plan and the Dental Plan (the Vision Plan has only one option to choose from); and.
2. The coverage level for each Plan. You can choose different coverage levels for each Plan.

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

Elections a la Carte!

You don't have to enroll for all the Plans. You can choose only the Plans that you want. For example, you could enroll for the Medical and Dental Plans and waive coverage from the Vision Plan. Or you could enroll for the Dental and Vision Plans and waive coverage from the Medical Plan. It's up to you!

Medical and Dental Plan Options

For details on the options available under the Medical Plan and the Dental Plan, see the subsections that describe each Plan:

The Medical Plan

The Dental Plan

Coverage Levels

The coverage levels available in the Medical, Dental and Vision Plans are:

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

If you are eligible for coverage and do not enroll in a Plan, your eligible dependents cannot be enrolled in that Plan.

You are responsible for understanding the dependent eligibility rules and abiding by them (see "Important Note on Dependent Eligibility" on page 32).

An Important Note on Dependent Coverage

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

Tax Treatment of Domestic Partner Coverage

If you're covering a domestic partner as described in "Eligible Dependents" on page 31, there are tax implications of which you should be aware.

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

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

Enrolling a Domestic Partner

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

How to Enroll

Participation in the Medical, Dental and Vision Plans is optional. You can enroll in all three Plans, or just two of them, or one, or you can waive coverage from all three Plans.

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

- Current, eligible employee, enrolling during Annual Benefits Enrollment;
- Newly hired employee; or
- Current, eligible employee, enrolling or changing your benefits outside of Annual Benefits Enrollment.

No Enrollment Needed for Wellness, EAP or Tobacco Cessation Programs, If Eligible

For benefits-eligible employees, no enrollment is necessary for the Wellness, EAP and Tobacco Cessation programs. These programs are provided to 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.

Enrolling if You Are an Employee

You have the ability to enroll in the Medical, Dental and Vision Plans once a year, during Annual Benefits Enrollment held in the fall (generally in the October time frame). Elections you make during Annual Benefits Enrollment are effective the following January 1.

At the beginning of each Annual Benefits Enrollment period, you'll receive information about the choices available to you and their costs. You need to review your available choices carefully and enroll in the Plans and options that best meet your needs.

You can view your available choices, their costs and make your elections through the Benefits Web Center on **My Health** or by calling HR Answers. Detailed instructions and deadlines will be included in the Annual Benefits Enrollment materials.

Remember, you can't change your choices during the year unless you have a Qualified Status Change. Please see "Changing Your Coverage Midyear" on page 38.

Enrolling if You Are a Newly Hired Employee

If you've just joined JPMorgan Chase and are enrolling for the first time, you need to make your choices through the Benefits Web Center on **My Health** or by calling HR Answers. If you are a full-time employee, you need to make your choices within 31 days of your date of hire. If you are a part-time employee, you need to make your choices within 31 days before becoming eligible.

- **If you are a full-time employee** (regularly scheduled to work 40 hours per week), you will receive information about benefits enrollment after your hire date with JPMorgan Chase. Your coverage will begin — meaning it will be effective — on the first of the month after your hire date, as long as you enroll within 31 days after your hire date. For example, if you are hired on June 17, you have between June 17 and July 18 to make your enrollment elections, and these elections will be effective on July 1.
- **If you are a part-time employee** (regularly scheduled to work at least 20 but less than 40 hours per week), your benefits effective date will be the first of the month following your 60-day waiting period, and you will receive your enrollment materials within 31 days before becoming eligible for coverage. You need to enroll within 31 days before your eligibility date.

You can access your benefits enrollment materials online at **My Health** > Benefits Enrollment.

If you are hired after October 1, you will be required to complete your newly eligible benefits enrollment elections for the current calendar year before making your enrollment elections for the subsequent calendar year.

Enrolling if You Have a Change in Work Status or Qualified Status Change

If you're enrolling during the year because you're a newly eligible employee due to a work status change, or if you have a Qualified Status Change (QSC), you'll have 31 days from the date of the change in status to make your new choices, including adding any eligible dependents directly impacted by the QSC. You can submit your choices through the Benefits Web Center on **My Health** or by calling HR Answers. Please see "Changing Your Coverage Midyear" on page 38.

Please Note: For a QSC, you have 31 days to add yourself or your dependent from the QSC date, except related to the birth/adoption of a child, in which case you have 90 days to add this eligible dependent (coverage will be retroactive to the date of the QSC). You will also have 90 days to add any newly eligible dependents to the Medical Plan should that dependent pass away within this 90-day period.

If You Do *Not* Enroll

Coverage if You Do Not Enroll and You Are an Employee

If you're already participating in the Medical, Dental and/or Vision Plans and do not change your elections or cancel coverage during Annual Benefits Enrollment, you'll generally keep the same Medical, Dental and Vision Plan coverage for the next plan year (if available). However, you'll be subject to any changes in the Plans and coverage costs.

Re-enrollment May Differ for Other Plans

This *Health Care Participation* section applies to the JPMorgan Chase Medical, Dental and Vision Plans. Other JPMorgan Chase benefit plans may have different rules for enrollment.

For example, if you are participating in the Health Care Spending Account and/or the Dependent Day Care Spending Account in one year, you will not automatically continue participating for the next year.

Coverage if You Do Not Enroll and You Are a Newly Hired or Newly Eligible Employee

If you're a new hire or newly eligible employee and do not enroll before the end of the 31-day enrollment period as described under "Enrolling if You Are a Newly Hired Employee" on page 35, you will not have coverage in the Medical, Dental, or Vision Plans.

Coverage if You Do Not Enroll When You Have a Qualified Status Change

Adding Coverage: If you have a Qualified Status Change (QSC) that allows you (and any eligible dependents directly impacted by the QSC) to enroll in the Medical, Dental or Vision Plan midyear and you do not enroll within the 31-day window (90-day window in the case of the birth/adoption of a child or death of a newly eligible dependent during the 90 day window) as described under "Enrolling if You Have a Change in Work Status or Qualified Status Change" on page 36, you will not have coverage in those Plans.

Deleting Coverage: If you have a QSC that causes your dependent to no longer be eligible for JPMorgan Chase Medical, Dental and Vision Plans, you should remove coverage for that dependent by submitting the change in the Benefits Web Center or call HR Answers within 31 days following the effective date of the change. If you fail to submit this change timely you may call HR Answers to report the change and coverage for the dependent will be canceled effective the date you call HR Answers.

Please see "Changing Your Coverage Midyear" on page 38.

When Coverage Begins

If you are an employee, the coverage you elect during Annual Benefits Enrollment takes effect at the beginning of the next plan year (January 1).

For benefits-eligible employees, no enrollment is necessary for Wellness, EAP and Tobacco Cessation programs and participation is not dependent upon enrolling in the Medical Plan. Your coverage begins on your date of hire or when you become benefits eligible.

If you are a newly hired or newly eligible employee, the coverage you elect as a new hire takes effect as follows:

- If you are a full-time employee (regularly scheduled to work 40 hours per week), coverage begins on the first of the month after your date of hire.
- If you are a part-time employee (regularly scheduled to work at least 20 but less than 40 hours per week), coverage begins on the first of the month after 60 days from your date of hire.

If you have a change in work status or Qualified Status Change, the coverage you elect because of a qualifying event (such as those described under "Changing Your Coverage Midyear" on page 38) will take effect as of the day of the qualifying event, if you enroll within 31 days of the event (90-day window in the case of the birth/adoption of a child or if your newly eligible dependent passes away during the 90-day window) and you have already met the Plan's eligibility requirements. Please see "Changing Your Coverage Midyear" on page 38.

When Payroll Contributions Begin

Your Medical, Dental and Vision Plan payroll contributions for the cost of coverage start when your coverage begins. Your contributions are automatically deducted from your pay in equal installments 24 times a year. This applies if you are a semimonthly paid employee or a biweekly paid employee. If you are paid biweekly and the month has three pay periods, no contributions will be taken from the third pay period.

If you have coverage but are not actively working because of an unpaid leave of absence, you will be directly billed for any required contributions on an after-tax basis.

Retroactive Contributions as Necessary

Be advised that payroll contributions are owed based upon your coverage effective date. Due to timing of payroll cycles, employees may experience retroactive payroll deductions where prior payroll contributions were due but not deducted due to timing of payroll processing. This can occur for any coverage election or change including new elections or midyear changes due to a qualifying event.

Changing Your Coverage Midyear

The Medical, Dental and Vision Plan elections you make during Annual Benefits Enrollment will stay in effect through the next plan year (or the current plan year if you enroll during the year as a newly eligible employee). However, you may be permitted to change your elections before the next Annual Benefits Enrollment if you have a Qualified Status Change (QSC). A QSC does not permit you to change your health care company during the year under the Medical Plan. **Please Note:** Any changes you make during the year must be consistent with your QSC. More information on QSCs is located in the *What Happens If* section.

Important Note About Providers Leaving Networks

If your doctor leaves a network, it does not qualify as an event that allows you to change coverage during the year. Each year during the fall Annual Benefits Enrollment, you may want to check with your provider to ensure that he or she plans to continue to participate in the network of your health care company.

Qualified Events

Qualified Status Changes (QSCs) include:

- Marriage/Domestic Partnership/Civil Union
  - You get married or establish a domestic partnership or civil union
  - You get legally separated, divorced or end a domestic partnership or civil union
- Children
  - You have a baby, complete an adoption, or assume guardianship
  - Your child no longer qualifies for JPMorgan Chase benefits
- Family Members
  - You or your family member loses benefits coverage under another employer's plan
  - You or your family member gains benefits coverage under another employer's plan
  - Your child/elder care arrangements change
  - A family member who is covered by JPMorgan Chase benefits dies
- Moving
  - You move out of your Medical or Dental Plan option's service area

Making the Changes

You need to enroll and/or add your eligible dependents **within 31 days following the Qualified Status Change (QSC)** (90 days if the qualifying event is the birth or adoption of a child) for benefits to be effective on the date of the event. **Please Note:** See "*If You Do Not Enroll*" on page 36 for details on what happens if you miss the 31-day enrollment period. (You will have 90 days from the QSC to add any newly eligible dependents to the Medical Plan should that dependent pass away within this 90-day period; please call HR Answers if this situation applies to you.)

You can make these elections through the Benefits Web Center on **My Health** or by calling HR Answers.

Please Note: Documentation of dependent eligibility will be required when a dependent is added for coverage and may be requested at any time by JPMorgan Chase or the claims administrator. JPMorgan Chase or an administrator appointed by JPMorgan Chase regularly conducts dependent eligibility verification to ensure that all covered dependents meet the current eligibility requirements of the JPMorgan Chase U.S. Benefits Program. For details, please see "Important Note on Dependent Eligibility" on page 32.

Allowable Changes

The chart below details the allowable changes due to a Qualified Status Change (QSC).

For domestic partnerships, the partnership must have been in effect for at least 12 continuous months, along with other criteria, before it makes the partner eligible to be covered by any JPMorgan Chase plan or program as a dependent.

QSC	Employee	Spouse/Domestic Partner	Dependent Child or Domestic Partner ("DP") Child
Marriage	Add	Add	Add
Domestic Partner Commitment	Add	Add	Add
Divorce, Legal Separation, or termination of DP commitment	Add	Drop	Drop
Death of Spouse/DP	Add*	Drop	Drop
Birth/Adoption/Legal Guardianship	Add	Add	Add
Child Gains Eligibility	Add	Add	Add
DP's Child becomes eligible	Add	Add	Add
Child Gains Eligibility due to QMCSO	Add	N/A	Add
Child/DP child no longer eligible	N/A	N/A	Drop
Death of Child/DP child	N/A	N/A	Drop
You or covered dependent gains other coverage	Drop/reduce # of dependents	Drop/reduce # of dependents	Drop/reduce # of dependents
You or covered dependent loses other coverage	Add	Add	Add
Change in dependent care provider or fees	N/A	N/A	N/A
Move out of provider service area	Change option	change option	change option
If you are enrolled in the Simplified and move out of AZ or OH	You will remain in the Simplified plan for the rest of the calendar year. You will be offered the appropriate Medical plan options during the next Annual Enrollment	You will remain in the Simplified plan for the rest of the calendar year. You will be offered the appropriate Medical plan options during the next Annual Enrollment	You will remain in the Simplified plan for the rest of the calendar year. You will be offered the appropriate Medical plan options during the next Annual Enrollment

* Call HR Answers

HIPAA Special Enrollment Rights

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

If you or your eligible dependent declined coverage under the Medical, Dental, or Vision Plan, you may enroll for health care coverage within 31 days of a qualifying event (90 days if the qualifying event is the birth or adoption of a child or if a newly eligible dependent should pass during this 90-day period) for coverage to be effective the date of the event. If you miss the 31-day window, you will not be able to make a change until the following Annual Benefits Enrollment. Qualifying events include:

- You and/or your eligible dependents lose other health care coverage because you no longer meet the eligibility requirements (because of legal separation, divorce, death, termination of employment, or reduced work hours);
- If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption (90 days for birth/adoption). If you are eligible for coverage but do not enroll, your dependent cannot enroll;
- Employer contributions for other coverage ends; or
- The other coverage was provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the COBRA coverage period ends.

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

Effective April 1, 2009, if you or your eligible dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may enroll for JPMorgan Chase coverage, as long as you make your request within 60 days of the event.

When Coverage Ends

Coverage and participation under the Medical, Dental, and Vision Plans will end on the last day of the month in which:

- Your employment with JPMorgan Chase is terminated for any reason (and you don't elect COBRA coverage, if available);
- You cancel coverage or participation because of a Qualified Status Change (QSC) (cancellation must be consistent with the QSC);
- You stop making required contributions;
- You no longer meet the eligibility requirements of the Plans;
- You have been on an approved long-term disability leave and have been receiving LTD benefits under the LTD Plan for 24 months (see the *Long-Term Disability* section for more details);
- The Plan is discontinued; or
- You pass away.

When Dependent Coverage Ends

Coverage for your dependents ends the earlier of when your coverage ends or when the dependent no longer meets the dependent eligibility requirements. For more details on dependent eligibility, see "Eligible Dependents" on page 31.

- For your spouse, this means the last day of the month in which you pass away (unless you are eligible for retiree medical, dental, or vision coverage) or you divorce.
- For your domestic partner, this means the last day of the month in which the domestic partner ceases to meet the eligibility requirements.
- For your child, this means the last day of the month in which he or she turns age 26.
  - **Please Note:** You can continue medical, dental, and vision coverage beyond age 26 for an unmarried child who is enrolled in that benefit and is deemed not capable of supporting himself or herself due to a mental or physical disability that began before the age limits described above and who is dependent on you for financial support. To continue coverage for a disabled dependent, that dependent must be enrolled in the Plan at the time they turn age 26. If your dependent loses coverage at 26, you will **not** be able to add them to your coverage at a later date.

Continuing Health Coverage Under COBRA

Health care and wellness program benefits for you, and your covered dependents, end as of the last day of the month in which you leave the firm. If you are currently enrolled in the Medical Plan (including the Medical Reimbursement Account [MRA]), Dental Plan, Vision Plan, or Health Care Spending Account, you may elect to continue this coverage for you and your covered dependents for up to 18 months by enrolling in the coverage available through the Consolidated Omnibus Budget Reconciliation Act (COBRA). Also under COBRA, you may elect to continue participating in certain wellness-related programs offered through a single "bundled" election, described under "What's Included with COBRA Medical Plan Coverage" on page 42.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents have the right to continue health care coverage at your own expense for a certain period of time if your JPMorgan Chase-provided health care coverage ends because of certain circumstances—called "qualifying events."

Your covered dependents include your spouse and your eligible dependent children who are covered at the time of a qualifying event (your "qualified beneficiaries," as defined below). For domestic partners, JPMorgan Chase may provide COBRA-like health coverage if the domestic partner was covered under the JPMorgan Chase Medical Plan, Dental Plan, Vision Plan, and/or Employee Assistance Program at the time coverage ended.

COBRA coverage applies to the:

- The Medical Plan, including the Prescription Drug Plan, the MRA (see "The MRA and COBRA" on page 46 for more information), Wellness Screenings at your doctor's office or qualifying labs and Tobacco Cessation program;
- Dental Plan;
- Vision Plan;
- Health Care Spending Account (through the end of the year in which the qualifying event occurs); and
- Onsite Health and Wellness Centers access, wellness screenings, tobacco cessation program and Employee Assistance Program as a bundled election, even if not electing any other benefits under COBRA.

What's Included with COBRA Medical Plan Coverage

If you elect COBRA Medical Plan coverage, the following are included:

- The Medical Plan which you were enrolled in as an active employee, including the Prescription Drug Plan and the MRA (see "The MRA and COBRA" on page 46 for more information);
- Wellness Screenings at your doctor's office or qualifying labs; and
- Tobacco cessation program.

If you do not elect COBRA Medical Plan coverage, we are required to offer you the ability to elect to continue participation in certain wellness-related programs. These programs are offered through a single "bundled" election. However, we strongly encourage you to consider the value in electing such programs:

- Access to the JPMorgan Chase on-site Health & Wellness Centers;
- Employee Assistance Program (EAP);
- Tobacco cessation program; and
- Wellness Screening at your doctor's office or qualifying labs.

If you elect COBRA coverage for these services, you are eligible to earn Wellness Rewards (a taxable incentive payable through payroll) by completing the Initial Wellness Activity(ies) during the annual designated timeframe. This maximum amount of Initial Wellness Rewards you can earn is determined by your Medical Plan eligibility: JPMC Core Medical Plan $200, JPMC Simplified Medical Plan $100. Additionally, your covered spouse/domestic partner is not eligible to earn any Additional Wellness Activities.

If you elect COBRA Medical Plan coverage and would like to continue to have access to the Employee Assistance Program and the JPMorgan Chase onsite Health & Wellness Centers, you should purchase the COBRA "bundled" coverage listed above.

Please Note: If you elect both COBRA Medical Plan coverage and COBRA "bundled" coverage, you will not be charged twice for the Tobacco cessation and Wellness Screening programs.

More details about coverage under COBRA are available by calling HR Answers.

Qualified Beneficiary

Individuals eligible for COBRA continuation coverage are called "qualified beneficiaries." A qualified beneficiary includes the covered spouse and eligible dependent children of a covered employee, and, in certain cases, the covered employee.

Under current law, to be considered a qualified beneficiary, an individual must generally be covered under a group health plan on the day before a qualifying event occurs that causes a loss in coverage (such as termination of employment or a divorce from or death of the covered employee). In addition, a newborn child or a child who is placed for adoption with the covered employee during the period of COBRA continuation coverage is also considered a qualified beneficiary.

Qualifying Events

You, your spouse, and your dependent children may elect COBRA coverage for varying lengths of time, depending on the circumstances under which your JPMorgan Chase health care coverage ends:

- **If Your Employment Terminates or Your Work Hours Are Reduced.** If you lose coverage because your employment terminates (for any reason other than gross misconduct) or your work hours are reduced, you and/or your covered dependents may purchase COBRA coverage for up to 18 months. Certain events may extend this 18-month COBRA continuation period:
  - If your covered dependents experience any second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).

- If you become eligible for Medicare while employed (even if this is not a qualifying event for your covered dependents because they do not lose coverage) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your covered dependents may elect COBRA continuation for up to 36 months from the date that you become eligible for Medicare.

- **If Your Covered Dependents Lose Coverage.** If your spouse and/or your dependent children lose coverage because of any of the circumstances listed below, they may purchase COBRA coverage for up to 36 months from the date that coverage ends because:
  - You pass away;
  - You divorce your spouse or become legally separated;
  - You become eligible for Medicare; or
  - Your dependent child loses dependent eligibility status under the terms of the plan (for example, the end of the month in which your dependent child reaches age 26).
- **If You or Your Covered Dependents Become Disabled.** If you or one of your covered dependents becomes disabled under the Social Security Administration guidelines within 60 days of a qualifying event, or you are disabled at the time COBRA coverage is initially offered, you and your covered dependents may continue COBRA coverage for an additional 11 months beyond the initial 18 months, to a total of 29 months. You must notify HR Answers, the COBRA Administrator, within 60 days after Social Security issues a determination of disability status and before the initial 18-month COBRA coverage period ends. You also must notify the COBRA Administrator within 30 days after Social Security determines the end of disability status for you or your covered dependent.

If a second qualifying event occurs at any time during this 29-month disability coverage period, your covered dependents (but not you) may continue COBRA coverage for an additional seven months, to a total of 36 months.

Continuation Coverage for a Domestic Partner Dependent

A domestic partner or the children of a domestic partner who are not your tax dependents are not eligible for COBRA continuation coverage under federal law. However, JPMorgan Chase provides COBRA-like coverage if your domestic partner (and his or her eligible children) was covered under the JPMorgan Chase Medical Plan, Dental Plan and Vision Plan, at the time coverage ended. Call HR Answers for more information.

The Employee Assistance Program is available under COBRA-like continuation coverage for all eligible dependents, although wellness screenings are limited to your domestic partner only (not eligible dependents). Access to on-site Health and Wellness Centers is not available to your domestic partner or any of your eligible dependents.

The rate for domestic partner continuation coverage will be the same as the COBRA rate. Contributions will be made on an after-tax basis and will represent the full value of the coverage plus 2%. If you pass away while continuing your own coverage under COBRA, coverage may be continued by your covered domestic partner for a total of 36 months.

If a second qualifying event occurs anytime within the original 18-month period, COBRA continuation coverage may be extended for an additional 18 months, for a total period of 36 months.

Giving Notice of a COBRA Qualifying Event

If your employment terminates, your work hours are reduced, or you pass away, and this results in a loss of benefits under the Medical, Dental, or Vision Plans, the COBRA Administrator automatically will notify you or your covered eligible dependents about your right to elect continued coverage under COBRA. You will receive the necessary election forms to your home address of record within 14 days from the date that the COBRA Administrator is notified of your eligibility for COBRA coverage.

However, if you divorce or your eligible dependent child loses dependent status under the terms of the plan, you or one of your covered dependents must call HR Answers within 60 days of any such event. If notice is not received within that 60-day period, your dependents will not be entitled to elect COBRA continuation coverage. Notice must be provided to the COBRA Administrator and must include the following information: the name of the employee or qualified beneficiaries requesting coverage, the qualifying event and the date of the qualifying event. In addition, you may be asked to provide supporting documentation such as a divorce decree. Otherwise, your covered dependents will not be eligible to elect continued coverage under COBRA.

If a qualified beneficiary experiences a second qualifying event that would entitle him or her to additional months of continuation coverage, he or she must notify the COBRA Administrator. This notice must include the:

- Name of the employee;
- Name of the qualified beneficiary receiving COBRA coverage; and
- Type and date of the second qualifying event.

This notice must be provided within 60 days from the date of the second qualifying event (or, if later, the date coverage would normally be lost because of the second qualifying event). In addition, the qualified beneficiary may be asked to provide a copy of a death certificate or divorce decree.

Updating Your Personal Contact Information

To ensure that you receive information to enroll in COBRA, please contact HR Answers to update your personal contact information as well as your dependent's contact information.

When the plan is notified that one of these events has happened, the qualified beneficiary will automatically be entitled to the extended period of COBRA continuation coverage. If a qualified beneficiary fails to provide the appropriate notice and requested supporting documentation during this 60-day notice period, the qualified beneficiary will not be entitled to extended continuation coverage.

If you are a former employee and you have a newborn or adopt a child while you are on COBRA continuation coverage and you enroll the new child for coverage, the new child will be considered a qualified beneficiary rather than an after-acquired dependent. This gives the child additional rights, such as the right to continue COBRA benefits even if you pass away during the COBRA period, and the right to an additional 18 months of coverage if a second qualifying event occurs during the initial 18-month COBRA period after your termination or retirement.

Choosing COBRA Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the:

- Date you and/or your covered eligible dependents would lose coverage because of the qualifying event; or
- Date you are notified of your and/or your covered eligible dependents' right to continue coverage because of the qualifying event (that is, the date of your COBRA Enrollment Notice).

If you make no election during the 60-day period, you waive your right to continue coverage. Each qualifying beneficiary has an independent right to elect COBRA coverage. Covered employees may elect coverage on behalf of their spouses, and parents may elect coverage on behalf of their children.

You will receive COBRA materials approximately two weeks after the date they are notified of the qualifying event. These materials will describe the enrollment instructions and time frames for making your elections. You will have a period of 60 days from the date of your qualifying event to elect COBRA coverage. **Important Notes:** You must make an election at the time COBRA coverage is offered—it is not automatically provided. Also, if you elect COBRA your coverage will stay with the carrier and current option you were with when you were active (Aetna or Cigna, Option 1 or Option 2); this also applies to Dental coverage. If you are still enrolled in COBRA during Annual Enrollment you will be able to change carriers then.

Premium Due Dates

If you elect to continue coverage under COBRA, you must pay the first two premiums (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums are due on the first calendar day of the month for that month's coverage, and must be paid within 30 days of each due date. If you elect to continue your coverage under COBRA but do not make timely payments in full (even if you do not receive a bill), your coverage will be terminated retroactively to the time frame applicable to your last full payment and will not be reinstated.

Coverage During the Continuation Period

With respect to Medical Plan, Dental Plan and Vision Plan coverage, you and your covered dependents may choose to continue the coverage option that you had as an active employee. You and your covered dependents may subsequently change coverage during the next Annual Benefits Enrollment, if a qualified change in status occurs, or at other times, to the same extent that active employees may do so.

COBRA Coverage Costs

If you choose to continue coverage under COBRA, you will generally pay the full cost* for yourself and/or your qualified beneficiaries, plus a 2% administrative fee. If COBRA coverage is extended because of a disability, the rates for coverage during the additional 11 months are 150% of the full cost.

If a second qualifying event occurs during the initial 18-month period of COBRA coverage, the 102% rate applies to you and your qualified beneficiaries for the full 36 months of COBRA coverage, even if you or one of your covered dependents becomes disabled. However, if a second qualifying event occurs during an extended disability coverage period, then the rates of coverage will continue at the higher disability coverage rates explained above.

* The cost of COBRA is based on your plan elections and your Total Annual Cash Compensation (TACC), as defined by the Plan. Your TACC is frozen as of the last day of active employment with JPMorgan Chase.

Company-Subsidized COBRA Coverage

If you are eligible for benefits under the U.S. Severance Pay Plan, you will receive a COBRA subsidy and will pay the active employee rate for medical coverage under COBRA for the lesser of 1) six months; or 2) the number of months of severance benefits you receive. For calculation purposes, four weeks of severance pay equal one month, and fractional months are rounded up to the next higher whole number of months (for example, 11 weeks would be rounded up to three months). This subsidy will apply to medical and dental coverage only (the Vision Plan, Health Care Spending Account Plan, and the Wellness Program are not subsidized by JPMorgan Chase, including under COBRA for individuals receiving severance benefits). Your eligibility for company-subsidized COBRA coverage is conditioned upon JPMorgan Chase's receipt of the executed Release. Regardless of whether you were ever informed that you are eligible for benefits under the U.S. Severance Pay Plan, JPMorgan Chase's discretionary determination that you engaged in misconduct or violated the company's Code of Conduct before or during the COBRA subsidy period or that you could have been terminated for cause will render you ineligible for a COBRA subsidy and premiums due will be recalculated retrospectively. Unsubsidized COBRA coverage (102% of the total cost of coverage) will be available after the end of the subsidized portion of the COBRA period for the remainder of the 18-month COBRA continuation period.

Company-subsidized COBRA coverage is also available for your eligible, covered survivors, if you pass away as an active employee. Continuing coverage is available at the active employee costs for up to 36 months.

How Continued Coverage Could End

Under COBRA rules, coverage will end for you and/or your covered dependents when the first of the following occurs:

- Your COBRA coverage period ends;
- You do not make the required premium payments for coverage on a timely basis;
- You obtain coverage under another group plan that does not exclude or limit coverage for pre-existing conditions. However, if the new plan does have pre-existing conditions or limits, you can continue your COBRA coverage for that specific condition up to the end of your original maximum COBRA period (18 or 36 months, depending on your situation);
- You and/or your covered dependents become eligible for Medicare. However, if you become eligible for Medicare before your covered dependents, your covered dependents may be eligible to continue coverage through COBRA for up to 36 months from the date of the original qualifying event;
- In the case of an extended disability coverage period, you or your covered dependent is no longer considered disabled under Social Security guidelines;
- For newborns and children adopted by or placed for adoption with you during your COBRA continuation period, the date your COBRA coverage period ends, unless a second qualifying event occurs; or
- JPMorgan Chase terminates the plan.

The MRA and COBRA

If you had an MRA as an active employee, you can use any remaining balance in your MRA to pay for eligible out-of-pocket medical and prescription drug expenses through the end of the month in which you terminate or while enrolled in COBRA medical coverage.

If you enroll in COBRA medical coverage, you can continue to earn Wellness Rewards to increase the value of your MRA, up to the full annual MRA earnings amount (see “The MRA” in the *Core Medical Plan* section). While enrolled in COBRA:

- Your MRA balances will roll over from one calendar year to the next; and
- You can use any remaining balance in your MRA through automatic claim payment or debit card payment method depending on the method you elect.
- Wellness Rewards are determined by the Medical Plan in which you are enrolled:
  - JPMC Core Medical Plan $1,000 or $1,400 if covering a spouse/domestic partner
  - JPMC Simplified Medical Plan $740 or $1,110 if covering a spouse/domestic partner

If you do not enroll in COBRA medical coverage, you cannot earn additional Wellness Rewards beyond your termination of employment. You can use your existing MRA funds to pay for out-of-pocket costs incurred prior to the end of the month of your termination date. For example, if you terminate as of January 5, 2021, any out-of-pocket medical and prescription drug expenses incurred through January 31, 2021, are eligible, but you must submit an MRA Claim Form by December 31, 2022, to receive a reimbursement. Any remaining MRA balance will be forfeited (unless you are retirement eligible in which case the balance remains intact and can be used to offset medical and prescription drug expenses until the account is depleted; administrative fees may be incurred).

If you completed the Initial Wellness Activity(ies) during the designated time frame in a given year, you will earn the corresponding wellness rewards in your MRA in January of the following year, presuming you are actively employed at that time or you elect COBRA Medical.

Those employees who terminate before the award date in mid-January and do not elect COBRA will not receive funds for completing the Initial Wellness Activity(ies).

If you elect COBRA medical coverage, no administrative fees are deducted from your MRA.

Special Rule for Health Care Spending Account Participants

Former employees may be eligible to continue participation in the Health Care Spending Account under COBRA, if you have not used your entire account balance prior to the date your participation would end. To continue participating under COBRA, you must make after-tax contributions equal to 102% of the total monthly contribution you were making to the Health Care Spending Account before your participation ended. Coverage may not be continued into the next plan year.

Please Note: You may want to elect to continue your participation in the Health Care Spending Account under COBRA if you have not used your entire account balance before your termination date and you anticipate that you will incur expenses after that date. Otherwise, only those expenses incurred through the end of the month in which your employee coverage ends will be eligible for reimbursement.

Additional Questions About COBRA Coverage

If you have additional questions about your COBRA coverage, please contact at (877) JPMChase ((877) 576-2427)), or (212) 552-5100, if calling from outside the United States. Service Representatives are available Monday – Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays.

Defined Terms

As you read this section, you'll come across some important terms related to the accounts. To help you better understand the accounts, 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 Medical, Dental and Vision Plans. JPMorgan Chase is not involved in deciding appeals for any benefit claim denied under the Medical, Dental and Vision Plans. All fiduciary responsibility and decisions regarding a claim for a denied benefit under the Plan rest solely with the claims administrator. **Please Note**: Claims and appeals relating to eligibility to participate in the Medical, Dental and Vision Plans are decided by the plan administrator. Consult the *Plan Administration* section for details.
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. This *Health Care Participation* section provides details on COBRA coverage. Publications 502, 503 and 15B are Internal Revenue Service (IRS) publications that can be used as a guide to determine eligible and ineligible expenses under the Health Care Spending Account, Dependent Care Spending Account and Transportation Spending Accounts. You can request a copy by calling the Internal Revenue Service (IRS) at (800) 829-FORM ((800) 829-3676), or you can view these publications by logging on to www.irs.gov.
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 Rewards for your MRA by completing Initial Wellness Activities and Additional 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 eligible out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments).

Medicare	Medicare is Health Insurance for the Aged and Disabled provisions of Title XVIII of the Social Security Act of the United States, as enacted or later amended. Coverage is available to most U.S. residents age 65 and older, those with a disability for at least 29 months, and those with end-stage renal disease (ESRD). Generally, Medicare is the primary coverage for individuals who are age 65 and older, unless those individuals are actively working.
Qualified Status Change	The JPMorgan Chase 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 Medical Plan, should that dependent pass away within this 90-day period.) **Please Note:** Regardless of whether you experience a qualified change in status, you cannot change your health care company during the year.

The U.S. Fertility Benefits Program

Effective 1/1/21

JPMorgan Chase is committed to assisting employees in meeting their diverse family planning needs. Through the Family Building Assistance Policy, financial support is provided to eligible employees to help offset the high cost of adoption, surrogacy, and certain fertility treatments. The U.S. Fertility Benefits Program provides assistance with fertility treatments for individuals who do not have a medical diagnosis of infertility.

This summary will provide you with a better understanding of how the Fertility Benefits Program works, including how and when benefits are paid.

Questions?

For questions or concerns regarding the U.S. Fertility Benefits Program, please contact the Program's service provider:

WINFertility
(833) 439-1517

Representatives are available Monday through Friday, from 9 a.m. to 7:30 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 U.S. Fertility Benefits Program, which is a benefit offered under the JPMorgan Chase U.S. Medical Plan. This summary plan description provides you with important information required by the Employee Retirement Income Security Act of 1974 (ERISA) about the Program.

While ERISA does not require JPMorgan Chase to provide you with benefits, it does mandate that JPMorgan Chase clearly communicate to you how the Program operates and what rights you have under the law regarding Program benefits. The U.S. Department of Labor requires JPMorgan Chase to routinely provide benefits plan summaries to Program participants. Please retain this section for your records.

Be sure to read the "Program Administration" section on page 354 for more important details about the Program and this summary plan description.

Please Note: No person or group (other than the plan administrator for the JPMorgan Chase U.S. Benefits Program) has any authority to interpret the plans (or official plan documents) or to make any promises to you about them. The plan administrator for the JPMorgan Chase U.S. Benefits Program has complete authority in his or her absolute discretion to construe and interpret the terms of the plans and any underlying insurance policies and/or contracts, including the eligibility to participate in the plans, and to make factual determinations.

All decisions of the plan administrator for the JPMorgan Chase U.S. Benefits Program are final and binding upon all affected parties. The plan administrators delegate their discretion to interpret the plans to the claims administrators, and to decide claims and appeals, including making factual determinations, to:

- The claims administrators; and
- The Health Care and Insurance Plans Appeals Committee.

No Assignment of Benefits

The plans are used exclusively to provide benefits to you and, in some cases, your survivors. Neither you nor JPMorgan Chase can assign, transfer, or attach your benefits, or use them as collateral for a loan. You may not assign your right to file actions under ERISA regarding the plans, or use power of attorney or similar arrangements for that purpose.

Please Note: You may assign to a health care service provider the right to payment. Please contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) for more information.

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. JPMorgan Chase & Co. 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 JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

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Fertility Benefits Highlights

parents@jpmc	**parents@jpmc** is your central online resource for information about expanding your family, parental leave and support for working parents. From **parents@jpmc** you can learn more about the fertility benefit available.
Eligibility	U.S. benefits-eligible employees who have completed the Introductory Period and their covered spouses/domestic partners are eligible for fertility benefits only if they meet the following requirements: ▪ The person receiving the fertility services is enrolled in the JPMorgan Chase U.S. Medical Plan ▪ The person receiving the fertility services and their partner (if applicable and clinically linked to the fertility treatment) have not received a medical diagnosis of infertility ▪ The person receiving the fertility services has enrolled with WINFertility, the administrator of fertility benefits ▪ The expenses are incurred while the person receiving the fertility services was enrolled in the Medical Plan Note: If a medical diagnosis of infertility is determined, the person receiving the fertility services may qualify for infertility benefits under the JPMorgan Chase U.S. Medical Plan in lieu of this fertility benefit. If, during the course or treatment, it is determined that there is a medical diagnosis of infertility, WINFertility will transfer you to your JPMorgan Chase U.S. Medical Plan health care company to utilize the infertility benefit.
You Must Enroll	To be eligible for benefits from the Program, you must enroll by calling WINFertility and complete a consultation with a WINFertility Nurse Care Manager. If you do not call and complete a consultation, you will not be eligible for benefits and you will not be eligible for reimbursement for fertility services incurred prior to enrollment.
Covered Services	Examples of fertility services that are covered include, but are not limited to, the following if performed on the individual enrolled in the U.S. Medical Plan: ▪ Intrauterine insemination (IUI); ▪ In vitro fertilization (IVF); ▪ Medications associated with an approved IUI or IVF cycle. For more details on the covered services and the exclusions, see “What the Plan Provides” on page 206 and “What’s Not Covered” on page 347.
WINFertility Network	WINFertility has a network of providers that feature credentialed reproductive endocrinologists and associated clinical staff, and has negotiated competitive pricing across this network. If you use an in-network WINFertility provider, you will have the associated costs automatically processed by WINFertility as the services are received, up to the lifetime maximum. This means you won’t have to pay out-of-pocket at the time of service and will not have to submit claims for reimbursement. Ancillary services prescribed by the WINFertility provider to outside labs, facilities, or providers may not be payable directly by WINFertility, but would be eligible for reimbursement. If you use an out-of-network provider, you will pay for those services out-of-pocket and then submit a request for reimbursement to WINFertility. Claims must be submitted within six months of when the expenses are incurred.
Lifetime Maximum Benefit	The Program provides benefits for covered services, up to a per-person lifetime maximum of $30,000 in benefits for medical and prescription drug costs.

Participating in the Program

Who's Eligible?

U.S. benefits-eligible employees who have completed the Introductory Period and their covered spouses/domestic partners are eligible for fertility benefits only if they meet the following requirements:

- The person receiving the fertility services is enrolled in the JPMorgan Chase U.S. Medical Plan,
- The person receiving the fertility services and their partner (if applicable and clinically linked to the fertility treatment) have not received a medical diagnosis of infertility,
- The person receiving the fertility services has enrolled with WINFertility, the administrator of fertility benefits, and
- The expenses are incurred while the person receiving the fertility services was enrolled in the Medical Plan.

Who's Not Eligible

You are not eligible for Fertility Program benefits if you do not meet the criteria under "Who's Eligible" or if there is a medical diagnosis of infertility. If there is a medical diagnosis of infertility, you may quality for infertility benefits under the JPMorgan Chase U.S. Medical Plan in lieu of this fertility benefit.

Your family members other than your spouse/domestic partner, such as your children, are not eligible for benefits under the Fertility Benefits Program, even if they are covered by the JPMorgan Chase U.S. Medical Plan.

The services incurred by egg and sperm donors that may be involved in the fertility treatment are not covered under this benefit.

Enrolling

To be eligible for benefits from the Fertility Benefits Program, you must enroll in the program by calling WINFertility and completing a consultation with a WINFertility Nurse Care Manager.

If you do not call and complete a consultation, you will not be eligible for benefits and you will not be reimbursed for fertility services incurred prior to enrollment.

When Coverage Begins

The Fertility Program's coverage begins immediately after you complete your consultation with a WINFertility Nurse Care Manager.

There is no retroactive coverage. For example, if you receive fertility services and then call WINFertility and have a consultation with a Nurse Care Manager *after* receiving those services, Fertility Benefits Program benefits will not be payable for any services received before your consultation.

Cost of Coverage

There is no additional payroll contribution cost for the Fertility Benefits Program benefits; your payroll contributions for the U.S. Medical Plan also covers the Fertility Benefits Program benefits. The Fertility Benefits Program benefits are in addition to the benefits you receive as a member of the U.S. Medical Plan.

When Coverage Ends

Your eligibility for the Fertility Benefits Program ends when your coverage under the JPMorgan Chase U.S. Medical Plan ends, unless you elect Medical Plan coverage under COBRA. For details, see “Continuing Health Coverage Under COBRA” on page 349.

Our Partner, WINFertility

JPMorgan Chase has partnered with WINFertility as the claims administrator for the Program. WINFertility is a fertility benefit management company that offers integrated fertility management services to participants in the JPMorgan Chase U.S. Medical Plan (e.g., clinical oversight, advocacy, and nurse care managers that provide support throughout the fertility journey).

Fertility-related medical and drug expenses incurred under the Fertility Benefits Program will be managed and processed by WINFertility, and not the carriers responsible for the U.S. Medical Plan (i.e., Aetna, Cigna or CVS Caremark).

WINFertility’s Network

WINFertility has a network of providers that feature credentialed reproductive endocrinologists and associated clinical staff, and has negotiated competitive pricing across this network.

If You Have Other Coverage

If your fertility care expenses are covered by another source (such as an insurance company) or under a plan maintained by your spouse/domestic partner’s employer or any government provided assistance, then those expenses will not be eligible for reimbursement under the JPMorgan Chase U.S. Fertility Benefits Program.

What’s Covered

The following services are covered up to a $30,000 total lifetime benefit maximum*:

- Artificial insemination / intrauterine insemination under medical supervision
- Advanced reproductive technologies:
  - In-Vitro Fertilization
  - Reciprocal IVF is covered if the patient receiving treatment is an eligible member and is enrolled in the program with WINFertility
  - Frozen Embryo Transfer
  - Cryopreservation for the following:
    - Blastocysts(s) and embryo(s) from covered IVF cycles. Covered blastocyst and embryo storage is limited to one year.
      - All frozen embryos stored after a completed cycle with ovarian stimulation must be utilized prior to coverage availability for another ovarian stimulation cycle. Embryo transfer guidelines per the American Society of Reproductive Medicine should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate
- Medically necessary diagnostic workup and radiology services

Confirm Coverage

The services listed here are not a complete list. To confirm that your treatment is covered under the plan, call WINFertility at (833) 439-1517, weekdays from 9 a.m. through 7:30 p.m. Eastern Time.

- Pathology and laboratory services, including:
  - Hormonal assays
  - Swimup semen analysis, as appropriate
  - Ultrasound exams
  - Ova identification
  - Fertilization and embryo culture
  - Embryo, gamete-zygote transfer
  - Preimplantation Genetic Diagnosis* and Preimplantation Genetic Screening
- Medications necessary for the procedures above, including parenteral injection and oral ovulation induction drugs.

* Preimplantation Genetic Diagnosis may be covered under your Medical Plan.

The Lifetime Maximum

Under the Program, the firm may pay for or reimburse qualified, non-duplicative expenses up to a lifetime maximum of $30,000 per eligible person receiving fertility services (i.e., the employee in the U.S. Medical Plan or their enrolled spouse/domestic partner) for fertility treatment.

Note that in cases where both individuals are employees of JPMorgan Chase and both are enrolled in the U.S. Medical Plan, the $30,000 lifetime maximum is for each employee.

The $30,000 lifetime maximum applies to all fertility-related expenses processed through the Fertility Benefits Program, including both in-network and out-of-network services. Expenses related to a person receiving healthcare services once pregnant, including the delivery, would be covered under the JPMorgan Chase U.S. Medical Plan.

If, during the course or treatment, it is determined that there is a medical diagnosis of infertility, WINFertility will assist you with transitioning to your JPMorgan Chase U.S. Medical Plan health care company to utilize the infertility benefit. The infertility benefit as a separate lifetime maximum and the expenses for treatment under the fertility benefit will not count towards the infertility maximum.

What's Not Covered

The following services are not covered:

- Donor expenses for donated oocytes or sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications)
- Surrogacy expenses
- Services requested which are not medically appropriate, as determined by WINFertility in its sole discretion
- Elective egg freezing
- Cryopreservation of sperm or oocytes prior to gender reassignment
- Embryo adoption
- Services not specifically listed as covered in this benefit
- At-home inseminations
- Fertility services for an eligible member who has a diagnosis of medical infertility

Claiming Benefits

The following explains when and how to file claims for fertility services. For more information on your rights with respect to claims, please see “Program Administration” on page 354.

How to File Claims

Rules regarding claims depend on whether you use a WINFertility in-network provider or an out-of-network provider, as shown below:

Provider	Claims Process
WINFertility In-Network Provider	If you use a WINFertility in-network provider, you will have the associated costs automatically processed by WINFertility as the services are received, up to the lifetime maximum. This means you won’t have out-of-pocket costs for services provided by the WINFertility provider and will not have to submit claims for reimbursement. Ancillary services prescribed by the WINFertility provider to outside labs, facilities, or providers may not be payable directly by WINFertility, but would be eligible for reimbursement.
Out-of-Network Provider	If you use an out-of-network provider, you will pay for those services out-of-pocket and then submit a request for reimbursement of eligible services to WINFertility, up to the lifetime maximum. Claims must be submitted within six months of when the eligible expenses are incurred. Please see “Where to Submit Claims” on page 211 for your claim administrator’s phone and address information.

Your request for reimbursement must include the following:

- A complete WINFertility Out-of-Network Reimbursement Form which can be found on parents@jpmc;
- An itemized statement or claim form indicating the description of services, dates incurred, amounts, and name of the patient/person receiving the fertility services;
- Proof of payment.

Separate claim forms must be submitted for each family member for whom a claim is made.

Where to Submit Claims

WINFertility is the Fertility Benefits Program’s claims administrator.

Documentation can be emailed to:

reimbursementclaims@winfertility.com

or mailed to:

WINFertility
Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831
Attn: Claims Department
(833) 439-1517

Representatives can be reached from 9 a.m. to 7:30 p.m., Eastern Time, Monday through Friday.

Appealing a Claim

If a claim for reimbursement under the Fertility Benefits Program is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in “Program Administration” on page 354.

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.

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 the HR Answers Benefits Contact Center.

What Happens If…

For many of the JPMorgan Chase Health Care and Insurance Plans for Active Employees benefits, certain life changes and events can give you special opportunities to change your decisions to participate or to decline coverage under certain benefits.

Because participation in the U.S. Fertility Benefits Program requires that you be enrolled for coverage in the JPMorgan Chase U.S. Medical Plan, please see the *What Happens If…*section of *Your JPMC Benefits Guide*, available at www.jpmcbenefitsguide.com and in print on request to the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576 2427), for details on when you can adjust your participation in the JPMorgan Chase U.S. Medical Plan. For more information, see the Benefits Status Change Guide on **My Health** > Learn About the JPMC Benefits Program.

Continuing Health Coverage Under COBRA

Health care and wellness program benefits for you, and your covered dependents, end as of the last day of the month in which you leave the firm. If you are currently enrolled in the Medical Plan (including the Fertility Benefits Program and Medical Reimbursement Account [MRA]), Dental Plan, Vision Plan, or Health Care Spending Account, you may elect to continue this coverage for you and your eligible covered dependents for up to 18 months by enrolling in the Consolidated Omnibus Budget Reconciliation Act (COBRA). Also under COBRA, you may elect to continue participating in certain wellness-related programs offered through a single “bundled” election.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents have the right to continue health care coverage at your own expense for a certain period of time if your JPMorgan Chase-provided health care coverage ends because of certain circumstances—called “qualifying events.”

Your covered dependents include your spouse and your eligible dependent children who are covered at the time of a qualifying event (your “qualified beneficiaries,” as defined below). For domestic partners, JPMorgan Chase may provide COBRA-like health coverage if the domestic partner was covered under the JPMorgan Chase Medical Plan, Dental Plan, Vision Plan, and/or Employee Assistance Program at the time coverage ended.

COBRA coverage applies to the Medical Plan as well as certain other health care plans.

If you elect COBRA Medical Plan coverage, the U.S. Fertility Benefits Program is included in that election. This section regarding COBRA may make references to dependent children. As a reminder, dependent children are not eligible for benefits under the Fertility Benefits Program.

More details about coverage under COBRA are available through the HR Answers Benefits Contact Center.

Qualified Beneficiary

Individuals eligible for COBRA continuation coverage are called "qualified beneficiaries." A qualified beneficiary includes the covered spouse and eligible dependent children of a covered employee, and, in certain cases, the covered employee.

Under current law, to be considered a qualified beneficiary, an individual must generally be covered under a group health plan on the day before a qualifying event occurs that causes a loss in coverage (such as termination of employment or a divorce from or death of the covered employee). In addition, a newborn child or a child who is placed for adoption with the covered employee during the period of COBRA continuation coverage is also considered a qualified beneficiary.

Qualifying Events

You, your spouse, and your dependent children may elect COBRA coverage for varying lengths of time, depending on the circumstances under which your JPMorgan Chase health care coverage ends:

- **If Your Employment Terminates or Your Work Hours Are Reduced.** If you lose coverage because your employment terminates (for any reason other than gross misconduct) or your work hours are reduced, you and/or your covered dependents may purchase COBRA coverage for up to 18 months. Certain events may extend this 18-month COBRA continuation period:
  - If your covered dependents experience any second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
  - If you become eligible for Medicare while employed (even if this is not a qualifying event for your covered dependents because they do not lose coverage) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your covered dependents may elect COBRA continuation for up to 36 months from the date that you become eligible for Medicare.
- **If Your Covered Dependents Lose Coverage.** If your spouse and/or your dependent children lose coverage because of any of the circumstances listed below, they may purchase COBRA coverage for up to 36 months from the date that coverage ends because:
  - You pass away;
  - You divorce your spouse or become legally separated;
  - You become eligible for Medicare; or
  - Your dependent child loses dependent eligibility status under the terms of the plan (for example, the end of the month in which your dependent child reaches age 26).
- **If You or Your Covered Dependents Become Disabled.** If you or one of your covered dependents becomes disabled under the Social Security Administration guidelines within 60 days of a qualifying event, or you are disabled at the time COBRA coverage is initially offered, you and your covered dependents may continue COBRA coverage for an additional 11 months beyond the initial 18 months, to a total of 29 months. You must notify HR Answers, the COBRA Administrator, within 60 days after Social Security issues a determination of disability status and before the initial 18-month COBRA coverage period ends. You also must notify the COBRA Administrator within 30 days after Social Security determines the end of disability status for you or your covered dependent.

If a second qualifying event occurs at any time during this 29-month disability coverage period, your covered dependents (but not you) may continue COBRA coverage for an additional seven months, to a total of 36 months.

Continuation Coverage for a Domestic Partner Dependent

A domestic partner or the children of a domestic partner who are not your tax dependents are not eligible for COBRA continuation coverage under federal law. However, JPMorgan Chase provides COBRA-like coverage if your domestic partner (and his or her eligible children) was covered under the JPMorgan Chase Medical Plan, Dental Plan and Vision Plan, at the time coverage ended. Call HR Answers for more information.

The rate for domestic partner continuation coverage will be the same as the COBRA rate. Contributions will be made on an after-tax basis and will represent the full value of the coverage plus 2%. If you pass away while continuing your own coverage under COBRA, coverage may be continued by your covered domestic partner for a total of 36 months.

If a second qualifying event occurs anytime within the original 18-month period, COBRA continuation coverage may be extended for an additional 18 months, for a total period of 36 months.

Giving Notice of a COBRA Qualifying Event

If your employment terminates, your work hours are reduced, or you pass away, and this results in a loss of benefits under the Medical, Dental, or Vision Plans, the COBRA Administrator automatically will notify you or your covered eligible dependents about your right to elect continued coverage under COBRA. You will receive the necessary election forms to your home address of record within 14 days from the date that the COBRA Administrator is notified of your eligibility for COBRA coverage.

However, if you divorce or your eligible dependent child loses dependent status under the terms of the plan, you or one of your covered dependents must contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) within 60 days of any such event. If notice is not received within that 60-day period, your dependents will not be entitled to elect COBRA continuation coverage. Notice must be provided to the COBRA Administrator and must include the following information: the name of the employee or qualified beneficiaries requesting coverage, the qualifying event and the date of the qualifying event. In addition, you may be asked to provide supporting documentation such as a divorce decree. Otherwise, your covered dependents will not be eligible to elect continued coverage under COBRA.

If a qualified beneficiary experiences a second qualifying event that would entitle him or her to additional months of continuation coverage, he or she must notify the COBRA Administrator. This notice must include the:

- Name of the employee;
- Name of the qualified beneficiary receiving COBRA coverage; and
- Type and date of the second qualifying event.

This notice must be provided within 60 days from the date of the second qualifying event (or, if later, the date coverage would normally be lost because of the second qualifying event). In addition, the qualified beneficiary may be asked to provide a copy of a death certificate or divorce decree.

When the plan is notified that one of these events has happened, the qualified beneficiary will automatically be entitled to the extended period of COBRA continuation coverage. If a qualified beneficiary fails to provide the appropriate notice and requested supporting documentation during this 60-day notice period, the qualified beneficiary will not be entitled to extended continuation coverage.

Updating Your Personal Contact Information

To ensure that you receive information to enroll in COBRA, please contact the HR Answers Benefits Contact Center to update your personal contact information as well as your dependent's contact information.

If you are a former employee and you have a newborn or adopt a child while you are on COBRA continuation coverage and you enroll the new child for coverage, the new child will be considered a qualified beneficiary rather than an after-acquired dependent. This gives the child additional rights, such as the right to continue COBRA benefits even if you pass away during the COBRA period, and the right to an additional 18 months of coverage if a second qualifying event occurs during the initial 18-month COBRA period after your termination or retirement.

Choosing COBRA Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the:

- Date you and/or your covered eligible dependents would lose coverage because of the qualifying event; or
- Date you are notified of your and/or your covered eligible dependents' right to continue coverage because of the qualifying event (that is, the date of your COBRA Enrollment Notice).

If you make no election during the 60-day period, you waive your right to continue coverage. Each qualifying beneficiary has an independent right to elect COBRA coverage. Covered employees may elect coverage on behalf of their spouses, and parents may elect coverage on behalf of their children.

You will receive COBRA materials approximately two weeks after the date they are notified of the qualifying event. These materials will describe the enrollment instructions and time frames for making your elections. You will have a period of 60 days from the date of your qualifying event to elect COBRA coverage. **Important Note:** You must make an election at the time COBRA coverage is offered—it is not automatically provided.

Premium Due Dates

If you elect to continue coverage under COBRA, you must pay the first two premiums (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums are due on the first calendar day of the month for that month's coverage, and must be paid within 30 days of each due date. If you elect to continue your coverage under COBRA but do not make timely payments (even if you do not receive a bill), your coverage will be terminated retroactively to the time frame applicable to your last payment and will not be reinstated. As it relates to the U.S. Fertility Benefits Program, the cost of this coverage is included in your U.S. Medical Plan premiums; there is not a separate premium for this program.

Coverage During the Continuation Period

With respect to Medical Plan and Dental Plan coverage, you and your covered dependents may choose to continue the coverage option that you had as an active employee or you may elect a different option at the time you initially enroll for COBRA coverage. (Because the Vision Plan has only one option, there is no opportunity to change that coverage if you continue it under COBRA.) If coverage is changed for active employees, the same changes will be provided to individuals with COBRA coverage. In addition, you and your covered dependents may change coverage during Annual Benefits Enrollment, if a qualified change in status occurs, or at other times, to the same extent that active employees may do so.

Please Note: Although JPMorgan Chase allows you to elect a different option at the time of your initial COBRA election, not all plans allow a change. Generally, all self-insured options allow a change at this time. It is the responsibility of the employee to contact the health care administrator of his or her Medical and Dental Plan option to verify if coverage is available.

COBRA Coverage Costs

If you choose to continue coverage under COBRA, you will generally pay the full cost for yourself and/or your qualified beneficiaries, plus a 2% administrative fee. If COBRA coverage is extended because of a disability, the rates for coverage during the additional 11 months are 150% of the full cost.

If a second qualifying event occurs during the initial 18-month period of COBRA coverage, the 102% rate applies to you and your qualified beneficiaries for the full 36 months of COBRA coverage, even if you or one of your covered dependents becomes disabled. However, if a second qualifying event occurs during an extended disability coverage period, then the rates of coverage will continue at the higher disability coverage rates explained above.

Company-Subsidized COBRA Coverage

If you are eligible for benefits under the U.S. Severance Pay Plan, you will receive a COBRA subsidy and will pay the active employee rate for medical coverage under COBRA for the lesser of 1) six months; or 2) the number of months of severance benefits you receive. For calculation purposes, four weeks of severance pay equal one month, and fractional months are rounded up to the next higher whole number of months (for example, 11 weeks would be rounded up to three months). This subsidy will apply to medical and dental coverage only (the Vision Plan, Health Care Spending Account Plan, and the Wellness Program are not subsidized by JPMorgan Chase, including under COBRA for individuals receiving severance benefits). Your eligibility for company-subsidized COBRA coverage is conditioned upon JPMorgan Chase's receipt of the executed Release. Regardless of whether you were ever informed that you are eligible for benefits under the U.S. Severance Pay Plan, JPMorgan Chase's discretionary determination that you engaged in misconduct or violated the company's Code of Conduct before or during the COBRA subsidy period or that you could have been terminated for cause will render you ineligible for a COBRA subsidy. Unsubsidized COBRA coverage (102% of the total cost of coverage) will be available after the end of the subsidized portion of the COBRA period for the remainder of the 18-month COBRA continuation period.

Company-subsidized COBRA coverage is also available for your eligible, covered survivors, if you pass away as an active employee. Continuing coverage is available at the active employee costs for up to 36 months.

How Continued Coverage Could End

Under COBRA rules, coverage will end for you and/or your covered dependents when the first of the following occurs:

- Your COBRA coverage period ends;
- You do not make the required premium payments for coverage on a timely basis;
- You obtain coverage under another group plan that does not exclude or limit coverage for pre-existing conditions. However, if the new plan does have pre-existing conditions or limits, you can continue your COBRA coverage for that specific condition up to the end of your original maximum COBRA period (18 or 36 months, depending on your situation);
- You become eligible for Medicare. However, if you become eligible for Medicare, your covered dependents may be eligible to continue coverage through COBRA for up to 36 months from the date of the original qualifying event;
- In the case of an extended disability coverage period, you or your covered dependent is no longer considered disabled under Social Security guidelines;
- For newborns and children adopted by or placed for adoption with you during your COBRA continuation period, the date your COBRA coverage period ends, unless a second qualifying event occurs; or
- JPMorgan Chase terminates the plan.

Additional Questions About COBRA Coverage

If you have additional questions about your COBRA coverage, please call the HR Answers Benefits Contact Center at (877) JPMChase ((877) 576-2427), or (212) 552-5100, if calling from outside the United States. Service Representatives are available Monday through Friday, from 8 a.m. to 7 p.m., Eastern Time, except certain U.S. holidays.

Program Administration

This section provides you with important information as required by the Employee Retirement Income Security Act of 1974 (ERISA) about the U.S. Fertility Benefits Program. While ERISA doesn't require JPMorgan Chase to provide you with benefits, by choosing to do so, ERISA mandates that JPMorgan Chase clearly communicate to you how the plans subject to the provisions of ERISA operate and what rights you have under the law regarding plan benefits.

About This Section

This section summarizes administrative and rights information for the U.S. Fertility Benefits Program. Please retain this section for your records.

For most plans, the summary plan description and the plan document are the same document. For plans where this is not the case, copies of the plan documents are filed with the plan administrator and are available upon request.

Questions?

For questions or concerns regarding the U.S. Fertility Benefits Program, please contact the Program's service provider, WINFertility, at (833) 439-1517. Representatives are available Monday through Friday, from 9 a.m. to 7:30 p.m. Eastern Time.

For questions about eligibility and plan operations, contact the HR Answers Benefits Contact Center, at 877-JPMChase ((877) 576-2427) (or (212) 552-5100, if calling from outside the United States). Service Representatives are available Monday through Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays.

General Information

The following summarizes important administrative information about the U.S. Fertility Benefits Program.

Keep Your Information Current

Update your contact information (home address and phone numbers) on My Personal Profile. To access My Personal Profile while actively employed, go to https://mpp.jpmchase.net

Program Sponsor

JPMorgan Chase Bank, NA
545 Washington Boulevard
12th Floor
Mail Code: NY1-G120
Jersey City, NJ 07310

(Certain participating companies have adopted the U.S. Fertility Benefits Program for their eligible employees. See "Participating Companies" on page 289 for a list of participating companies.)

Program Year

January 1 – December 31

Plan Administrator

JPMorgan Chase U.S. Benefits Executive
c/o JPMorgan Chase Benefits Administration
545 Washington Boulevard
12th Floor
Mail Code: NY1-G120
Jersey City, NJ 07310

Claims Administrator

WINFertility, at (833) 439-1517.

COBRA Administrator

COBRA questions should be directed to JPMorgan Chase HR Answers Benefits Contact Center.

COBRA payments should be directed to:

COBRA Payments JPMorgan Chase
P.O. Box 27524
New York, NY 10087-7524

(877) 576-2427

Benefits Fiduciaries

Please see “About Plan Fiduciaries” on page 357 for information on benefits fiduciaries.

Agent for Service of Legal Process

Legal Papers Served:

JPMorgan Chase & Co.
4 Chase Metrotech Center
FL 18, NY1-C312
Brooklyn, NY 11245

Service of legal process may also be made upon a plan trustee or the Plan Administrator.

Employer Identification Number

13-4994650

Plan Administrative Information

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
JPMorgan Chase Medical Plan (U.S. Fertility Benefits Program)/502	Not Applicable (no insurer)	WINFertility, Inc. Greenwich American Center One American Lane Terrace Level Greenwich, CT 06831 (833) 439-1517	Self-Insured/Trustee

Participating Companies

In some cases, affiliates or subsidiaries of JPMorgan Chase have decided to participate in the U.S. Fertility Benefits Program. These affiliates or subsidiaries are referred to here as "participating companies." The list may change from time to time, and any company may end its participation in a plan at any time.

- Bear Stearns Asset Management, Inc.
- Connexions Loyalty Acquisition, LLC
- eCast Settlement Corp
- FNBC Leasing Corporation
- Highbridge Capital Mgmt, LLC
- InstaMed Communications, LLC
- J.P. Morgan Alternative Asset Management, Inc.
- J.P. Morgan Chase Custody Services, Inc.
- J.P. Morgan Electronic Financial Services, Inc.
- J.P. Morgan Institutional Investments, Inc.
- J.P. Morgan Investment Holdings LLC
- J.P. Morgan Investment Management Inc.
- J.P. Morgan Securities, LLC
- J.P. Morgan Trust Company of Delaware
- JPMorgan Chase Bank, National Association
- JPMorgan Chase Holding LLC
- JPMorgan Distribution Services, Inc.
- Neovest, Inc.
- Paymentech, LLC
- Security Capital Research & Management, Incorporated
- WePay Inc.
- 55i, LLC

Your Rights Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) gives you certain rights and protections while you are a participant in the U.S. Fertility Benefits Program. It is unlikely you will need to exercise these rights, but it is important that you be aware of what they are.

ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the office of the Plan Administrator, all plan documents including insurance contracts and copies of all documents filed by the plans with the U.S. Department of Labor, such as detailed annual reports (Form 5500 Series).
- Obtain, upon written request to the Plan Administrator, copies of all plan documents and other plan information (for example, insurance contracts, Form 5500 Series, and updated summary plan descriptions). The plan administrator may require reasonable charges for the copies.
- Receive a summary of the plans' annual financial reports. (The plan administrator is required by law to furnish each participant with a copy of such reports.)
- Continue health care coverage for yourself, your spouse, or your eligible dependents if there is a loss of coverage under the plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision free of charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of the plans' documents or the latest annual report from the plan administrator and do not receive it within 30 days, you may file suit in a U.S. federal court. In such a case, the court may require the plan administrator to provide the information and pay up to $110 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a U.S. state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If it should happen that the plans' fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a U.S. federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

Keep Your Contact Information Current

Active participants are required to update their personal contact information, including mailing address, to receive benefits-related information and correspondence. You can make changes online via My Personal Profile at mpp.jpmorganchase.com. You can also call the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427).

About Plan Fiduciaries

The plan "fiduciary" is the individual or organization responsible for plan administration, claims administration, and managing plan assets. The plan fiduciary has a duty to administer the plan prudently and in the best interest of all plan members and beneficiaries.

Prudent Actions by Plan Fiduciaries

In addition to establishing the rights of plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefits plans. Certain individuals who are responsible for the plans are called "fiduciaries," and they have a duty to administer the plans prudently and in the interest of you, other plan members, and beneficiaries. While participation in these plans does not guarantee your right to continued employment, no one — including your employer or any other person — may terminate you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

Health Care and Insurance Plans for Active Employees

For the U.S. Fertility Benefits Program, the Plan Administrators delegate fiduciary responsibility for claims and appeals to the claims administrators, and to the Health Care and Insurance Plans Appeals Committee, where that committee is authorized to decide appeals as described in this summary.

Assistance with Your Questions

If you have any questions about the U.S. Fertility Benefits Program, you should contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427). If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Regional Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by visiting www.dol.gov/ebsa via the Internet.

You should also contact the Department of Labor if you need further assistance or information about your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with respect to health benefits that are offered through a group health plan, as well as the remedies available if a claim is denied in whole or in part.

Privacy Information

The privacy of your health information is important to you and to JPMorgan Chase. We are committed to protecting your personal health information, and complying with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). This means that when you complete a Wellness Screening or a Wellness Assessment, participate in any health coaching activities, or receive health care treatment of any kind, your personal health information is not disclosed to anyone, including JPMorgan Chase, without your authorization and except as permitted by HIPAA. (For detailed information about your HIPAA Privacy Rights, please see the Privacy Notice found on **My Health**.)

If you are enrolled in the U.S. Fertility Benefits Program, WINFertility may have access to your individual health care and prescription claims data related to fertility services. WINFertility maintains the confidentiality of your information in accordance with privacy regulations such as HIPAA.

Privacy Notice

JPMorgan Chase is committed to maintaining the highest level of privacy and discretion about your personal compensation and benefits information.

However, federal legislation under the Health Insurance Portability and Accountability Act (HIPAA) legally requires employers—like JPMorgan Chase—to specifically communicate how certain “protected health information” under employee and retiree health care plans may be used and disclosed, as well as how plan participants can get access to their protected health information.

What Is Protected Health Information?

Protected health information is considered to be individually identifiable health information as it relates to the:

- Past, present, or future health of an individual; or
- Health care services or products provided to an individual; or
- Past, present, or future payment for health care services or products.

The information included in this section is a summary of HIPAA privacy regulations. To comply with the law, JPMorgan Chase will distribute to you once every three years, a “Privacy Notice of Protected Health Information Under the JPMorgan Chase Health Care Plans” that describes in detail how your personal health information may be used and your rights with regard to this information.

You can access the Privacy Notice at **My Health** or by contacting the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) at any time to request a paper copy. Under HIPAA, protected health information is confidential, personal, identifiable health information about you that is created or received by a claims administrator (like those under the JPMorgan Chase Medical Plan), and is transmitted or maintained in any form. ("Identifiable" means that a person reading the information could reasonably use it to identify an individual.)

Under HIPAA, the Medical Plan, which includes the U.S. Fertility Benefits Program, may only use and disclose participants' protected health information in connection with payment, treatment, and health care operations. In addition, the Medical Plan must restrict access to and use of protected health information by all employees/groups except for those specifically involved in administering the Medical Plan, including payment and health care operations. In compliance with HIPAA, the Medical Plan agrees to:

- Not use or further disclose protected health information other than as permitted or required by law;
- Not use or disclose protected health information that is genetic information for underwriting purposes;
- Ensure that any agents (such as an outside claims administrator) to whom the Medical Plan gives protected health information agree to the same restrictions and conditions that apply to the Medical Plan with respect to this information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of JPMorgan Chase;
- Notify you if a breach of your protected health information is discovered;
- Report to the JPMorgan Chase HIPAA Privacy Officer any use or disclosure of the information that is inconsistent with the designated protected health information uses or disclosures;
- Obtain your authorization for any use or disclosure of protected health information for marketing, or that is a sale of the protected health information as defined under applicable law;
- Make available protected health information in accordance with individuals' rights to review such personal information;
- Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules;
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules;
- Make the Medical Plan's internal practices, books, and records relating to the use and disclosure of protected health information received from the claims administrators available to the Secretary of Health and Human Services for purposes of determining the Medical Plan's compliance with HIPAA;
- Return or destroy all protected health information received in any form from the claims administrators. The Medical Plan will not retain copies of protected health information once it is no longer needed for the purpose of a disclosure. An exception may apply if the return or destruction of protected health information is not feasible. However, the Medical Plan must limit further uses and disclosures of this information to those purposes that make the return or destruction of the information infeasible; and
- Request your authorization to use or disclose psychotherapy notes except as permitted by law, which would include for the purposes of carrying out the following treatment, payment or health care operations:
  - Use by the originator of psychotherapy notes for treatment;
  - Use or disclosure by the Medical Plan for its own training program; or
  - Use or disclosure by the Medical Plan to defend itself in a legal action or other proceeding brought by you.

If you believe that your rights under HIPAA have been violated, you can file a complaint with the JPMorgan Chase HIPAA Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the JPMorgan Chase HIPAA Privacy Officer, please contact the Privacy Officer for the JPMorgan Chase Health Care Plans in writing at this address:

HIPAA Privacy Officer for the JPMorgan Chase Health Care Plans
JPMorgan Chase Corporate Benefits
4041 Ogletown Road, Floor 02
Newark, DE, 19713-3159
Mail Code: DE6-1470

Claims Related to Eligibility to Participate in the Plans and Plan Operations

This section provides information about the claims and appeals process for questions relating to eligibility to participate in the Program, such as whether you meet the requirements of employees/dependents/beneficiaries who are allowed to obtain benefits under the plans. In addition, if you have a type of claim that is not otherwise described in this summary, including claims related to general plan operations, lawfulness of plan provisions, or Section 510 of ERISA, you must file your claim in accordance with this section. For information on filing claims for benefits, please see “Claiming Benefits” beginning on page 361.

Help Pursuing Claims for Eligibility

You may authorize someone else to pursue claim information on your behalf. If you would like to designate an authorized representative for claims related to eligibility to participate in a plan, please contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427).

How to File This Type of Claim and What You Can Expect

For questions about eligibility to participate in the Program and to receive benefits or about general plan operations, please contact the HR Answers Benefits Contact Center.

If you are not satisfied with the response, you may file a written claim with the plan administrator at the address provided in “General Information” on page 354. The plan administrator will assign your claim for a determination. You must file your claim within 90 days of the event giving rise to your claim. You will receive a written decision within 90 days of receipt of your claim. Under certain circumstances, this 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your request. In this situation, you will receive written notice of the extension and the reasons for it, as well as the date by which a decision is expected to be made, before the end of the initial 90-day period. If the extension is required because of your failure to submit information necessary to decide the claim, the period for making the determination will begin as of the date you submit the additional information, assuming it is provided in a timely fashion.

If Your Claim Is Denied

If you receive a notice that your claim has been denied, either in full or in part, the notice will explain the reason for the denial, including references to specific plan provisions on which the denial was based. If your claim was denied because you did not furnish complete information or documentation, the notice will state the additional materials needed to support your claim. The notice will also tell you how to request a review of the denied claim and the time limits applicable to those procedures.

To appeal a denial of the type of claims described in this section, you must submit a written request for appeal of your claim to the plan administrator within 60 days after receiving the notice of denial. In connection with your appeal, you may submit written comments, documents, records, or other information relevant to your claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to your claim. The Plan Administrator will decide appeals under the Program.

In most cases, a decision will be made within 60 days after you file your appeal. But if special circumstances require an extension of time for processing, and you are notified that there will be a delay and the reasons for needing more time, there will be an extension of up to 60 days for deciding your appeal. If an extension is necessary because you did not submit enough information to decide your appeal, the timing for making a decision about your appeal is stopped from the date the plan administrator sends you an extension notification until the date that you respond to the request for additional information, assuming your response comes within a reasonable time frame.

Once a decision is reached, you will be notified in writing of the outcome. If an adverse benefit determination is made on review, the notice will include the specific reasons for the decision, with references to specific plan provisions on which it is based.

If you would like to file a court action after your appeal, please see “Filing a Court Action” on page 298, which sets forth the rules that will apply.

Claiming Benefits

This section explains the benefits claims and appeals process for the benefits of the U.S. Fertility Benefits Program. It includes detailed information about what happens at each step in the process and includes important timing requirements. This section also includes information about each plan’s “fiduciary” and contact information. See “About Plan Fiduciaries” on page 357 and “Contacting the Claims Administrator” on page 365. For claims relating to eligibility questions or claims, please see “Claims Related to Eligibility to Participate in the Plans and Plan Operations” on page 360.

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.

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.

Steps in the Benefits Claims and Appeals Process

Step 1: Filing Your Initial Claim for Benefits

In general, when you file a claim for benefits, it is paid according to the provisions of the U.S. Fertility Benefits Program. Your initial claims must be filed no later than six months of when the expenses are incurred. Generally, in-network claims filing is performed by the physician or care provider.

Step 2: Receiving Notification from the Claims Administrator/Plan Administrator if an Initial Claim for Benefits Is Denied

If an initial claim for benefits is denied, the claims administrator or plan administrator will notify you within a "reasonable" period, not to exceed:

- As soon as reasonably possible but no more than 72 hours for claims involving urgent care, where the life of a claimant could be jeopardized (may be oral, with written confirmation within three days). **Please Note**: You must be notified if your claim is approved or denied.
- 15 days for pre-service claims, where approval is required before receiving benefits, plus one 15-day extension because of matters beyond the plan's control.
- 30 days for post-service claims, where the claim is made after care is received, plus one 15-day extension because of matters beyond the plan's control.

What Qualifies as a "Denied Benefit"?

A "denied benefit" is any denial, reduction, or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit. In addition, a benefit may be denied if you didn't include enough information with your initial claim.

Under certain circumstances, the claims administrator or Plan Administrator, as applicable, is allowed an extension of time to notify you of a denied benefit.

Please Note: If an extension is necessary because you did not submit necessary information needed to process your claim, the timing for making a decision about your claim is stopped from the date the claims administrator or plan administrator sends you an extension notification until the date that you respond to the request for additional information. You generally have 45 days from the date you receive the extension notice to send the requested information to the claims administrator or Plan Administrator.

Please Note: Concurrent care claims are claims for which the plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments. Concurrent care claims may fall under any of the other steps in the claims appeal process, depending on when the appeal is made. However, the plan must give you sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

The Explanation You'll Receive from the Claims Administrator/Plan Administrator in the Case of a Denied Benefit

If your initial claim is denied, the claims administrator or plan administrator is legally required to provide an explanation for the denial, which will include the following:

- The specific reason(s) for the denial;
- References to the specific plan provisions on which the denial is based;
- A description of any additional material or information needed to process your claim and an explanation of why that material or information is necessary; and
- A description of the plan's appeal procedures and time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA after, and if, your appeal is denied.
- If the benefit was denied based on medical appropriateness, an experimental or unproven treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge upon request.

Step 3: Filing an Appeal to the Claims Administrator/Plan Administrator if an Initial Claim for Benefits Is Denied

If you have filed a claim for benefits and your claim is denied, you have the right to appeal the decision. JPMorgan Chase is not involved in deciding appeals for any denied benefit claim under the U.S. Fertility Benefits Program.

The plan administrators delegate all fiduciary responsibility and decisions about a claim for a denied benefit under the Fertility Benefits Program to WINFertility.

Under certain plans including the U.S. Fertility Benefits Program, final appeals for denied claims will be heard by a review panel that is independent of both the company and the claims administrators.

If your initial claim for benefits is denied, you — or your authorized representative — may file an appeal of the decision with the claims administrator or plan administrator within 180 days after receipt of the claim denial.

In your appeal, you have the right to:

- Submit written comments, documents, records, and other information relating to your claim.
- Request, free of charge, reasonable access to, and copies of, all documents, records, and other information that:
  - Was relied upon in denying the benefit.
  - Was submitted, considered, or generated in the course of denying the benefit, regardless of whether it was relied on in making this decision.
  - Demonstrates compliance with the administrative processes and safeguards required in denying the benefit.
  - For health care: constitutes a policy statement or plan guideline concerning the denied benefit regardless of whether the policy or guideline was relied on in denying the benefit.

You also have the right to receive:

- A review that does not defer to the initial benefit denial and that is conducted by someone other than the person who made the denial or that person's subordinate.
- For a denied benefit based on medical judgment (including whether a particular treatment, drug, or other item is experimental or unproven), a review in which the plan fiduciary/claims administrator consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was not consulted in connection with the initial benefits denial, nor the subordinate of this person.
- The identification of medical or vocational experts whose advice was obtained in connection with denying the benefit, regardless of whether the advice was relied on in making this decision.
- In the case of an urgent care claim where the life of a claimant could be jeopardized, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of a denied benefit.
  - All necessary information, including the decision on your appeal, will be transmitted between the plan fiduciary/claims administrator and you by telephone, facsimile, or other available similarly prompt method.

Step 4: Receiving Notification from the Claims Administrator/Plan Administrator if Your Appeal Is Denied

If your appeal is subsequently denied, the claims administrator or plan administrator is legally required to notify you in writing of this decision within a "reasonable" period of time according:

- As soon as reasonably possible but no more than 72 hours for claims where the life of a claimant could be jeopardized (urgent care)
- 15 days where approval is required before receiving benefits (pre-service claims)
- 30 days where the claim is made after care is received (post-service claims)

The claims administrator or the plan administrator is allowed to take an extension to notify you of a denied appeal under certain circumstances. If an extension is necessary, the claims administrator or plan administrator will notify you before the end of the original notification period. This notification will include the reason(s) for the extension and the date the claims administrator or the plan administrator expects to provide a decision on your appeal for the denied benefit. **Please Note**: If an extension is necessary because you did not submit enough information to decide your appeal, the time frame for decisions is stopped from the date the claims administrator or the plan administrator sends you an extension notification until the date that you respond to the request for additional information.

The Explanation You'll Receive from the Claims Administrator/Plan Administrator in the Case of a Denied Benefit

If an appeal is denied, the claims administrator or plan administrator is legally required to provide an explanation for the denial, which will include the following:

- The specific reason(s) for the denial;
- References to the specific plan provisions on which the denial is based;
- A statement that you're entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement describing any appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring a civil action under ERISA.
- If the benefit was denied based on medical appropriateness, experimental, or unproven treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A description of the expedited review process for urgent care claims in the Medical Plan, where the life of the claimant could be jeopardized.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge upon request in the Medical Plan.

The U.S. Fertility Benefits Program requires two levels of appeal, which you must complete if you would like to pursue your claim further.

Step 5: Receiving a Final Appeal by an Independent Review Panel

If your appeal of a benefits claim is denied, your final appeal for coverage will be heard by a review panel that is independent of both the company and the claims administrator.

The independent review panel hears only appeals that involve medical judgment or a rescission of coverage; the panel does not hear appeals about eligibility to participate in a plan or legal interpretation of a plan that does not involve medical judgment.

Filing a Court Action

If an appeal is denied (in whole or in part), you may file suit in a U.S. federal court. If you are successful, the court may order the defending person or organization to pay your related legal fees. If you lose, the court may order you to pay these fees (for example, if the court finds your claim frivolous). You may contact the U.S. Department of Labor or your state insurance regulatory agency for information about other available options.

If you bring a civil action under ERISA, you must start the action by the earlier of: (i) one year after the date of the denial of your final appeal; or (ii) three years after the date when your initial claim should have been filed, regardless of any state of federal statutes relating to limitations of actions. If, however, the applicable state or federal law relating to limitations of actions would result in a shorter limitations period within which to start the action, the shorter limitations period will apply. You cannot file a suit unless you have completed two appeals, if required by the claims administrators.

Contacting the Claims Administrator

WINFertility

Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831

(833) 439-1517

If You Are Covered by More Than One Health Care Plan

The JPMorgan Chase U.S. Fertility Benefits Program has provisions to ensure that payments from all of your group health care plans don't exceed the amount the JPMorgan Chase plans would pay if they were your only coverage.

The rules described here apply to JPMorgan Chase Program. The following rules do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

The JPMorgan Chase health care plans do not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. The non-duplication provisions of the JPMorgan Chase health care plans will ensure that, in total, you receive benefits up to what you would have received with the JPMorgan Chase plans as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount.

A summary of coordination rules (that is, how JPMorgan Chase coordinates coverage with another group plan to ensure non-duplication of benefits) follows. If you have questions, please contact your health care company for help.

Here's an example of how the JPMorgan Chase health care plans coordinate benefits with other group health care plans:

- Assume your spouse/domestic partner has a necessary covered procedure with a reasonable and customary (R&C) charge of $100 after meeting any deductible.
- If your spouse/domestic partner's plan (which we'll assume is primary) pays 70% for that procedure, your spouse/domestic partner will receive a $70 benefit (70% of $100).
- Also assume that your JPMorgan Chase health care plan (which we'll assume is your spouse/domestic partner's secondary coverage and that the deductible has already been satisfied)—would pay 80% for this necessary procedure. In this case, your spouse/domestic partner normally would receive an $80 benefit (80% of $100) from the JPMorgan Chase plan.

- Since your spouse/domestic partner already received $70 from his or her primary plan, he or she would receive the balance ($10) from the JPMorgan Chase plan.
- If, however, your JPMorgan Chase plan considered the R&C charge to be $80, no additional benefit would be payable, as the JPMorgan Chase plan would pay 80% of $80, or $64. As that amount would have already been paid by your spouse/domestic partner's plan, no additional benefit would be payable from the JPMorgan Chase plan.

Determining Primary Coverage

To determine which health care plan pays first as the primary plan, here are some general guidelines:

- If you are enrolled in the JPMorgan Chase plan and another plan and your other health care plan doesn't have a coordination of benefits provision, that plan will be considered primary, and it will pay first for you and your covered dependents.
- If your covered dependent has a claim, the plan covering your dependent as an employee or retiree will be considered primary to this plan.
- If your claim is for a covered child who is enrolled in coverage under both parents' plans, the plan covering the parent who has the earlier birthday in a calendar year (based on the month and date of birthday only, not the year) will be considered primary. In the event of divorce or legal separation, and in the absence of a qualified medical child support order, the plan covering the parent with court-decreed financial responsibility will be considered primary for the covered child. If there is no court decree, the plan of the parent who has custody of the covered child will be considered primary for the covered child. (Please see "Qualified Medical Child Support Orders" in the *Health Care Participation* section.)
- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

After it is determined which plan is primary, you'll need to submit your initial claim to that plan.

After the primary plan pays benefits (up to the limits of its coverage), you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You'll need to include a copy of the written Explanation of Benefits from your primary plan.

Coordination with Medicare

Medicare is a national health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). It generally provides coverage for Americans ages 65 and older. It also provides coverage to younger people with a qualifying disability. As long as you remain an active employee with JPMorgan Chase, your JPMorgan Chase coverage will be primary, and any Medicare coverage for you will be secondary. Additionally, any covered dependents who become eligible for Medicare, while you remain an active employee, will also have JPMorgan Chase coverage as primary.

- While you remain an active JPMorgan Chase employee, the JPMorgan Chase health care plans will be primary for you and your covered dependents unless those dependents have primary coverage elsewhere. If your covered dependents have primary coverage elsewhere, those claims will be considered by that primary coverage first, JPMC coverage will be secondary and Medicare will consider claims for those health care expenses tertiary (third) Even if you work past age 65 and you and/or a covered spouse/domestic partner enroll in Medicare, the JPMorgan Chase plans will consider claims for your health care expenses before Medicare while you are an active employee.
- When you are no longer an active JPMC employee or are receiving LTD benefits, Medicare coverage will be primary for the Medicare enrolled individual. JPMC coverage will be terminated upon Medicare eligibility and coverage in Medicare plans is available from Via Benefits.

Right of Recovery

If the JPMorgan Chase plan provides benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the JPMorgan Chase plans have the right to recover these payments from you or from the person or company who is determined to be legally responsible. Assignment of your claim to a third party does not exempt you from your responsibility for repaying the plan. You must notify the JPMorgan Chase plan promptly of any circumstance in which a third party may be responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plan making payments on your behalf.

Subrogation of Benefits

The purpose of the JPMorgan Chase health care plans is to provide benefits for eligible health care expenses that are not the responsibility of any third party. The JPMorgan Chase plans have the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plans making payments on your behalf or on behalf of a covered dependent. This is known as subrogation of benefits. The following rules apply to the plan's subrogation of benefits rights:

- The JPMorgan Chase plans have first priority from any amounts recovered from a third party for the full amount of benefits the plans have paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the JPMorgan Chase plans use this right when requested.
- If you fail to help the JPMorgan Chase plans use this right when requested, the plans may deduct the amount the plans paid from any future benefits payable under the plans.
- The JPMorgan Chase plans have the right to take whatever legal action they deem appropriate against any third party to recover the benefits paid under the plans.
- If the amount you receive as a recovery from a third party is insufficient to satisfy the JPMorgan Chase plans' subrogation claim in full, the plans' subrogation claim shall be first satisfied before any part of a recovery is applied to your claim against the third party.
- The JPMorgan Chase plans are not responsible for any attorney fees, attorney liens, or other expenses you may incur without the plans' prior written consent. The "common fund" doctrine does not apply to any amount recovered by any attorney you retain regardless of whether the funds recovered are used to repay benefits paid by the plans.

If you receive a subrogation request and have questions, please contact your health care company.

Right of Reimbursement

In addition to their subrogation rights, the JPMorgan Chase health care plans are entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for health care expenses that have been paid by the plans. The following rules apply to the plans' right of reimbursement:

- You must reimburse the JPMorgan Chase plans in first priority from any recovery from a third party for the full amount of the benefits the plan paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- Regardless of any allocation or designation of your recovery made in a settlement agreement or court order, the JPMorgan Chase plans shall have a right of full reimbursement, in first priority, from the recovery.

- You must hold in trust for the benefit of the JPMorgan Chase plans the gross proceeds of a recovery, to be paid to the plans immediately upon your receipt of the recovery. You must reimburse the plans, in first priority and without any set-off or reduction for attorney fees or other expenses. The "common fund" doctrine does not apply to any funds recovered by any attorney you retain, regardless of whether the funds recovered are used to repay benefits paid by the plans.
- If you fail to reimburse the JPMorgan Chase plans, the plans may deduct any unsatisfied portion of the amount of benefits the plans have paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plans.

If you fail to disclose the amount of your recovery from a third party to the JPMorgan Chase plans, the plans shall be entitled to deduct the full amount of the benefits the plans paid on your behalf from any future benefits payable under the plans.

Special Notice for Employees Who Have Been Rehired by JPMorgan Chase

If your employment has been reinstated with JPMorgan Chase (that is, you have been rehired within 31 days of your employment termination date or your coverage termination date), you and your dependents will be assigned the same U.S. Medical Plan coverage (which includes Fertility Benefits Program coverage) you had before your coverage termination date. **Please Note**: If you are a retired employee when rehired, you must take active employee coverage and discontinue any retiree coverage you may have elected.

Please Note: If you are rehired after 31 days of your termination date, you will need to make new benefits elections for all plans for which you would like to participate.

Defined Terms

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

Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Program. For the Fertility Benefits Program benefits, the claims administrator is WINFertility.
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. "Continuing Health Coverage Under COBRA" on page 282 provides details on COBRA coverage. You must elect JPMorgan Chase Medical Plan coverage under COBRA to continue the Fertility Benefit under COBRA. There is no additional charge for the Fertility Benefit under COBRA if Medical Plan coverage is elected.
Covered Services	Covered services are services and procedures that are generally reimbursable by the Program. While the Program 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 Program. Please see the sections that explain what the Program covers and what is not covered for more details.
Introductory Period	All employees, including re-employed individuals, begin employment with a 90-day introductory period, regardless of the length of the break in employment for re-employed individuals. The introductory period does not apply if an employee transfers or is promoted into a new position or if the employee joins the firm through a merger or acquisition. During the 90-day introductory period of continuous service, employees demonstrate their performance capabilities and assess whether the position is suited to them. The manager also assesses whether the employee is appropriately qualified and suited for the position. The introductory period may also serve as a period of time to complete any training or licensing requirements for the position in which the employee was hired. At JPMorgan Chase's discretion, there may be times when the introductory period will be extended beyond 90 days. During an employee's introductory period (and throughout employment with JPMorgan Chase) an employee's employment may be terminated at any time without prior warning.
In-Network Provider/Out-of-Network Provider	"In-network" and "out-of-network" are terms referring to whether a provider is part of the WINFertility network (in-network provider) or is not part of the WINFertility network (out-of-network provider).

Plan Administration

Effective 1/1/21

This section of the Guide provides you with important information as required by the Employee Retirement Income Security Act of 1974 (ERISA) about the JPMorgan Chase Health Care and Insurance Plans for Active Employees. While ERISA doesn't require JPMorgan Chase to provide you with benefits, by choosing to do so, ERISA mandates that JPMorgan Chase clearly communicate to you how the plans subject to the provisions of ERISA operate and what rights you have under the law regarding plan benefits. This section is part of the summary plan description of each of your JPMorgan Chase Health Care and Insurance Plans for Active Employees governed by ERISA. This section of the Guide also provides important information about certain benefits plans that are not governed by ERISA, such as the Personal Excess Liability Plan.

While the U.S. Fertility Benefits Program is a benefit offered under the Medical Plan, the section describing the Fertility Benefits Program includes the information that is included in this Plan Administration section for most other plans.

For most plans, the summary plan description and the plan document are the same document. For plans where this is not the case, copies of the plan documents are filed with the plan administrator and are available upon request. For plans that are funded through insurance, if there is a discrepancy between the insurance policy and the SPD, the insurance policy will govern.

About This Section

This section summarizes administrative information and rights for the Health Care and Insurance Plans for Active Employees. Please retain this section for your records. Other sections may be needed in addition to this section to provide a complete summary plan description (SPD) and/or plan document for a plan, including the sections that describe the benefits the plan provides.

These SPDs/plan documents do not include all of the details contained in the applicable insurance contracts, if any. For plans with applicable insurance contracts, if there is a discrepancy between the insurance contract and the SPD/plan document, the insurance contract will control.

Questions?

Please see the *Contacts* section as well as the "Questions?" box at the start of each section of this Guide for details on where to call and how to access the appropriate web center for each benefit plan. Each section of the Guide also includes a subsection titled "Claims Administrators' Contact Information."

For questions about eligibility and plan operations, contact HR Answers, at 877-JPMChase ((877) 576-2427) (or (212) 552-5100, if calling from outside the United States). Service Representatives are available Monday – Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays.

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. JPMorgan Chase & Co. 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 JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

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General Information

The following summarizes important administrative information about the JPMorgan Chase Health Care and Insurance Plans for Active Employees governed by ERISA. **Please Note**: Each plan can be identified by a specific plan number, which is on file with the U.S. Department of Labor. Please see "Plan Administrative Information" on page 355 for a listing of official plan names and numbers.

Keep Your Information Current

Update your contact information (home address and phone numbers) on **me@JPMC** To access My Personal Profile while actively employed, go to **me@JPMC** – Personal Information – Contact Information.

Plan Sponsor

JPMorgan Chase Bank, NA
545 Washington Boulevard
12th Floor
Mail Code: NY1-G120
Jersey City, NJ 07310

(Certain participating companies have adopted some or all of the plans for their eligible employees. See "Participating Companies" on page 356 for a list of participating companies.)

Plan Year

January 1 – December 31

Plan Administrator

For all plans described in this Guide except for the Business Travel Accident Insurance and the Short-Term Disability Plan:

JPMorgan Chase U.S. Benefits Executive
c/o JPMorgan Chase Benefits Administration
545 Washington Boulevard
12th Floor
Mail Code: NY1-G120
Jersey City, NJ 07310

For the Business Travel Accident Insurance Plan:

JPMorgan Chase Corporate Insurance Services
JPMorgan Chase & Co.
8181 Communications Pkwy Bldg B, Floor 03
Mail Code TXW-3305
Plano, TX 75024-0239, United States

For Short-Term Disability Plan (Not applicable to the JPMorgan Chase Long-Term Disability Plan):

JPMorgan Chase Employee Relations Executive
JPMorgan Chase & Co.
28 Liberty Street
22nd Floor
Mail Code: NY1-A302
New York, NY 10005-1401

Claims Administrator

The contact information for claims administrators for the various benefits plans can be found under “Contacting the Claims Administrator” on page 365 and “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 489.

COBRA Administrator

COBRA questions should be directed to JPMorgan Chase HR Answers.

COBRA payments should be directed to:

COBRA Payments JPMorgan Chase
P.O. Box 27524
New York, NY 10087-7524

(877) 576-2427

Benefits Fiduciaries

Please see “About Plan Fiduciaries” on page 357 for information on benefits fiduciaries.

Agent for Service of Legal Process

Legal Papers Served:

JPMorgan Chase & Co.
4 Chase Metrotech Center
FL 18, NY1-C312
Brooklyn, NY 11245

Service of legal process may also be made upon a plan trustee or the plan administrator.

Employer Identification Number

13-4994650

Plan Administrative Information

The following chart shows the information that varies by plan. All of the following plans are governed by ERISA. (The Dependent Care Spending Account, Transportation Spending Accounts, and the Group Personal Excess Liability Insurance Plan are not governed by ERISA and are not listed here. For more information, see “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 489.)

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Medical Plan/502	See “Contacting the Claims Administrator” on page 365 for names, addresses, and telephone numbers for the Medical Plan and the Prescription Drug Plan.	See “Contacting the Claims Administrator” on page 365 for names, addresses and telephone numbers for the Medical Plan and the Prescription Drug Plan.	Self-Insured/Trustee

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Dental Plan/502	See "Contacting the Claims Administrator" on page 365 for names and addresses for the Preferred Dentist Program (PDP) Option, the Dental Maintenance Organization (DMO) Option, the Dental Health Maintenance Organization (DHMO) Option, and the Expatriate Dental Option.	See "Contacting the Claims Administrator" on page 365 for names, addresses, and telephone numbers for the PDP Option, the DMO Option, the DHMO Option, and the Expatriate Dental Option.	Self-Insured/Trustee: PDP Option and Expatriate Dental Option Fully Insured: DMO Option and DHMO Option
The JPMorgan Chase Vision Plan/502 (Group 1018009)	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111	Fully Insured
The JPMorgan Chase Basic Life Insurance Plan/502*	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured
The JPMorgan Chase Supplemental Term Life Insurance Plan/502*	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured
The JPMorgan Chase Accidental Death and Dismemberment (AD&D) Insurance Plan/502	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017	Fully Insured
The JPMorgan Chase Long-Term Disability Plan's Group (LTD)/502	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176	Fully Insured
The JPMorgan Chase Long-Term Disability Plan's Individual Disability Insurance (IDI)/502	Unum 1 Fountain Square Chattanooga, TN 37402	Unum The Benefits Center P.O. Box 100262 Columbia, SC 29202-3262	Fully-Insured

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Group Legal Services Plan/502	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114	Fully Insured
The JPMorgan Chase Employee Assistance Program (EAP)/502	Administrator: Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152	Administrator: Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152	Fully-Insured (CA & NV—clinical component only) Pre-Paid Service (all other)
The JPMorgan Chase Back-up Child Care Plan/502	N/A	Bright Horizons Family Solutions 200 Talcott Avenue, South Watertown, MA 02472	Self-Insured
The JPMorgan Chase Business Travel Accident (BTA) Insurance Plan/506	AIG — National Union Fire Insurance Company of Pittsburgh, PA 17200 West 119 St. Shawnee Mission, KS 66225	AIG — National Union Fire Insurance Company of Pittsburgh, PA 17200 West 119 St. Shawnee Mission, KS 66225	Fully Insured
The JPMorgan Chase Health Care Spending Account Plan/510	N/A	See “Contacting the Claims Administrator” on page 365 for names, addresses, and telephone numbers for the Health Care Spending Account Plan	Salary Reduction/ Paid from the general assets of the employer
The JPMorgan Chase Short-Term Disability Plan/548	N/A	Sedgwick Claims Management Services JPMorgan Chase Leave of Absence Service Center P.O. Box 14648 Lexington, KY 40512-4648	Self-Insured

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
The JPMorgan Chase Health & Wellness Centers Plan/559	N/A	JPMorgan Chase Medical Director JPMorgan Chase & Co. 270 Park Avenue, 11th Floor Mail Code: NY1-K318 New York, NY 10017-2014	Self-Insured

* The JPMorgan Chase Basic Life Insurance Plan and the JPMorgan Chase Supplemental Term Life Insurance Plan are collectively referred to as the "Life Insurance Plan" in this SPD.

Participating Companies

In some cases, affiliates or subsidiaries of JPMorgan Chase have decided to participate in the JPMorgan Chase benefits plans and offer the benefits described in this Guide. These affiliates or subsidiaries are referred to here as "participating companies." The list may change from time to time, and any company may end its participation in a plan at any time.

- Bear Stearns Asset Management, Inc.
- Connexions Loyalty Acquisition, LLC
- eCast Settlement Corp
- FNBC Leasing Corporation
- Highbridge Capital Mgmt, LLC
- InstaMed Communications, LLC
- J.P. Morgan Alternative Asset Management, Inc.
- J.P. Morgan Chase Custody Services, Inc.
- J.P. Morgan Electronic Financial Services, Inc.
- J.P. Morgan Institutional Investments, Inc.
- J.P. Morgan Investment Holdings LLC
- J.P. Morgan Investment Management Inc.
- J.P. Morgan Securities, LLC
- J.P. Morgan Trust Company of Delaware
- JPMorgan Chase Bank, National Association
- JPMorgan Chase Holding LLC
- JPMorgan Distribution Services, Inc.
- Neovest, Inc.
- Paymentech, LLC
- Security Capital Research & Management, Incorporated
- WePay Inc.
- 55i, LLC

Your Rights Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) gives you certain rights and protections while you are a participant in the JPMorgan Chase employee benefits plans described in this Guide. It is unlikely you will need to exercise these rights, but it is important that you be aware of what they are.

An Important Note

The Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan are not subject to the provisions of ERISA.

ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the office of the plan administrator, all plan documents including insurance contracts and copies of all documents filed by the plans with the U.S. Department of Labor, such as detailed annual reports (Form 5500 Series).
- Obtain, upon written request to the plan administrator, copies of all plan documents and other plan information (for example, insurance contracts, Form 5500 Series, and updated summary plan descriptions). The plan administrator may require reasonable charges for the copies.
- Receive a summary of the plans' annual financial reports. (The plan administrator is required by law to furnish each participant with a copy of such reports.)
- Continue health care coverage for yourself, your spouse, or your eligible dependents if there is a loss of coverage under the plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision free of charge, and to appeal any denial, all within certain time schedules.

Keep Your Contact Information Current

Active participants are required to update their personal contact information, including mailing address, to receive benefits-related information and correspondence. You can make changes online via **me@JPMC** – Personal Information – Contact Information. You can also contact HR Answers. See the *Contacts* section.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of the plans' documents or the latest annual report from the plan administrator and do not receive it within 30 days, you may file suit in a U.S. federal court. In such a case, the court may require the plan administrator to provide the information and pay up to $110 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the plan administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a U.S. state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If it should happen that the plans' fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a U.S. federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

About Plan Fiduciaries

The plan "fiduciary" is the individual or organization responsible for plan administration, claims administration, and managing plan assets. The plan fiduciary has a duty to administer the plan prudently and in the best interest of all plan members and beneficiaries.

Prudent Actions by Plan Fiduciaries

In addition to establishing the rights of plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefits plans. Certain individuals who are responsible for the plans are called "fiduciaries," and they have a duty to administer the plans prudently and in the interest of you, other plan members, and beneficiaries. While participation in these plans does not guarantee your right to continued employment, no one — including your employer or any other person — may terminate you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

Health Care and Insurance Plans for Active Employees

For each of the following plans that are governed by ERISA, the plan administrators delegate fiduciary responsibility for claims and appeals to the claims administrators, and to the Health Care and Insurance Plans Appeals Committee, where that committee is authorized to decide appeals as described in this Guide:

- Medical Plan;
- Prescription Drug Plan;
- Fertility Benefits Program;
- Dental Plan;
- Health Care Spending Account Plan;
- Vision Plan;
- Health & Wellness Centers Plan;
- Life and AD&D Insurance Plans;
- Business Travel Accident Insurance Plan;
- Long-Term Disability Plan, including Group LTD and Individual Disability Insurance;
- Short-Term Disability Plan;
- Employee Assistance Program;
- Group Legal Services Plan; and
- Back-Up Child Care Plan.

Assistance with Your Questions

If you have any questions about the JPMorgan Chase Health Care and Insurance Plans for Active Employees, you should contact HR Answers. (See the *Contacts* section.) If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Regional Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by visiting www.dol.gov/ebsa via the Internet.

You should also contact the Department of Labor if you need further assistance or information about your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with respect to health benefits that are offered through a group health plan, as well as the remedies available if a claim is denied in whole or in part.

Privacy Information

The privacy of your health information is important to you and to JPMorgan Chase. We are committed to protecting your personal health information, and complying with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). This means that when you complete a Wellness Screening or a Wellness Assessment, participate in any health coaching activities, or receive health care treatment of any kind, your personal health information is not disclosed to anyone, including JPMorgan Chase, without your authorization and except as permitted by HIPAA. (For detailed information about your HIPAA Privacy Rights, please see the Privacy Notice found on **My Health**.

If you are enrolled in the Medical Plan, your health care company will have access to your individual health care and prescription claims data, in addition to the results of your Wellness Screening and Wellness Assessment. A medical professional at your health care company will review the results and may contact you to discuss ways to improve your health. Your health care company maintains the confidentiality of your information in accordance with privacy regulations such as HIPAA.

Similarly, if you have waived coverage under the JPMorgan Chase Medical Plan and you participate in the Wellness Screening and Wellness Assessment, a medical professional at Cigna will review the results and may contact you to discuss ways to improve your health. Cigna will maintain the confidentiality of your information in accordance with privacy regulations such as HIPAA.

If you use a JPMorgan Chase Health & Wellness Center, your personal health information is likewise kept confidential. While the JPMorgan Chase Health & Wellness Centers are staffed with nurses and some doctors who are employed by JPMorgan Chase, they are medical professionals and do not disclose your personal health information to anyone outside the Center without your permission. If you choose to visit one of our onsite Health & Wellness Centers, and/or share your Wellness Screening results or any other health information with staff in the Centers, that information will be kept private and will not be shared with management, Human Resources, or any other individual or group within JPMorgan Chase. For more information, go to **My Health** > Benefits Enrollment > Benefits Resources > Privacy Notice.

Privacy Notice

JPMorgan Chase is committed to maintaining the highest level of privacy and discretion about your personal compensation and benefits information.

However, federal legislation under the Health Insurance Portability and Accountability Act (HIPAA) legally requires employers—like JPMorgan Chase—to specifically communicate how certain “protected health information” under employee and retiree health care plans may be used and disclosed, as well as how plan participants can get access to their protected health information.

What Is Protected Health Information?

Protected health information is considered to be individually identifiable health information as it relates to the:

- Past, present, or future health of an individual; or
- Health care services or products provided to an individual; or
- Past, present, or future payment for health care services or products.

The information included in this section is a summary of HIPAA privacy regulations. To comply with the law, JPMorgan Chase will distribute to you once every three years, a "Privacy Notice of Protected Health Information Under the JPMorgan Chase Health Care Plans" that describes in detail how your personal health information may be used and your rights with regard to this information.

You can access the Privacy Notice at **My Health** or by contacting HR Answers at any time to request a paper copy. Under HIPAA, protected health information is confidential, personal, identifiable health information about you that is created or received by a claims administrator (like those under the JPMorgan Chase Medical Plan), and is transmitted or maintained in any form. ("Identifiable" means that a person reading the information could reasonably use it to identify an individual.)

Under HIPAA, the Medical Plan may only use and disclose participants' protected health information in connection with payment, treatment, and health care operations. In addition, the Medical Plan must restrict access to and use of protected health information by all employees/groups except for those specifically involved in administering the Medical Plan, including payment and health care operations. In compliance with HIPAA, the Medical Plan agrees to:

- Not use or further disclose protected health information other than as permitted or required by law;
- Not use or disclose protected health information that is genetic information for underwriting purposes;
- Ensure that any agents (such as an outside claims administrator) to whom the Medical Plan gives protected health information agree to the same restrictions and conditions that apply to the Medical Plan with respect to this information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of JPMorgan Chase;
- Notify you if a breach of your protected health information is discovered;
- Report to the JPMorgan Chase HIPAA Privacy Officer any use or disclosure of the information that is inconsistent with the designated protected health information uses or disclosures;
- Obtain your authorization for any use or disclosure of protected health information for marketing, or that is a sale of the protected health information as defined under applicable law;
- Make available protected health information in accordance with individuals' rights to review such personal information;
- Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules;
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules;
- Make the Medical Plan's internal practices, books, and records relating to the use and disclosure of protected health information received from the claims administrators available to the Secretary of Health and Human Services for purposes of determining the Medical Plan's compliance with HIPAA;
- Return or destroy all protected health information received in any form from the claims administrators. The Medical Plan will not retain copies of protected health information once it is no longer needed for the purpose of a disclosure. An exception may apply if the return or destruction of protected health information is not feasible. However, the Medical Plan must limit further uses and disclosures of this information to those purposes that make the return or destruction of the information infeasible; and
- Request your authorization to use or disclose psychotherapy notes except as permitted by law, which would include for the purposes of carrying out the following treatment, payment or health care operations:
  - Use by the originator of psychotherapy notes for treatment;
  - Use or disclosure by the Medical Plan for its own training program; or
  - Use or disclosure by the Medical Plan to defend itself in a legal action or other proceeding brought by you.

If you believe that your rights under HIPAA have been violated, you can file a complaint with the JPMorgan Chase HIPAA Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the JPMorgan Chase HIPAA Privacy Officer, please contact the Privacy Officer for the JPMorgan Chase Health Care Plans in writing at this address:

HIPAA Privacy Officer for the JPMorgan Chase Health Care Plans
JPMorgan Chase Corporate Benefits
4041 Ogletown Road, Floor 02
Newark, DE, 19713-3159
Mail Code: DE6-1470

Claims Related to Eligibility to Participate in the Plans and Plan Operations

This section provides information about the claims and appeals process for questions relating to eligibility to participate in the plans, such as whether you meet the requirements of employees/dependents/beneficiaries who are allowed to obtain benefits under the plans, and whether you are eligible for Medical Reimbursement Account (MRA) funds. In addition, if, with respect to the plans subject to ERISA, you have a type of claim that is not otherwise described in this Guide, including claims related to general plan operations or Section 510 of ERISA, you must file your claim in accordance with this section. For information on filing claims for benefits, please see “Claiming Benefits” beginning on page 361.

In addition, for appeals relating to eligibility to participate in the Short-Term Disability Plan, the plan administrator delegates responsibility to decide the appeals to the Short-Term Disability Plan Appeals Committee.

Help Pursuing Claims for Eligibility

You may authorize someone else to pursue claim information on your behalf. If you would like to designate an authorized representative for claims related to eligibility to participate in a plan, please contact HR Answers.

How to File This Type of Claim and What You Can Expect

For questions about eligibility to participate in the Health Care and Insurance Plans for Active Employees and to receive benefits or about general plan operations, please contact HR Answers. (See the *Contacts* section.)

For the plans that are subject to ERISA, if you are not satisfied with the response, you may file a written claim with the appropriate plan administrator at the address provided in “General Information” on page 354. The plan administrator will assign your claim for a determination. You must file your claim within 90 days after the day you knew, or reasonably should have known, that you have a dispute with the plan regarding the matter that you wish to have revised or addressed. You will receive a written decision within 90 days of receipt of your claim. Under certain circumstances, this 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your request. In this situation, you will receive written notice of the extension and the reasons for it, as well as the date by which a decision is expected to be made, before the end of the initial 90-day period. If the extension is required because of your failure to submit information necessary to decide the claim, the period for making the determination will begin as of the date you submit the additional information, assuming it is provided in a timely fashion.

If Your Claim Is Denied

If you receive a notice that your claim has been denied, either in full or in part, the notice will explain the reason for the denial, including references to specific plan provisions on which the denial was based. If your claim was denied because you did not furnish complete information or documentation, the notice will state the additional materials needed to support your claim. The notice will also tell you how to request a review of the denied claim and the time limits applicable to those procedures.

To appeal a denial of the type of claims described in this section for any of the Health Care and Insurance Plans for Active Employees, you must submit a written request for appeal of your claim to the appropriate plan administrator within 60 days after receiving the notice of denial. In connection with your appeal, you may submit written comments, documents, records, or other information relevant to your claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to your claim. The plan administrator for the Business Travel Accident Insurance Plan will decide your appeal under that plan. The plan administrator for the Short Term Disability Plan will decide appeals under that plan. The Health Care and Insurance Plans Appeals Committee is delegated responsibility for deciding appeals under all other Health Care and Insurance Plans for Active Employees. For appeals regarding general plan operations that are not otherwise described in this plan description, including claims related to general plan operations or Section 510 of ERISA, the appeal will be decided by the Plan Administrator or its delegate.

In most cases, a decision will be made within 60 days after you file your appeal. But if special circumstances require an extension of time for processing, and you are notified that there will be a delay and the reasons for needing more time, there will be an extension of up to 60 days for deciding your appeal. If an extension is necessary because you did not submit enough information to decide your appeal, the timing for making a decision about your appeal is stopped from the date the plan administrator sends you an extension notification until the date that you respond to the request for additional information, assuming your response comes within a reasonable time frame.

Once a decision is reached, you will be notified in writing of the outcome. If an adverse benefit determination is made on review, the notice will include the specific reasons for the decision, with references to specific plan provisions on which it is based.

If you would like to file a court action after your appeal, please see “Filing a Court Action” on page 365, which sets forth the rules that will apply.

Claiming Benefits: Plans Subject to ERISA

This section explains the benefits claims and appeals process for the benefits of the JPMorgan Chase Health Care and Insurance Plans for Active Employees that are subject to the Employee Retirement Income Security Act of 1974 (ERISA). It includes detailed information about what happens at each step in the process and includes important timing requirements. This section also includes information about each plan’s “fiduciary” and contact information. See “About Plan Fiduciaries” on page 357 and “Contacting the Claims Administrator” on page 365. For claims relating to eligibility questions or plan operations, please see “Claims Related to Eligibility to Participate in the Plans and Plan Operations” on page 477.

Please Note: Any claims or appeals that are related to a disability will be handled in accordance with the Department of Labor regulations found in Code 29 Section 2560. This section of the Code provides certain procedural protections and safeguards for disability benefit claims. For example, the regulations require that disability claimants receive a clear explanation of why their claim was denied and of their rights to appeal a claim denial. It also allows claimants to review and respond during the course of an appeal to any new or additional evidence that the Plan relied on in connections with the claim.

An Important Reminder

The Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan are not subject to the provisions of ERISA described in this section. For information about those plans, please see “Contacting the Claims Administrators: Plans Not Subject to ERISA” beginning on page 489.

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.

Steps in the Benefits Claims and Appeals Process

Step 1: Filing Your Initial Claim for Benefits

In general, when you file a claim for benefits, it is paid according to the provisions of the specific benefits plan. There are different timing requirements for different plans, as outlined in the following table. For all initial benefits claims, please contact the appropriate claims administrator for the plan. See “Contacting the Claims Administrator” on page 365.

Plan/Option	Appropriate Claims Administrator	Timing for Filing Your Initial Claim
Medical Plan*, including the Medical Reimbursement Account	Claims administrator for your Medical Plan option	No later than December 31 of the year after the year in which services were provided. Please contact your claims administrator for more information.
Prescription Drug Plan	CVS Caremark	
Dental Plan*	Claims administrator for your Dental Plan option	
Vision Plan*	FAA/EyeMed Vision Care	
Fertility Benefits Program	WINFertility	Your initial claims must be filed no later than six months of when the expenses are incurred. Generally, in-network claims filing is performed by the physician or care provider.
Health Care Spending Account	Claims administrator for your Health Care Spending Account	March 31 of the year following the year for which the expense is incurred.
Life Insurance Plan	Metropolitan Life Insurance Company (MetLife)**	There is no time limit to file a claim after a covered individual passes away.
AD&D Insurance Plan	Metropolitan Life Insurance Company (MetLife)**	Notification of a loss must be made 20 days from the date of loss. Proof must be provided to MetLife within 90 days following the date of an employee’s loss.
Business Travel Accident Insurance Plan	AIG-National Union Fire Insurance Company of Pittsburgh, PA	Within 20 days after an employee’s loss, or as soon as reasonably possible thereafter.
Group Long-Term Disability	The Prudential Insurance Company of America	Within 272 days (nine months) following the start of the disability***.

Plan/Option	Appropriate Claims Administrator	Timing for Filing Your Initial Claim
Individual Disability Insurance	Unum	Within 30 days following the start of the disability.
Short-Term Disability Plan	Sedgwick	Within 30 days of first day of absence from work.
Group Legal Services Plan****	MetLife Legal Plans, Inc.	No later than December 31 of the year following the year in which services were provided.
Employee Assistance Program	Cigna Behavioral Health, Inc. Insured (CA & NV residents): Cigna Health and Life Insurance Company	Within 90 days from date of service.
Health & Wellness Centers Plan	JPMorgan Chase Medical Director JPMorgan Chase & Co. 270 Park Avenue, 11th Floor Mail Code: NY1-K318 New York, NY 10017-2014?	No later than December 31 of the year following the year in which services were provided.
Back-up Child Care Plan	Bright Horizons Family Solutions 200 Talcott Avenue, South Watertown, MA 02472	Within 60 days from the date of service.

* Generally, in-network claims filing is performed by the physician or care provider.

** Notification of a death must be reported to JPMorgan Chase HR Answers; Bereavement Services within HR Answers will notify MetLife of the death on your behalf, allowing you to initiate the claims process. Please note that MetLife has sole responsibility and discretion to resolve any issues regarding beneficiary designations.

*** In certain circumstances, the time limit to file a claim may be up to 637 days (one year and nine months) following the start of the disability. The time limit may be even longer if the employee lacks legal capacity to file a claim earlier.

**** Generally, in-network services are filed by the Group Legal plan attorney.

Life Insurance Claims & Appeals

Life insurance claims and appeals are divided between two parties.

- The plan administrator handles all eligibility and other administrative decisions concerning your life insurance benefits.
- MetLife is primarily responsible for determining your beneficiaries. If you submit a claim/appeal regarding a beneficiary designation to the plan administrator, it will be re-rerouted to MetLife.

Step 2: Receiving Notification from the Claims Administrator/Plan Administrator if an Initial Claim for Benefits Is Denied

If an initial claim for benefits is denied, the claims administrator or plan administrator will notify you within a "reasonable" period, not to exceed the time frames outlined in the following table.

Under certain circumstances, the claims administrator or plan administrator, as applicable, is allowed an extension of time to notify you of a denied benefit.

Please Note: If an extension is necessary because you did not submit necessary information needed to process your health care claim or life and AD&D insurance claim, the timing for making a decision about your claim is stopped from the date the claims administrator or plan administrator sends you an extension notification until the date that you respond to the request for additional information. You generally have 45 days from the date you receive the extension notice to send the requested information to the claims administrator or plan administrator.

What Qualifies as a "Denied Benefit"?

A "denied benefit" is any denial, reduction, or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit. In addition, a benefit may be denied if you didn't include enough information with your initial claim.

Plan/Option	Timing for Notification of a Denial of Benefits Claim
Medical Plan, Prescription Drug Plan, Fertility Benefits Program, Dental Plan, Vision Plan, Health Care Spending Account, Employee Assistance Program, and Health & Wellness Centers	• As soon as reasonably possible but no more than 72 hours for claims involving urgent care, where the life of a claimant could be jeopardized (may be oral, with written confirmation within three days). **Please Note**: You must be notified if your claim is approved or denied. • 15 days for pre-service claims, where approval is required before receiving benefits, plus one 15-day extension because of matters beyond the plan's control. • 30 days for post-service claims, where the claim is made after care is received, plus one 15-day extension because of matters beyond the plan's control.
Life Insurance Plan	60 days to make a determination once all claim information has been submitted, plus one extension
AD&D Insurance Plan	45 days, plus one 45-day extension for matters beyond the plan's control.
Business Travel Accident Insurance Plan	90 days, plus one 90-day extension for matters beyond the plan's control
Group Long-Term Disability	45 days, plus two 30-day extensions for matters beyond the plan's control.
Individual Disability Insurance	45 days
Short-Term Disability Plan	45 days, with 2-day extensions
Group Legal Services Plan	30 days, with no extensions
Back-up Child Care Plan	90 days, plus one 90-day extension for matters beyond the plan's control

Please Note: Concurrent care claims are claims for which the plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments. Concurrent care claims may fall under any of the other steps in the claims appeal process, depending on when the appeal is made. However, the plan must give you sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

The Explanation You'll Receive from the Claims Administrator/Plan Administrator in the Case of a Denied Benefit

If your initial claim is denied, the claims administrator or plan administrator is legally required to provide an explanation for the denial, which will include the following:

- The specific reason(s) for the denial;
- References to the specific plan provisions on which the denial is based;
- A description of any additional material or information needed to process your claim and an explanation of why that material or information is necessary; and
- A description of the plan's appeal procedures and time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA after, and if, your appeal is denied.

If your claim is for the Medical Plan, the explanation must also include:

- If the benefit was denied based on a medical necessity, an experimental or unproven treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge upon request. This requirement also applies to denials under the Short-Term Disability Plan and the Long-Term Disability Plan, including the Individual Disability Insurance Plan.

Step 3: Filing an Appeal to the Claims Administrator/Plan Administrator if an Initial Claim for Benefits Is Denied

If you have filed a claim for benefits and your claim is denied, you have the right to appeal the decision. JPMorgan Chase is not involved in deciding appeals for any denied benefit claim under the:

- Medical Plan, including Prescription Drug Plan and Fertility Benefits Program;
- Preferred Dentist Program (PDP); Dental Maintenance Organization (DMO) Option; and Dental Health Maintenance Organization (DHMO) Option;
- Vision Plan;
- Health Care Spending Account;
- Long-Term Disability Plan, including Group LTD and Individual Disability Insurance;
- Short-Term Disability Plan;
- Life and AD&D Insurance Plans;
- Business Travel Accident Insurance Plan;
- Back-Up Child Care Plan
- Group Legal Services Plan; and
- Employee Assistance Program.

The plan administrators delegate all fiduciary responsibility and decisions about a claim for a denied benefit under these plans to the applicable claims administrator.

Under certain plans, final appeals for denied claims will be heard by a review panel that is independent of both the company and the Medical Plan claims administrators. The independent review panel will hear appeals for the following plans:

- Medical Plan;
- Prescription Drug Plan;

- Fertility Benefits Program; and
- Health & Wellness Centers Plan.

Please Note: Appeals related to denied claims under the Short-Term Disability Plan are determined by Sedgwick. Employees who work in New Jersey have the right to appeal to the Division of Temporary Disability Insurance for the State Temporary Disability Insurance portion of the JPMorgan Chase Short Term Disability Plan. You have one year from the date your disability began to file this appeal.

Send your written appeal to:

Division of Temporary Disability Insurance Private Plan Operations
Claims Review Unit
P.O. Box 957
Trenton, NJ 08625-0957

Telephone: (609) 292-6135

If your initial claim for benefits is denied, you — or your authorized representative — may file an appeal of the decision with the applicable claims administrator or plan administrator within the time frames indicated below, after receipt of the claim denial.

Plan	Timing for Filing an Appeal of a Denial of Benefits Claim
Medical Plan and Prescription Drug Plan	180 days
Fertility Benefits Program	
Dental Plan	
Vision Plan	
Health Care Spending Account	
Long-Term Disability, including Individual Disability Insurance	
Short-Term Disability Plan	
Business Travel Accident Insurance Plan	
Employee Assistance Program	
Health & Wellness Centers Plan	
Life and AD&D Insurance Plans	60 days
Group Legal Services Plan	
Back-up Child Care Plan	180 days

In your appeal, you have the right to:

- Submit written comments, documents, records, and other information relating to your claim.
- Request, free of charge, reasonable access to, and copies of, all documents, records, and other information that:
  - — Was relied upon in denying the benefit.
  - — Was submitted, considered, or generated in the course of denying the benefit, regardless of whether it was relied on in making this decision.
  - — Demonstrates compliance with the administrative processes and safeguards required in denying the benefit.
  - — For health care: constitutes a policy statement or plan guideline concerning the denied benefit regardless of whether the policy or guideline was relied on in denying the benefit.

If your appeal is for health care, you also have the right to receive:

- A review that does not defer to the initial benefit denial and that is conducted by someone other than the person who made the denial or that person's subordinate.
- For a denied benefit based on medical judgment (including whether a particular treatment, drug, or other item is experimental or unproven), a review in which the plan fiduciary/claims administrator consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was not consulted in connection with the initial benefits denial, nor the subordinate of this person.
- The identification of medical or vocational experts whose advice was obtained in connection with denying the benefit, regardless of whether the advice was relied on in making this decision.
- In the case of an urgent care claim where the life of a claimant could be jeopardized, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of a denied benefit.
  - All necessary information, including the decision on your appeal, will be transmitted between the plan fiduciary/claims administrator and you by telephone, facsimile, or other available similarly prompt method.

Step 4: Receiving Notification from the Claims Administrator/Plan Administrator if Your Appeal Is Denied

If your appeal is subsequently denied, the claims administrator, plan administrator, or Short-Term Disability Plan Appeals Committee is legally required to notify you in writing of this decision within a "reasonable" period of time according to the time frames outlined in the following table.

Plan/Option	Timing for Notification of a Denial of Benefits Claim
Medical Plan, Prescription Drug Plan, Fertility Benefits Program, Dental Plan, Vision Plan, Health Care Spending Account, Employee Assistance Program, and Health & Wellness Centers	• As soon as reasonably possible but no more than 72 hours for claims where the life of a claimant could be jeopardized (urgent care) • 15 days where approval is required before receiving benefits (pre-service claims) • 30 days where the claim is made after care is received (post-service claims)
Group Long-Term Disability	• **45 days**, plus **one 45-day** extension for matters beyond the plan's control.
Individual Disability Insurance	• **45 days**, plus **one 45-day** extension for matters beyond the plan's control.
Short-Term Disability Plan	• **45 days**, plus **one 45-day** extension for matters beyond the plan's control.
Life Insurance Plan	• 60 days to review and make a determination once all the information has been submitted plus one extension
AD&D Insurance Plan	45 days, plus one 45-day extension for matters beyond the plan's control
Business Travel Accident Insurance Plan	The decision on appeal will be made on the date of the next meeting of the claims administrator's appeal committee, subject to extensions permitted by law
Group Legal Services Plan	60 days
Back-up Child Care Plan	45 days, plus one 60-day extension for matters beyond the plan's control

Except in the case of urgent care claims related to health, the claims administrator or the plan administrator is allowed to take an extension to notify you of a denied appeal under certain circumstances. If an extension is necessary, the claims administrator or plan administrator will notify you before the end of the original notification period. This notification will include the reason(s) for the extension and the date the claims administrator or the plan administrator expects to provide a decision on your appeal for the denied benefit. **Please Note**: If an extension is necessary because you did not submit enough information to decide your appeal, the time frame for decisions is stopped from the date the claims administrator or the plan administrator sends you an extension notification until the date that you respond to the request for additional information.

The Explanation You'll Receive from the Claims Administrator/Plan Administrator in the Case of a Denied Benefit

If an appeal is denied, the claims administrator or plan administrator is legally required to provide an explanation for the denial, which will include the following:

- The specific reason(s) for the denial;
- References to the specific plan provisions on which the denial is based;
- A statement that you're entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement describing any appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring a civil action under ERISA.

If your appeal is for Medical Plan, the explanation must also include:

- If the benefit was denied based on a medical necessity, experimental, or unproven treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A description of the expedited review process for urgent care claims in the Medical Plan, where the life of the claimant could be jeopardized.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge upon request in the Medical Plan.

The health care plans generally require two levels of appeal, which you must complete if you would like to pursue your claim further.

The Group Long Term Disability coverage under the LTD Plan permits a voluntary second appeal. You must file the voluntary second appeal within 180 days after the denial of the first appeal. The insurer of the coverage, Prudential Insurance Company, can provide additional information about the voluntary second appeal.

Step 5: Receiving a Final Appeal by an Independent Review Panel

If your appeal of a benefits claim is denied, your final appeal for coverage will be heard by a review panel that is independent of both the company and the claims administrators. The independent review panel will hear appeals for the following plans:

- Medical Plan;
- Prescription Drug Plan;
- Fertility Benefits Program; and
- Health & Wellness Centers Plan.

The independent review panel hears only appeals that involve medical judgment or a rescission of coverage; the panel does not hear appeals about eligibility to participate in a plan or legal interpretation of a plan that does not involve medical judgment.

You are not required to file an appeal with the independent review panel before filing a court action. This level of appeal is voluntary.

Filing a Court Action

If an appeal under a plan subject to ERISA is denied (in whole or in part), you may file suit in a U.S. federal court. If you are successful, the court may order the defending person or organization to pay your related legal fees. If you lose, the court may order you to pay these fees (for example, if the court finds your claim frivolous). You may contact the U.S. Department of Labor or your state insurance regulatory agency for information about other available options.

If you bring a civil action under ERISA, you first must follow the procedures described above regarding filing a claim and up to two levels of internal appeals with the claims administrator. You must start the court action by the earlier of: (i) one year after the date of the denial of your final appeal; or (ii) three years after the date when your initial claim should have been filed, regardless of any state of federal statutes relating to limitations of actions. If, however, the applicable state or federal law relating to limitations of actions would result in a shorter limitations period within which to start the action, the shorter limitations period will apply. For the health plans, you cannot file a suit unless you have completed two appeals, if required by the claims administrators.

Contacting the Claims Administrators: Plans Subject to ERISA

This section provides specific contact information for each benefit plan covered by ERISA.

For contact information for the plans that are not subject to ERISA (which include the Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan), please see “Contacting the Claims Administrators: Plans Not Subject to ERISA” on page 489

Generally for all health care and insurance plans, questions related to general plan administration and eligibility to participate in the plans can be addressed by HR Answers. (See the *Contacts* section.)

For questions related to plan interpretation, filing initial claim, benefit provision under the plan, payment of benefits, or denial of benefits, please refer to the appropriate claims administrator for each benefit plan, as listed below.

Medical Plan Claims Administrators	
Medical Plan	
Aetna	Aetna P.O. Box 14079 Lexington, KY 40512-4079 (800) 468-1266
Cigna	Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 790-3086
Prescription Drug Plan*	CVS Caremark Attention: Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196 866-209-6093

Medical Plan Claims Administrators	
WINFertility	WINFertility, Inc. Greenwich American Center One American Lane Terrace Level Greenwich, CT 06831 (833) 439-1517
Expatriate Medical Option*	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050 (800) 390-7183 (302) 797-3644 (if calling from outside the U.S.)

* Options marked with an asterisk are self-insured. All other options are fully insured.

Dental Plan Claims Administrators	
Preferred Dentist Program (PDP)*	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 (888) 673-9582
Dental Maintenance Organization (DMO) Option	Aetna, Inc. P.O. Box 14094 Lexington, KY 40512 (800) 843-3661
Dental Health Maintenance Organization (DHMO) Option	Cigna Dental Health P.O. Box 188045 Chattanooga, TN 37422-8045 (800) 790-3086
Expatriate Dental Option*	Cigna International JPMorgan Chase Dedicated Service Center P.O. Box 15050 Wilmington, DE 19850-5050 (800) 390-7183 (302) 797-3644 (if calling from outside the U.S.)

* Options marked with an asterisk are self-insured. All other options are fully insured.

Other Health Care and Insurance Plans Subject to ERISA	
Plan	**Contact**
Vision Plan	FAA/EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111 (833) 279-4363

Other Health Care and Insurance Plans Subject to ERISA	
Plan	**Contact**
Health Care Spending Accounts	Refer to the same provider that you selected for your Medical Plan coverage. If you do not enroll in the Medical Plan coverage, contact Cigna. Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 790-3086 Payflex, an Aetna company Payflex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 (888) 678-8242
Back-Up Child Care Plan	Bright Horizons Children's Centers LLC. 2 Wells Ave. Newton, MA 02459 (888) 701-2235
Health & Wellness Centers Plan	JPMorgan Chase & Co. Health Services Dept. 277 Park Ave, 1st Floor Mail Code: NY1-L085 New York, NY 10172 (212) 270-5555
Group Long-Term Disability	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176 (877) 361-4778
Individual Disability Insurance	Unum The Benefits Center P.O. Box 100262 Columbia, SC 29202-3262 (888) 226-7959
Short-Term Disability Plan*	Sedgwick Claims Management Services JPMorgan Chase Leave of Absence Service Center P.O. Box 14648 Lexington, KY 40512-4648 (888) 931-3100
Life and AD&D Insurance Plans	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10017 (800) MET-LIFE ((800) 638-5433)
Business Travel Accident Insurance Plan	JPMorgan Chase Corporate Insurance Services JPMorgan Chase & Co. 8181 Communications Pkwy Bldg B, Floor 03 Mail Code TXW-3305 Plano, TX, 75024-0239, United States

Other Health Care and Insurance Plans Subject to ERISA	
Plan	**Contact**
Group Legal Services Plan	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114 (800) 821-6400
Employee Assistance Program	Cigna Behavioral Health, Inc. Attn: Karen Cierzan, President 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344 Insurer: Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Hartford, CT 06152 (877) 576-2007

* Options marked with an asterisk are self-insured. All other options are fully insured.

Contacting the Claims Administrators: Plans Not Subject to ERISA

Plans that are not subject to ERISA include the Dependent Care Spending Account, Transportation Spending Accounts, and Group Personal Excess Liability Insurance Plan.

Although these plans are not subject to the claims process described under “Claiming Benefits” on page 361, you can always contact the claims administrator listed for each plan with questions about the eligibility of an expense for reimbursement, payment of benefits, or denial of plan benefits. For claims relating to questions of eligibility for benefits under the plans and how the plans operate, please see “Claims Related to Eligibility to Participate in the Plans and Plan Operations” on page 477.

For questions related to plan interpretation, filing initial claim, benefit provisions under the plan, payment of benefits, or denial of benefits, please refer to the appropriate claims administrator for the benefit plan, as listed below.

Plan	Contact
Dependent Care Spending Accounts	Refer to the same provider that you selected for your Medical Plan coverage. If you do not enroll in the Medical Plan coverage, contact Cigna. Cigna P.O. Box 188061 Chattanooga, TN 37422-8061 (800) 790-3086 Payflex, an Aetna company Payflex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 (888) 678-8242
Transportation Spending Accounts	Health Equity P.O. Box 14053 Lexington, KY 40511 (877) 924-3967

Plan	Contact
Group Personal Excess Liability Insurance Plan	Arthur J. Gallagher & Co. 250 Park Avenue, 5th Floor New York, NY 10177 (866) 631-4630

If You Are Covered by More Than One Health Care Plan

The JPMorgan Chase medical and dental plans (including the plans for expatriates) all have provisions to ensure that payments from all of your group health care plans don't exceed the amount the JPMorgan Chase plans would pay if they were your only coverage.

The rules described here apply to the JPMorgan Chase plans. The following rules do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

The JPMorgan Chase health care plans do not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. The non-duplication provisions of the JPMorgan Chase health care plans will ensure that, in total, you receive benefits up to what you would have received with the JPMorgan Chase plans as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount.

A summary of coordination rules (that is, how JPMorgan Chase coordinates coverage with another group plan to ensure non-duplication of benefits) follows. If you have questions, please contact your health care company for help. (Please see contact information in the *Contacts* section.)

Here's an example of how the JPMorgan Chase health care plans coordinate benefits with other group health care plans:

- Assume your spouse/domestic partner has a necessary covered procedure with a reasonable and customary (R&C) charge of $100 after meeting any deductible.
- If your spouse/domestic partner's plan (which we'll assume is primary) pays 70% for that procedure, your spouse/domestic partner will receive a $70 benefit (70% of $100).
- Also assume that your JPMorgan Chase health care plan (which we'll assume is your spouse/domestic partner's secondary coverage and that the deductible has already been satisfied)—would pay 80% for this necessary procedure. In this case, your spouse/domestic partner normally would receive an $80 benefit (80% of $100) from the JPMorgan Chase plan.
- Since your spouse/domestic partner already received $70 from his or her primary plan, he or she would receive the balance ($10) from the JPMorgan Chase plan.
- If, however, your JPMorgan Chase plan considered the R&C charge to be $80, no additional benefit would be payable, as the JPMorgan Chase plan would pay 80% of $80, or $64. As that amount would have already been paid by your spouse/domestic partner's plan, no additional benefit would be payable from the JPMorgan Chase plan.

Determining Primary Coverage

To determine which health care plan pays first as the primary plan, here are some general guidelines:

- If you are enrolled in the JPMorgan Chase plan and another plan and your other health care plan doesn't have a coordination of benefits provision, that plan will be considered primary, and it will pay first for you and your covered dependents.
- If your covered dependent has a claim, the plan covering your dependent as an employee or retiree will be considered primary to this plan.
- If your claim is for a covered child who is enrolled in coverage under both parents' plans, the plan covering the parent who has the earlier birthday in a calendar year (based on the month and date of birthday only, not the year) will be considered primary. In the event of divorce or legal separation, and in the absence of a qualified medical child support order, the plan covering the parent with court-decreed financial responsibility will be considered primary for the covered child. If there is no court decree, the plan of the parent who has custody of the covered child will be considered primary for the covered child. (Please see "Qualified Medical Child Support Orders" in the *Health Care Participation* section.)
- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

After it is determined which plan is primary, you'll need to submit your initial claim to that plan.

After the primary plan pays benefits (up to the limits of its coverage), you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You'll need to include a copy of the written Explanation of Benefits from your primary plan.

Coordination with Medicare

Medicare is a national health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). It generally provides coverage for Americans ages 65 and older. It also provides coverage to younger people with a qualifying disability. As long as you remain an active employee with JPMorgan Chase, your JPMorgan Chase coverage will be primary, and any Medicare coverage for you will be secondary. Additionally, any covered dependents who become eligible for Medicare, while you remain an active employee, will also have JPMorgan Chase coverage as primary.

- While you remain an active JPMorgan Chase employee, the JPMorgan Chase health care plans will be primary for you and your covered dependents unless those dependents have primary coverage elsewhere. If your covered dependents have primary coverage elsewhere, those claims will be considered by that primary coverage first, JPMC coverage will be secondary and Medicare will consider claims for those health care expenses tertiary (third) Even if you work past age 65 and you and/or a covered spouse/domestic partner enroll in Medicare, the JPMorgan Chase plans will consider claims for your health care expenses before Medicare while you are an active employee.
- When you are no longer an active JPMC employee or are receiving LTD benefits, Medicare coverage will be primary for the Medicare enrolled individual. JPMC coverage will be terminated upon Medicare eligibility and coverage in Medicare plans is available from Via Benefits. Please see "You Work Past Age 65" in the *What Happens If ...* section.

Right of Recovery

If the JPMorgan Chase plan provides benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the JPMorgan Chase plans have the right to recover these payments from you or from the person or company who is determined to be legally responsible. Assignment of your claim to a third party does not exempt you from your responsibility for repaying the plan. You must notify the JPMorgan Chase plan promptly of any circumstance in which a third party may be responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plan making payments on your behalf.

Subrogation of Benefits

The purpose of the JPMorgan Chase health care plans is to provide benefits for eligible health care expenses that are not the responsibility of any third party. The JPMorgan Chase plans have the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plans making payments on your behalf or on behalf of a covered dependent. This is known as subrogation of benefits. The following rules apply to the plan's subrogation of benefits rights:

- The JPMorgan Chase plans have first priority from any amounts recovered from a third party for the full amount of benefits the plans have paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the JPMorgan Chase plans use this right when requested.
- If you fail to help the JPMorgan Chase plans use this right when requested, the plans may deduct the amount the plans paid from any future benefits payable under the plans.
- The JPMorgan Chase plans have the right to take whatever legal action they deem appropriate against any third party to recover the benefits paid under the plans.
- If the amount you receive as a recovery from a third party is insufficient to satisfy the JPMorgan Chase plans' subrogation claim in full, the plans' subrogation claim shall be first satisfied before any part of a recovery is applied to your claim against the third party.
- The JPMorgan Chase plans are not responsible for any attorney fees, attorney liens, or other expenses you may incur without the plans' prior written consent. The "common fund" doctrine does not apply to any amount recovered by any attorney you retain regardless of whether the funds recovered are used to repay benefits paid by the plans.

If you receive a subrogation request and have questions, please contact your health care company (see contact information in the *Contacts* section).

Right of Reimbursement

In addition to their subrogation rights, the JPMorgan Chase health care plans are entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for health care expenses that have been paid by the plans. The following rules apply to the plans' right of reimbursement:

- You must reimburse the JPMorgan Chase plans in first priority from any recovery from a third party for the full amount of the benefits the plan paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- Regardless of any allocation or designation of your recovery made in a settlement agreement or court order, the JPMorgan Chase plans shall have a right of full reimbursement, in first priority, from the recovery.
- You must hold in trust for the benefit of the JPMorgan Chase plans the gross proceeds of a recovery, to be paid to the plans immediately upon your receipt of the recovery. You must reimburse the plans, in first priority and without any set-off or reduction for attorney fees or other expenses. The "common fund" doctrine does not apply to any funds recovered by any attorney you retain, regardless of whether the funds recovered are used to repay benefits paid by the plans.
- If you fail to reimburse the JPMorgan Chase plans, the plans may deduct any unsatisfied portion of the amount of benefits the plans have paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plans.

If you fail to disclose the amount of your recovery from a third party to the JPMorgan Chase plans, the plans shall be entitled to deduct the full amount of the benefits the plans paid on your behalf from any future benefits payable under the plans.

Special Notice for Employees Who Have Been Rehired by JPMorgan Chase

If your employment has been reinstated with JPMorgan Chase (that is, you have been rehired within 31 days of your employment termination date or your coverage termination date), your coverage for certain benefits under the JPMorgan Chase U.S. Benefits Program may be affected, as highlighted in the following chart:

Medical (including Medical Reimbursement Account and Prescription Drug Plan), Dental, Fertility Benefits Program, and Vision Plans	You and your dependents will be assigned the same coverage you had before your coverage termination date. **Please Note**: If you are a retired employee when rehired, you must take active employee coverage and discontinue any retiree coverage you may have elected.
Health Care Spending Account	Your previously elected annual contribution amount will be reinstated and prorated accordingly for the balance of the plan year. **Please Note**: Expenses incurred during your break in service are not eligible for reimbursement, unless you elected to make after-tax contributions under COBRA.
Dependent Care Spending Account	Your previously elected annual contribution amount will be reinstated and prorated accordingly for the balance of the plan year. **Please Note**: Expenses incurred during your break in service are not eligible for reimbursement.
Transportation Spending Accounts (Transit/Parking)	There are no reinstatement provisions for these accounts. You will need to make a new enrollment election upon your date of hire.
Life Insurance Plan	You and your dependents will be assigned the same coverage amount in effect before your termination date.
Accidental Death and Dismemberment (AD&D) Insurance Plan	You and your dependents will be assigned the same coverage amount in effect before your termination date.
Group Personal Excess Liability Insurance Plan	You will be assigned the same coverage in effect before your termination date.
Group Legal Services Plan	You will be assigned the same coverage in effect before your termination date.

Please Note: If you are rehired after 31 days of your termination date, you will need to make new benefits elections for all plans for which you would like to participate.

Contacts

Effective 1/1/21

My Health, My Rewards and HR Answers for More Information

My Health	In addition to the provider resources noted below, **My Health** provides one-stop access to all your Medical Plan, prescription drug, Medical Reimbursement Account, Spending Accounts, JPMorgan Chase Health & Wellness Centers, wellness programs, and access to the Benefits Web Center where you can access information about the Dental and Vision Plans as well as Life and AD&D Insurance, Group Legal and Personal Excess Liability Insurance. Simply use your Single Sign-On password to access other sites from **My Health.** ▪ From work: My Health from the intranet. ▪ From home: https://myhealth.jpmorganchase.com. **Please Note:** Your covered spouse/domestic partner can access **My Health** without a password, but their health care company's site will require a username and password.
My Rewards	In addition to the provider resources noted below, **My Rewards** provides one-stop access to retirement and savings information. Simply use your Single Sign-On password to access other sites from **My Rewards**. ▪ From work: **My Rewards** from the intranet. ▪ From home: https://myrewards.jpmorganchase.com/.
HR Answers	Like **My Health** and **My Rewards**, HR Answers provides access to benefits information. ▪ 877-JPMChase ((877) 576-2427) ▪ *Quick Path:* Enter your Standard ID or Social Security number; press 1; enter your PIN; press 1. If calling from outside the United States: ▪ (212) 552-5100 (GDP# 352-5100) Service Representatives are available Monday – Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays. For assistance with the Retirement Plan, representatives are available until 8:30 p.m.

Issue/Benefit	Contact Information
Medical (Not Including Prescription Drugs)	Aetna (800) 468-1266 8 a.m. to 8 p.m., all time zones, Monday – Friday **My Health** or www.aetna.com Cigna (800) 790-3086 24/7 **My Health** or www.mycigna.com
Prescription Drugs	CVS Caremark (866) 209-6093 24/7 www.caremark.com
Employee Assistance Program (EAP)	Cigna (EAP) and LifeCare (Work-Life) (877) 576-2007 www.eapandworklife.com
Tobacco Cessation Program	(866) QUIT-4-LIFE ((866) 784-8454) myquitforlife.com/jpmorganchase.com
Expert Medical Advice	Grand Rounds (888) 868-4693 8 a.m. to 9 p.m. Eastern time, Monday – Friday www.grandrounds.com/jpmc
Health Care Spending Account **Dependent Care Spending Account**	Your Medical Plan carrier — Aetna or Cigna — is the administrator of your Health Care and Dependent Care Spending Accounts. If you are not enrolled in the Medical Plan, Cigna is your administrator of these accounts. **Aetna (PayFlex is an Aetna company)** PayFlex Systems USA, Inc. P.O. Box 14879 Lexington, KY 40512-4879 Fax: (888) 238-3539 Phone: (800) 468-1266 **Cigna** (800) 790-3086 24/7 www.mycigna.com You can check your spending account balances through **My Health**.

Issue/Benefit	Contact Information
Dental	**Aetna, Inc. Dental Maintenance Organization (DMO) Option: Aetna** (800) 843-3661 8 a.m. to 6 p.m. Eastern time, Monday – Friday www.aetna.com **Cigna Dental Health Maintenance Organization (DHMO) Option: Cigna Dental Health** (800) 790-3086 24/7 http://mycigna.com/ **MetLife Preferred Dentist Program (PDP) Option: MetLife Dental** (888) 673-9582 8 a.m. to 11 p.m. Eastern time, Monday – Friday https://mybenefits.metlife.com
Vision	EyeMed Vision Care (833) 279-4363 7:30 a.m. to 11 p.m. Eastern time, Monday – Saturday 11 a.m. to 8 p.m. Eastern time, Sunday **My Health >** Benefits Web Center
Transportation Spending Accounts (including for questions about eligibility and enrollment)	Health Equity (877) 924-3967 8 a.m. to 8 p.m., all time zones, Monday – Friday www.healthequity.com You can check your Transportation Spending Accounts balances on from the Transportation Spending Accounts Web Center via **My Rewards**. (myrewards.jpmorganchase.com)
Group Long –Term Disability	The Prudential Insurance Company of America (877) 361-4778 Monday – Friday from 8 a.m. to 11 p.m. Eastern time
Individual Disability Insurance	Covala Group (800) 235-3551 Monday – Friday from 8:30 a.m. to 5:30 p.m. Eastern time
Short-Term Disability Plan	Sedgwick Claims Management Services, Inc. (888) 931-3100 Service Representatives are available 24/7, Sunday through Saturday. You can also obtain answers to your questions 24 hours a day, seven days a week online at claimlookup.com/jpmc.
Life and Accidental Death & Dismemberment Insurance	Metropolitan Life Insurance Company (MetLife) (800) MET-LIFE ((800) 638-5433) 8 a.m. to 8 p.m. Eastern time, Monday – Friday **My Health >** Benefits Web Center
SurvivorSupport® Financial Counseling Services	The Ayco Company (800) 235-3417 8 a.m. to 5 p.m. Eastern time, Monday – Friday

Issue/Benefit	Contact Information
ID Theft Assistance Program, Travel Assistance, and Emergency Evacuation Services	AXA Assistance (800) 454-3679 (outside the U.S., call collect at (312) 935-3783) 24/7
Funeral Concierge Services	Dignity Memorial (866) 853-0954
Business Travel Accident Insurance	AIG-National Union Fire Insurance Company of Pittsburgh, PA (800) 551-0824 or (302) 661-4176 8 a.m. to 5 p.m. Central time, Monday – Friday
401(k) Savings Plan	**My Rewards >** My Web Centers > 401(k) Savings Plan 401(k) Savings Plan Call Center (866) JPMC401k ((866) 576-2401) TTY number (800) 345-1833 Outside the U.S.: (303) 737-7249 Speak to a Representative 8 a.m. to 10 p.m. Eastern Time, Monday – Friday (except NYSE holidays)
Retirement (Pension) Plan	**My Rewards >** My Web Centers > Pension Plan HR Answers (877) JPMChase ((877) 576-2427) Outside the U.S.: (212) 552-5100 Speak to a Representative 8 a.m. to 8:30 p.m. Eastern Time, Monday – Friday (except certain U.S. holidays)
Health & Wellness Centers	The Health & Wellness Centers Directory on **My Health** has a list of JPMorgan Chase Health & Wellness Centers locations, phone numbers, and hours. Go to **My Health** > Wellness Activities & Services.
Group Legal Plan	MetLife Legal Plans, Inc. (800) 821-6400 8 a.m. to 8 p.m. Eastern time, Monday – Friday
Personal Excess Liability Insurance	Arthur J. Gallagher Risk Management Services (866) 631-4630 9 a.m. to 5 p.m. Eastern time, Monday – Friday
Back-up Child Care Plan	Bright Horizons (877) BH-CARES ((877) 242-2737) https://backup.brighthorizons.com/jpmc (for reservations) **me@jpmc** > Health, Life & Parenting > parents@jpmc (for information about the Plan)
Expatriate Medical and Dental Plans	Cigna Global Health Benefits (800) 390-7183 (outside the U.S., call collect at (302) 797-3644 24/7 www.CignaEnvoy.com