Life and Accident Insurance

Effective 1/1/21

The JPMorgan Chase Life and Accident Insurance Plans ("Plans") provide eligible employees with the security that comes from knowing you have a complete package of insurance protection suited to your personal situation. You're automatically provided with certain company-paid life and business travel accident insurance to help provide financial protection to your beneficiaries if you become injured or die. You can also purchase employee and dependent supplemental term life insurance and accidental death and dismemberment (AD&D) insurance at group rates.

This section will provide you with a better understanding of how your coverage under the Life and Accident Insurance Plans works, including how and when benefits are paid.

Be sure to see important additional information about the Plans, 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 JPMorgan Chase Life and Accident Insurance Plans. Please retain this section for your records. Other sections may also constitute the complete SPD/plan document, including the *Plan Administration* section.

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

Questions?

If you still have questions after reviewing this Guide, there are a number of resources that can provide answers. As a first stop for this insurance, contact Metropolitan Life Insurance, Co., (MetLife), the Plans' claims administrator:

(800) MET-LIFE ((800) 638-5433)

Representatives are available from 8 a.m. to 8 p.m. Eastern Time, Monday – Friday.

For additional resources, including information on how to contact the Business Travel Accident plan administrator, 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 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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Life and Accident Insurance Highlights

Automatic, Company-Provided Coverage

If you're an eligible employee, you are automatically covered with basic life insurance that pays benefits to your designated beneficiary(ies) if you die while actively employed and business travel accident insurance if you die or are injured while traveling on business for JPMorgan Chase. You don't need to enroll or provide evidence of insurability (EOI), and JPMorgan Chase pays the full cost of this coverage.

Optional Coverage

You can elect to purchase supplemental term life and accidental death and dismemberment insurance for yourself and/or your eligible dependents through MetLife, the insurance carrier on an after-tax basis. You may have to provide EOI before certain levels of life insurance become effective.* Your choices for supplemental life and accident insurance include:

- **Employee supplemental term life insurance.** You can purchase coverage in $10,000 increments up to 10 times your Total Annual Cash Compensation (TACC) (rounded to the next $10,000) to a maximum of $3 million. **Please Note:** If your TACC decreases in the future, your maximum insurance amount of 10 times your TACC will be likewise reduced. Also please note that you cannot waive the company-provided basic life and enroll for employee supplemental term life coverage — you must have the basic coverage to purchase the supplemental coverage.
- **Dependent supplemental term life insurance.** Generally, you can purchase coverage in $10,000 increments up to a maximum of $300,000 for your spouse/domestic partner and/or $5,000, $10,000, $15,000 or $20,000 in coverage for each child. **Please Note:** You do not have to elect supplemental coverage for yourself in order to purchase dependent supplemental term life insurance.
- **Employee accidental death and dismemberment (AD&D) insurance.** You can purchase AD&D insurance for financial protection in case of accidental death or certain accidental injuries. Coverage is available in $10,000 increments up to 10 times your Eligible Compensation (rounded to the next $10,000) to a maximum of $3 million. **Please Note:** If your Eligible Compensation decreases in the future, your maximum insurance amount of 10 times your Eligible Compensation will be likewise reduced.
- **Dependent accidental death and dismemberment (AD&D) insurance.** You can purchase coverage between $10,000 and $600,000 (in increments of $10,000) for your spouse/domestic partner and/or $10,000 increments up to a maximum of $100,000 for each child. To purchase AD&D insurance for your dependent child(ren), you must elect either employee coverage or spouse/domestic partner AD&D coverage, or both.

Different Compensation Definitions

Your employee coverage is based on your compensation, but there are two different definitions used – Total Annual Cash Compensation (TACC) and Eligible Compensation:

- Basic Life insurance is based on Total Annual Cash Compensation (TACC).
- The maximum amount of supplemental term life insurance you can purchase is based on TACC.
- AD&D insurance is based on Eligible Compensation.

See the definitions in "Defined Terms" on page 331.

Name Your Beneficiaries

The Online Beneficiary Designations site provides a convenient way to name, review and update your beneficiary information for your life and accident coverage, You can access the site:

- From work: **My Health** > Dental, Vision, and Other Insurance > Online Beneficiary Designation
- From home: beneficiary.jpmorganchase.com

You can also contact HR Answers.

Costs

JPMorgan Chase pays the full cost of your basic life insurance and business travel accident insurance.

You pay the full cost of the supplemental term life insurance and accidental death and dismemberment (AD&D) insurance you elect for yourself, your spouse/domestic partner, and your eligible dependents on an after-tax basis.

Additional Basic Life Benefits	In addition to life insurance coverage, the company-provided basic life insurance includes the Identity Theft (ID) Assistance Program, Travel Assistance and Emergency Evacuation services, funeral concierge services, and SurvivorSupport® Financial Counseling Services. See "Additional Benefits" on page 316 for more information.
Convertibility and Portability of Coverage	If you leave JPMorgan Chase, generally employee and dependent supplemental term life and AD&D insurance coverage is generally convertible, portable, or both — meaning you can continue coverage through a direct billing arrangement with MetLife at a higher rate. More details are found within each insurance section.

* Certain states have additional, specific requirements. Please refer to MetLife for state-specific rules.

Eligibility and Enrollment

The general guidelines for participating in the JPMorgan Chase Life and Accident Insurance Plans are described in this section.

Insurance Rules Govern

Because most benefits described here are provided by insurance, the terms of the insurance policy or certificate will control eligibility for benefits. If there is a discrepancy between this description and the policy or certificate, the policy or certificate will control.

Who's Eligible?

In general, you are eligible to participate 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.

However, in the case of the Business Travel Accident Insurance Plan, all employees of JPMorgan Chase or a participating company are automatically covered by this insurance.

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 Plan, 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.

Eligible Dependents

For details about your eligible dependents under the Dependent Supplemental Term Life Insurance Plan and the Dependent Accidental Death and Dismemberment (AD&D) Insurance Plan, please see "Eligible Dependents" in the *Health Care Participation* section.

Cost of Coverage

JPMorgan Chase pays the full cost of your coverage under the Basic Life Insurance Plan and the Business Travel Accident Insurance Plan.

You pay the full cost of any employee and dependent coverage you elected on an after-tax basis under the Supplemental Term Life Insurance Plan and the Accidental Death and Dismemberment (AD&D) Insurance Plan.

Your cost for coverage for supplemental term life insurance for a plan year depends on your and/or your spouse's/domestic partner's age as of December 31 of that plan year, tobacco user status, and elected amount of coverage. The cost you pay for your children is the same, regardless of the number of children you have. The cost you pay for AD&D insurance for yourself and/or your dependents, including your spouse/domestic partner or children, depends on the amount of coverage you elect.

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

From time to time, refunds or adjustments of contributions and proceeds from demutualizations are received, which are associated with these and other plans and prior plans of heritage companies. These funds will be placed in trust and will be used solely for the employee plan purposes for which employees pay the costs, including the reduction of contributions for life, AD&D, disability, or other employee-paid insurance. Or, these funds will be used to provide benefits under such plans or prior plans.

Imputed Income

You must pay income taxes on the value of your company-provided basic life insurance above $50,000. This value is called "imputed income" and becomes part of your taxable income reported on your W-2. If your Total Annual Cash Compensation (TACC) is greater than $50,000, you can choose to limit your basic life coverage to $50,000. However, if you later wish to increase your coverage, evidence of insurability (EOI) rules will apply. Contact HR Answers for more information.

Tobacco User Status

Employees and their covered spouses/domestic partners who do not use tobacco products pay less for supplemental term life insurance coverage. Your contribution(s) may be greater if you or your covered spouse/domestic partner was a tobacco user during the prior calendar year. Use of tobacco means use of tobacco in any form including cigarettes, cigars, pipes, or smokeless tobacco (dip, chewing). 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 under the applicable Plans.

To be considered a non-tobacco user and pay lower, non-tobacco user rates 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 an approved tobacco cessation course 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.

How Tobacco User Is Defined

Under the JPMorgan Chase Benefits Program, a person who has used any type of tobacco product, smoked or not smoked (e.g., cigarettes, cigars, pipes, chewing tobacco, snuff, etc.) regardless of the frequency or location (this includes daily, occasionally, socially, at-home only, etc.) in the 12 months preceding any January 1 is considered a "tobacco user."

First Year Opportunity

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 even if you declare yourself and/or covered spouse/domestic partner as tobacco users, because you may not have had an opportunity to complete a tobacco cessation course in order 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 a tobacco cessation course, as described in the preceding paragraph.

If you were hired on or after October 1, for the current plan year and in the following plan year, you will be assigned non-tobacco user rates for your 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, because you may not have had an opportunity to complete a tobacco cessation program in order to qualify for the lower, non-tobacco user rates.

You'll receive more information regarding the opportunity to update your tobacco user status during each annual benefits enrollment period.

For more information on the Tobacco Cessation Program, please go to **My Health**.

How to Enroll

Participation in the Basic Life Insurance Plan and Business Travel Accident Insurance Plan is automatic — you don't need to enroll. The Basic Life Insurance Plan also includes the following additional benefits:

- Identity (ID) Theft Assistance Program;
- Travel Assistance and Emergency Evacuation Services;
- Funeral Concierge Services; and
- SurvivorSupport® Financial Counseling Services.

Participation in the Supplemental Term Life Insurance Plan and Accidental Death and Dismemberment (AD&D) Insurance Plan is optional. You must enroll during an enrollment period to have coverage.

EOI May Be Required

Depending on your Supplemental Term Life Insurance Plan election, you may be required to provide evidence of insurability (EOI). (Please see "Evidence of Insurability" on page 319 for more information.) **Please Note:** There are no EOI requirements for AD&D insurance. Life insurance changes made during Annual Benefits Enrollment (following your new hire election period) will require EOI. Your new coverage — and any associated contributions — will not take effect until it is approved by the insurance carrier.

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.

Enrolling if You Are an Employee

During Annual Benefits Enrollment, you can make your elections through the Benefits Web Center on **My Health** or through HR Answers. At the beginning of each enrollment period, you'll receive instructions on how to enroll.

You'll also receive information about the choices available to you and their costs at that time. You need to review your available choices carefully and enroll in the option that best meets your needs. You can't change your choices during the year unless you have a Qualified Status Change (QSC). Please see "Changing Your Coverage Midyear" on page 313 for more information.

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 through HR Answers within 31 days of your date of hire if you are a full-time employee, and within 31 days prior to becoming eligible if you are a part-time employee, as explained below:

- **If you are a full-time employee** (regularly scheduled to work 40 hours per week), you may receive information about benefits enrollment after accepting a position with JPMorgan Chase but before your hire date. Your coverage will begin on the first of the month after your hire date, as long as you enroll before your hire date or within 31 days after your hire date.
- **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.

If you enroll for supplemental term life insurance when you are a newly hired employee, you are allowed to enroll for supplemental term life insurance for an amount up to the lesser of three times your Total Annual Cash Compensation (TACC) or up to $500,000 without having to submit EOI. You can enroll a spouse/domestic partner for an amount up to $50,000 without having to submit EOI. Elected amounts above these guaranteed issue amounts will be subject to EOI and will not be effective until approved by MetLife. Please see "Evidence of Insurability" on page 319 for more information. Note that special enrollment periods may be offered from time to time, and the insurance carrier may have slightly different EOI rules during that special enrollment period.

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

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 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 through the Benefits Web Center on **My Health** or through HR Answers. Please see "Changing Your Coverage Midyear" on page 313 for more information.

Beneficiaries

A beneficiary is the person, people, estate, or entity you name to receive benefits from the Life and Accident Insurance Plans if you die. You can name anyone as your beneficiary — including a trust — or you can name more than one person to share the benefit. You can also change your beneficiary at any time, and you can have different beneficiaries for each separate benefit plan.

Keep in mind that if you name more than one person as your primary beneficiary, you should specify what percentage of your benefit each primary beneficiary would receive and these amounts must total 100%. You may also name contingent beneficiaries; these beneficiaries are entitled to receive a benefit only in the event the primary beneficiary(ies) predecease the employee. (The distribution across contingent beneficiaries must total 100%.) If you do not specify what percentage of your benefit should be distributed to each named beneficiary, the allocation occurs equally within each category.

If you do not have a designated beneficiary (or all of your named beneficiaries die before you), benefits will be paid in the following order:

- **For company-paid life and business travel accident insurance, employee supplemental term life insurance and employee accidental death and dismemberment (AD&D) insurance:**
  - — Surviving spouse
  - — Surviving children (in equal shares)
  - — Surviving parents (in equal shares)
  - — Surviving siblings (in equal shares)
  - — Your estate

To designate a beneficiary (including a domestic partner), you must submit an online beneficiary designation form. The form is available:

- **From the intranet:** me@jpmc > Benefits & Rewards > View or Update Beneficiaries
- **From the internet:** beneficiary.jpmorganchase.com
- A paper form is also available by calling HR Answers.

Note: The beneficiary information you provide online or through a paper form must be completed correctly. Please note that MetLife has been delegated responsibility to review beneficiary designations. In the event MetLife rejects a beneficiary election, the most recent prior designation on file, if any, will remain in effect until receipt of a new valid election. All questions concerning the status of an individual as beneficiary under the Plan shall be referred to MetLife for review, with MetLife making the final decision. A beneficiary designation form will remain in force until a new valid form is received. Therefore, if you have designated your spouse by name as your beneficiary on a Beneficiary Designation form, and you subsequently divorce, your beneficiary designation of your former spouse remains in effect until you designate a new beneficiary(ies) even if you were to remarry. If you would like to designate your new spouse as your beneficiary, you must complete a new Beneficiary Designation Form.

- **For dependent supplemental term life insurance, and dependent accidental death and dismemberment (AD&D) insurance:** You're automatically the beneficiary for your spouse/domestic partner and/or children. If you and your spouse/domestic partner both work for JPMorgan Chase, the parent who covers the child(ren) is the beneficiary.
- **For Business Travel Accident Plan:** If your spouse/domestic partner and/or dependent child pass away while they accompany or are on their way to accompany you on an authorized, company-paid business trip while you are covered under the plan, you are the beneficiary for that covered individual. If you and your spouse/domestic partner both work for JPMorgan Chase, and your dependent child passes away while accompanying either parent or on their way to accompany either parent on an authorized business trip, the beneficiary is the parent whose business travel was involved when the dependent child's death occurred.

Assignment of Benefits

You're entitled to transfer your basic and supplemental term life insurance and accidental death and dismemberment (AD&D) insurance ownership rights to another person, people, trust, or estate. Generally, the primary reason for making an assignment (i.e., transfer ownership) of your life insurance is estate planning. For more information, please contact MetLife at (800) MET-LIFE [(800)-638-5433].

If You Do *Not* Enroll

Coverage if You Do Not Enroll and You Are an Employee

If you're already participating in the life and accident insurance plans and do not change your elections or cancel coverage during Annual Benefits Enrollment, you'll generally keep the same coverage you had before Annual Benefits Enrollment for the next year. However, you'll be subject to any changes in the Plan and coverage costs.

Please Note: If you are participating at the maximum level of employee supplemental term life insurance and/or employee accidental death and dismemberment (AD&D) insurance and your Total Annual Cash Compensation and/or Eligible Compensation decreases, your employee supplemental term life insurance and/or AD&D insurance will also decrease.

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

If you're a newly hired or newly eligible employee and do not enroll before the end of the designated 31-day enrollment period, you will not be able to make the change in coverage until the following annual benefits enrollment period. Supplemental term life insurance elections will require you to provide evidence of insurability (EOI) at that time. Please see "Changing Your Coverage Midyear" on page 313 for more information.

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

If you have a Qualified Status Change (QSC) that allows you to enroll in supplemental term life insurance and/or accidental death and dismemberment (AD&D) insurance midyear and you do not actively enroll within the designated 31-day period, you won't be able to choose supplemental term life insurance and/or AD&D insurance until the next annual benefits enrollment period.

Please see "Changing Your Coverage Midyear" on page 313 for more information. Supplemental term life insurance elections will require you to provide evidence of insurability. Please see "Evidence of Insurability" on page 319 for more information.

When Coverage Begins

Basic life insurance begins on the first day of the month following your date of hire, if you are a full-time employee. Coverage for part-time employees begins on the first of the month following 60 days from your date of hire. In either case, you must be actively-at-work on the date that your coverage is scheduled to begin.

Business travel accident insurance begins on your date of hire for both full-time and part-time employees. You must be actively-at-work on the date that your coverage is scheduled to begin.

Supplemental Term Life Insurance

Coverage begins based on how you enrolled in the Plan:

- If you complete the enrollment process within 31 days of becoming eligible for insurance, coverage begins as follows:
  - If you **are not required** to give Evidence of Insurability (EOI), your coverage will begin on the date you become eligible if you are actively at work on that date. Payroll deductions will begin as soon as administratively possible.
  - If you **are required** to give EOI and MetLife approves your EOI, your coverage will begin on the date MetLife states in writing, provided you are actively at work on that date. Payroll deductions begin as soon as administratively possible.
  - If you are not actively at work on your coverage begin date, coverage will begin on the day you resume active work. Payroll deductions begin as soon as administratively possible.
- If you enroll or make changes during an annual enrollment period, coverage begins as follows:
  - For any amount for which you **are not required** to give EOI, coverage begins on the first day of the calendar year following the annual enrollment period, if you are actively at work on that date. Payroll deductions occur in first payroll cycle.
  - For any amount for which you **are required** to give EOI and MetLife approves that amount, coverage begins on the date MetLife states in writing, if you are actively at work on that date.
    - If EOI is approved before the beginning of the year, payroll deductions begin with first pay cycle of the year.

- If EOI is approved after the first of the year, then payroll deductions begin as soon as administratively possible after approval.

— If you are not actively at work on the date coverage would begin, coverage will begin on the day you return to active work. Payroll deductions begin as soon as administratively possible.

- If your coverage changes due to a Qualified Status Change (QSC), coverage will begin as follows:

— For any amount for which you **are not required** to give EOI, your coverage will begin on the date of your QSC, if you are actively at work on that date. Payroll deductions begin as soon as administratively possible.

— For any amount for which you **are required** to give EOI and MetLife approves, coverage begins on the date MetLife states in writing, if you are actively at work on that date. Payroll deductions begin as soon as administratively possible.

- If you are not actively at work, then coverage and payroll deductions will begin when you return to work.

Accidental Death and Dismemberment (AD&D) Insurance

The coverage you elect during Annual Benefits Enrollment generally takes effect the beginning of the following plan year (January 1) as long as you are actively-at-work on your first scheduled day on or after this effective date. There is no EOI required for AD&D insurance.

If you are newly eligible for coverage and complete the enrollment process within 31 days of becoming eligible for insurance, your coverage will begin on the date you become eligible if you are actively at work on that date. Payroll deductions will begin as soon as administratively possible. If you are not actively at work, coverage and payroll deductions begin when you return to active work. There is no EOI required for AD&D insurance.

If you have a change in work status, or experience a Qualified Status Change (QSC), and you elect to change your AD&D elections based on that status change, your coverage will begin on the date of the status change. Payroll deductions begin as soon as administratively possible. There is no EOI required.

Changing Your Coverage Midyear

The Supplemental Term Life Insurance Plan and/or Accidental Death and Dismemberment (AD&D) Insurance Plan elections you make during Annual Benefits Enrollment will stay in effect through the following 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). **Please Note:** Any changes you make during the year must be consistent with your QSC.

You need to enroll, add and/or drop your eligible dependents **within 31 days of the qualifying event** for benefits to be effective on the date of the event. **Please Note:** See "*If You Do Not Enroll*" on page 311 for details on what happens if you miss the 31-day enrollment period.

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 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" under "Eligible Dependents", in the *Health Care Participation* section.

You and/or your eligible dependents may need to satisfy certain evidence of insurability (EOI) requirements for the Supplemental Term Life Insurance Plan, as determined by the claims administrator, before coverage due to a QSC can begin. (Please see "Evidence of Insurability" on page 319 for more information.) See "When Coverage Begins" on page 312 for details.

Qualified changes in status under the Supplemental Term Life Insurance Plan and Accidental Death and Dismemberment (AD&D) Insurance Plan are listed in the following table.

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

When Coverage Ends

Generally, your coverage for Basic Life, Supplemental Term Life Insurance, AD&D, and BTA ends on the last day of active employment with JPMorgan Chase. Your coverage can also end when:

- You stop paying applicable premiums; or
- After you have been receiving long-term disability benefits for 24 months
  - For the Business Travel Accident Insurance, coverage ends the first day you begin receiving long-term disability benefits, unless you are temporarily approved for additional leave under another JPMorgan Chase Policy, such as the Disability and Reasonable Accommodation Policy.

When Dependent Coverage Ends

Coverage for your dependents ends when your coverage ends (such as if you leave JPMorgan Chase or otherwise become ineligible for JPMorgan Chase coverage).

Your dependents' coverage can end sooner, when the dependent(s) no longer meet the eligibility requirements for the applicable plan.

- For your spouse, this means the last day of the month in which you pass away 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 described the descriptions of domestic partner eligibility.
- For your child, this means the last day of the month in which he or she turns age 26.
  - **Please Note:** You can continue child life insurance coverage beyond age 26 for an unmarried child who is enrolled for that coverage 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 and this has been verified by the claims administrators.

Continuing Coverage After It Ends

When employee group coverage for certain insurance plans ends, the insurer may offer ways to continue coverage. The two most common options for continuing coverage are “conversion” and “portability” (also known as “porting” coverage).

- With conversion, you transfer the coverage to non-group coverage without having to meet any eligibility requirements.
- Portability allows you to continue your coverage after it ends, under a separate group policy with group rates. When you port a policy, you must provide proof of insurability to receive preferred, or less expensive, premiums.

The options to continue coverage are described in each of the plan-specific sections that follow.

Please Note: Your coverage under the Business Travel Accident Insurance Plan ends on your termination date. You may not convert or port this coverage to an individual policy.

Company-Paid Basic Life Insurance

Your company-paid basic life insurance is equal to one times your Total Annual Cash Compensation (TACC), up to $100,000. If your TACC is not an even multiple of $1,000, your coverage will be raised to the next higher $1,000. JPMorgan Chase pays the full cost of this coverage.

Please Note: Separate definitions other than what are described here 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.

Upon termination of employment, your company-paid Basic Life Insurance is cancelled.

Your basic life insurance benefit is paid to your beneficiary upon your death, regardless of the reason for your death. Please see “Beneficiaries” on page 310 for more information about naming a beneficiary.

The Basic Life Insurance Plan is provided through an insurance policy issued by Metropolitan Life Insurance Company (MetLife).

Imputed Income

Under the Internal Revenue Code, JPMorgan Chase must report as income the value of any company-provided basic life insurance in excess of $50,000. This value is called “imputed income,” and it becomes part of your taxable income reported on your W-2. If your Total Annual Cash Compensation (TACC) is greater than $50,000, you can choose to limit your basic life insurance amount to $50,000 to avoid imputed income. If you do that, your coverage amount will remain fixed at $50,000 even if your TACC increases. Please contact HR Answers if this applies to you.

Please Note: If you choose to limit the amount of your basic life insurance, you will need to satisfy evidence of insurability (EOI) to increase coverage at a later date. Please see “Evidence of Insurability” on page 319 for more information.

When Benefits Are Paid

Employee basic life insurance is paid to your beneficiary. Payment is made after MetLife, the claims administrator, receives satisfactory evidence of a covered person's death (e.g., a certified death certificate).

Accelerated Benefit Option

If you are diagnosed with a terminal illness that's expected to result in death within 12 months, you can apply for an accelerated benefit option equal to 80% of your basic life coverage amount, not to exceed $80,000.

Upon payment of this benefit, your life insurance is reduced by the amount approved for payment. Accelerated benefit option payments are excluded from your gross income and, therefore, are exempt from federal income tax. Please see your tax advisor regarding any other tax consequences. Upon your death, the reduced amount of life insurance will be paid to the beneficiary. Please see "Beneficiaries" on page 310 for more information.

If you elect the Accelerated Benefit Option, you may still receive SurvivorSupport® Financial Counseling Services.

Converting Basic Life Insurance

Your company-paid coverage under the Basic Life Insurance Plan ends on your termination date. You have the ability to convert your coverage to a policy with MetLife. Upon receipt of your conversion package at your address on record, and within 31 days of your termination date, you may convert any portion of your Basic Life Insurance to an individual policy by contacting MetLife. 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.

Additional Benefits

As an added benefit of your company-paid Basic Life Insurance Plan, you are entitled to the following programs. **Please Note:** You cannot port or convert coverage under the following programs following your termination date.

SurvivorSupport® Financial Counseling Services

If you die while actively employed or while receiving long-term disability (LTD) benefits (please see "You Go on Long-Term Disability" in the *What Happens If …* section, the Plan provides your surviving spouse or other key adult survivor with free financial planning services for a period of six months following your date of death. These services are provided by Ayco Company, a nationally recognized financial consulting firm. (Ayco does not sell any products or services.) Ayco is not an affiliate of MetLife. Services include assistance with:

- Settling the estate;
- Cash-flow planning;
- Income-tax counseling; and
- Insurance and estate planning.

Participants receive comprehensive, objective financial counseling from experienced Ayco counselors familiar with JPMorgan Chase's benefits. The counselor coordinates the efforts of the participant's attorney, accountant, insurance agent, and/or broker to develop a strategy and implement it. Participants receive:

- A telephone counseling session with an Ayco counselor in which financial concerns will be identified and resolved. Family members, attorneys, and other support people are encouraged to attend. Additional meetings may be scheduled, depending on the complexity of the issues.

- A personalized financial plan to help organize the steps to take now and in the future.
- The SurvivorSupport® Reference Guide — an interactive workbook that includes step-by-step worksheets, tables, and illustrations to help the participant evaluate relevant aspects of his or her financial situation.
- Direct toll-free telephone access to financial counselors for six months from the date of death.
- Monthly telephone follow-up.

This list is subject to change at any time.

Identity (ID) Theft Assistance Program

You are entitled to identity theft protection, provided at no cost to you, offered by AXA Assistance. The ID Theft Assistance Program educates you about the threats of identity theft and how you and your eligible dependents can ensure the security of your personal information. AXA Assistance can help guide you through the recovery process if your identity or that of your eligible dependents is compromised. The service can be accessed 24 hours a day, 365 days a year. (AXA is not an affiliate of MetLife.) This benefit is also available to your family members.

Travel Assistance and Emergency Evacuation Services

Travel Assistance and Emergency Evacuation Services are administered by AXA Assistance, and are provided to you and your family members at no cost. Services include direct, worldwide access to prompt assistance in the event of an unexpected medical emergency when you are traveling 100 miles (100 kilometers outside the United States) or more from home, up to certain dollar limits and a 120-day limit. These services can also provide you with domestic and international legal referrals. This benefit is also available to your family members. Your family members do not need to be enrolled in coverage (as long as you are an active employee enrolled in Basic Life Insurance).

A full range of emergency assistance services is available to you, including:

- Emergency medical evacuation;
- Political and natural disaster evacuation;
- Medically necessary repatriation;
- Transportation of mortal remains;
- Transportation of escort;
- Family visitation;
- Minor children return/escort;
- Vehicle return;
- 24-hour information service;
- Medical monitoring;
- Medical referral;
- Guarantee of medical expenses;
- Insurance coordination;
- Lost document service;
- Legal assistance;
- Emergency delivery of prescription items;

- Emergency cash transfers and advances; and
- Language assistance.

This list is subject to change at any time.

The Travel Assistance and Emergency Evacuation Services Center's multilingual staff (including physicians and nurses) is available 24 hours a day, 365 days a year to provide prompt assistance when you have an emergency.

For more information or to secure services please contact:

Within the United States: (800) 454-3679
Outside the United States Call Collect: (312) 935-3783
Or log onto:
www.metlife.com/travelassist

Funeral Concierge Services

Funeral Planning Services, offered by Dignity Memorial, (the largest U.S. funeral network) is available to the insured, their spouse and extended family (children, parents, grandparents and great-grandparents) and provides discounts of up to 10% off of funeral, cremation and cemetery services. This service provides unlimited access to Dignity Memorial's planning website, a comprehensive end-of-life planning tool, a funeral planning resource library, a Dignity Memorial funeral home locator tool, bereavement travel services, catering, floral arrangements, Compassion Helpline®, as well as veteran's burial benefits and military funeral honors.

Additional Services: Grief counseling, assistance with locating a funeral home and cemetery, and cost comparisons for funeral planning options is available through LifeWorks. LifeWorks is not a concierge service.

Supplemental Term Life Insurance

The Supplemental Term Life Insurance Plan is provided through an insurance policy issued by Metropolitan Life Insurance Company (MetLife). You may elect to obtain supplemental term life insurance for yourself, as well as your spouse/domestic partner and your eligible children. The following information describes your options under the Supplemental Term Life Insurance Plan.

Employee Supplemental Term Life Insurance

The Supplemental Term Life Insurance Plan lets you choose amounts of employee coverage according to your own needs. You can enroll for coverage in $10,000 increments up to 10 times your Total Annual Cash Compensation (TACC) (rounded up to the next $10,000) to a maximum of $3 million. **Please Note:** If you enroll for the maximum amount of coverage and your TACC subsequently decreases, your coverage will decrease accordingly.

Dependent Supplemental Term Life Insurance

JPMorgan Chase also offers dependent supplemental term life insurance for your spouse/domestic partner and each of your eligible children. Your options include:

- Spouse/domestic partner coverage in $10,000 increments up to a maximum of $300,000; and/or
- Child coverage of $5,000, $10,000, $15,000 or $20,000 per child.

Please Note: You may choose supplemental term life insurance for your spouse/domestic partner and child(ren) even if you do not elect coverage for yourself.

If your spouse is also a JPMorgan Chase employee, he or she can elect coverage as an employee and be also covered as your spouse.

Evidence of Insurability

In certain instances, you may need to provide evidence of insurability (EOI) if you want to elect supplemental term life insurance above a certain amount for yourself and/or your spouse/domestic partner. (There are no EOI requirements to cover children.) EOI may be required for coverage elected during your designated enrollment period if:

- You're electing new coverage or increasing employee supplemental term life insurance; or
- You're electing new coverage or increasing adult dependent supplemental term life insurance.

You can access and complete the EOI form online on the Benefits Web Center.

If you do not complete the form online, you will be mailed a paper copy by Metropolitan Life Insurance Company (MetLife), the claims administrator, after you enroll. If you do not complete and return the EOI form, or if your application is not approved by the claims administrator, only elected coverage amounts not requiring EOI, if any, will be effective.

If you cancel or decrease coverage for yourself or your spouse/domestic partner and choose to increase coverage at a later date due to a Qualified Status Change (QSC) or during Annual Benefits Enrollment, all new coverage will be subject to EOI requirements at the time you make the new election.

When you are first eligible for coverage, evidence of insurability is generally required:

- If employee coverage is greater than the lesser of three times your Total Annual Cash Compensation (TACC) or $500,000; and
- If spouse/domestic partner coverage exceeds $50,000.

Special Enrollment Opportunities

Note that special enrollment periods may be offered from time to time, and the insurance carrier may have slightly different EOI rules during that special enrollment period. Special enrollments will be communicated by the plan administrator.

When Benefits Are Paid

Employee supplemental term life insurance is paid to your beneficiary. Dependent supplemental term life insurance benefits are paid to you in the event of a covered person's death. In all cases, payment is made after Metropolitan Life Insurance Company (MetLife), the claims administrator, receives satisfactory evidence of a covered person's death (e.g., a certified death certificate).

Accelerated Benefit Option

If you are diagnosed with a terminal illness that's expected to result in death within 12 months, you can apply for an accelerated benefit equal to 80% of your supplemental life insurance coverage amount, not to exceed an accelerated benefit of $500,000.

Accelerated benefits for supplemental term life insurance are also available for:

- Dependent spouse supplemental term life insurance, at 80% of your coverage, not to exceed $240,000; and
- Child supplemental term life insurance, at 80% of your coverage, not to exceed $16,000.

Upon payment of this benefit, the covered person's supplemental term life insurance contributions will be reduced to reflect the new lower coverage amount. Accelerated benefit option payments are excluded from gross income and, therefore, are exempt from federal income tax. Please see your tax advisor regarding any other tax consequences. Upon the covered person's death, the reduced amount of life insurance will be paid to the beneficiary. Please see "Beneficiaries" on page 310 for more information

If you elect the Accelerated Benefit Option, you may still receive SurvivorSupport® Financial Counseling Services.

Converting or Porting Supplemental Term Life Insurance

Coverage under the Supplemental Term Life Insurance Plan for active employees ends on your termination date. Within 31 days of your termination date, you have the option to convert your employee and/or dependent life insurance coverage to an individual 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/Domestic Partner 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/Domestic Partner Life Insurance alone) to a maximum of the lesser of your total dependent spouse/domestic partner 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.

Accidental Death and Dismemberment (AD&D) Insurance

The Accidental Death and Dismemberment (AD&D) Insurance Plan is provided through an insurance policy issued by Metropolitan Life Insurance Company (MetLife). You may elect to obtain AD&D coverage for yourself, as well as your spouse/domestic partner and your eligible children under this Plan. The following information describes your options under the AD&D Insurance Plan.

Employee AD&D Insurance

Employee accidental death and dismemberment (AD&D) insurance will pay the full amount of your coverage to your beneficiary if you die as a result of an accident. You'll receive a portion of the benefit if you sustain certain injuries, such as the loss of a limb.

You can enroll for coverage in $10,000 increments up to 10 times your Eligible Compensation (rounded up to the next $10,000) to a maximum of $3 million.

Employee AD&D Insurance Limit Due to Age
When you are age 75 or older, but less than age 80, your amount of Employee AD&D Insurance will be reduced to a maximum amount of $200,000. When you are age 80 or older, your amount of insurance will be further reduced to a maximum amount of $100,000. If you reach age 75 or 80 while insured, this limit will not apply until the January 1 following the date you reach that age.

Dependent AD&D Insurance

Like employee accidental death and dismemberment (AD&D) insurance, dependent AD&D insurance will pay the full benefit in the event of your dependent's accidental death. You'll receive a percentage of the benefit if your dependent sustains certain injuries, such as the loss of a limb. Your options include:

- Spouse/domestic partner coverage in $10,000 increments up to $600,000; and/or
- Child coverage in $10,000 increments up to a maximum of $100,000 per child.

Please Note: As long as you have company-paid Basic Life, you may choose dependent AD&D insurance for your spouse/domestic partner and eligible children/domestic partner's children even if you do not elect AD&D coverage for yourself.

If your spouse is also a JPMorgan Chase employee, he or she can elect coverage as an employee and be also covered as a spouse.

Employee and dependent AD&D insurance will pay benefits for any of the losses listed in the following chart. However, the loss must be caused by accidental means and must be the result of the injury — directly and independently of all other sources.

How the Plan Pays Benefits

Type of Loss	Benefit Amount Payable
Loss of life Disappearance will be considered as loss of life after one year, and "exposure to the elements" will be treated as an accidental injury	100%
Loss of a hand permanently severed at or above the wrist but below the elbow	100%
Loss of a foot permanently severed at or above the ankle but below the knee	100%
Loss of an arm permanently severed at or above the elbow	75%
Loss of a leg permanently severed at or above the knee	75%
Loss of sight in one eye	50%
Loss of sight in both eyes	100%
Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.	
Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of the thumb and index finger of same hand or loss of four fingers on the same hand	25%
Loss of thumb or other finger means that the finger is permanently severed at or above the point at which it is attached to the hand.	
Loss of all toes on one foot	25%
Loss of the big toe	13%
Loss of big toe or other toe means that the toe is permanently severed at or above the point at which it is attached to the foot.	
Loss of speech and loss of hearing in both ears	100%
Loss of speech or loss of hearing in both ears	50%
Loss of hearing in one ear	25%

Type of Loss	Benefit Amount Payable
Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury. **Loss of hearing** means the entire and irrecoverable loss of hearing that continues for 6 consecutive months following the accidental injury.	
Paralysis of both arms and both legs	100%
Paralysis of both legs	75%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%
Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.	
Brain Damage	100%
Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.	
Coma	1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 100 months
Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.	

Additional Plan Benefits

Employee and dependent AD&D insurance also includes these additional benefits, except as noted below:

- **Seat Belt Benefit:** Your beneficiary will receive an additional 10% of the principal sum (to a maximum of $25,000) if you die as a result of an automobile accident while wearing a seat belt.
- **Air Bag Benefit:** Your beneficiary will receive an additional 10% of the principal sum (to a maximum of $10,000) if you die as a result of an automobile accident while in an automobile containing an air bag.
- **Workplace Felonious Assault Benefit (Note: Does not apply to dependent AD&D coverage):** For an assault committed during the commission of a felony as defined by the laws of the jurisdiction in which the act was committed, you or your beneficiary will receive an amount equal to the lesser of 20% of the AD&D insurance on the employee or $25,000, if the accidental injury was caused by a felonious assault committed at a JPMorgan Chase place of business or while you are engaged in business for JPMorgan Chase.
- **Surviving Spouse Benefit:** If you or your spouse/domestic partner dies as a result of an accidental injury
  - The Plan will pay an additional amount equal to the lesser of 3% of the full amount of insurance or $1,000 under the AD&D insurance for each of the 6 months immediately following the date of such person's death.
  - If this benefit is in effect on the date of death and there is no spouse who could qualify for payment, the Plan will pay $1,000 to your beneficiary in one sum.

- **Hospital Confinement Benefit:** If the Plan received proof that you or your dependent are confined in a hospital as a result of an accidental injury, which is the direct cause of such confinement independent of other causes; and benefit is in effect on the date of the injury, the Plan will pay:
  - 1% of the full amount of your AD&D coverage; and
  - $2,500; on a monthly basis beginning on the 5th day of confinement for up to 12 months of continuous confinement.
- **Child Education Benefit:** If you or your covered spouse/domestic partner dies as a result of an accidental injury, this feature pays for each child who qualifies for this benefit, an amount equal to the tuition charges incurred for a period of up to four consecutive academic years, not to exceed:
  - an academic year maximum of $10,000;
  - an overall maximum of 20% of full amount of your benefit;

  In the event that both you and your spouse/domestic partner die such that each death would cause a payment to be made for a child under the Additional Benefit, the following rules apply:
  - The academic year maximum will be 2 times the amount stated above;
  - The overall maximum will be equal to the stated percentage applied to the sum of the full amounts shown in MetLife's Schedule of Benefits for both you and your spouse; and
  - In no event will the amount paid under all Child Education benefits exceed the amount of tuition incurred.

  MetLife will pay the above additional Child Education benefit if:
  - A benefit is paid for loss of such person's life under the AD&D section;
  - The paid benefit is in effect on the date of the injury; and
  - Proof is received that on the date of death a Child was:
    - Enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or
    - At the 12th grade level and, within one year after the date of death, enrolls as a full-time student in an accredited college, university or vocational school.

  The child tuition benefit is paid semi-annually.
- **Spouse/Domestic Partner Education Benefit for Employee AD&D Coverage (does not apply to dependent AD&D coverage):** In the event of your death, this feature will pay an amount equal to the tuition charges incurred for a period of up to one academic year, not to exceed:
  - An academic year maximum of $5,000; and
  - An overall maximum of 5% of the full amount of your AD&D insurance.
- **Child Care Benefit:** In the event of your or your covered spouse/domestic partner's death, this feature pays an amount equal to the child care center charges incurred for a period of up to four consecutive years for each child under the age of 13 who qualifies for this benefit, not to exceed:
  - An annual maximum of $5,000; and
  - An overall maximum of 12% of the full amount of the AD&D insurance on the insured.

  In the event that both you and your spouse/domestic partner die such that each death would cause a payment to be made for a child under this Child Care Benefit, the following rules apply:
  - The annual maximum will be two times the amount stated above;
  - The overall maximum will be equal to the stated percentage applied to the sum of full amount of coverage for both you and your spouse/domestic partner;

— In no event will the amount paid under all Child Care benefits exceed the amount of Child Care charges incurred; and

— Child Care Center charges incurred after the date a Child attains age 13 will not be covered.

For purposes of this benefit, a child care center is a facility or individual which operates pursuant to state law, is not a family member, and primarily provides care and supervision to children in a group setting on a regular, daily basis. In order to qualify, the child must be wholly dependent on you for support and maintenance on the date of the death and must either be enrolled in a child care center at date of death or must become enrolled at a child care center within 12 months of the date of death.

- **Common Carrier Benefit:** A common carrier is a government-regulated entity that is in the business of transporting fare paying passengers. It does not include 1) chartered or other privately arranged transportation; 2) taxis; or 3) limousines. If you or a dependent die as a result of an accidental injury while traveling in a common carrier, the Common Carrier Benefit pays a full amount of the covered person's AD&D benefit (in addition to the regular benefit paid for loss of live, as shown above, under "How the Plan Pays Benefits" on page 321). To receive the benefit, you must provide proof that the injury resulting in the death occurred while traveling in a common carrier.
- **Therapeutic Counseling Benefit:** For a loss resulting from an accidental injury to you or a dependent, this benefit covers therapeutic counseling that has been prescribed for you, your spouse/domestic partner or your children within 90 days of the covered loss by an attending physician to treat an emotional or psychological condition resulting from the covered loss. This benefit will pay an amount equal to the least of:

  — the actual charges incurred for the therapeutic counseling;

  — 10% of the full amount of AD&D coverage; or

  — $10,000

  This benefit will be paid in the month when you provide proof that you have paid charges for therapeutic counseling. Payment will be made to the person who paid such charges. Such therapeutic counseling must be provided within one year of the prescription by a physician, therapist or counselor licensed to provide the counseling in the jurisdiction where such services are performed.
- **Common Disaster Benefit:** If you and your spouse/domestic partner are injured in the same accident and die within 365 days as a result of injuries in such accident, the benefit paid for your spouse's/domestic partner's loss of life will be increased to equal the full amount payable for your loss of life.

For additional information about the benefits described above, please contact Metropolitan Life Insurance Company (MetLife) from 8 a.m. to 8 p.m. Eastern Time, Monday – Friday.

What Is *Not* Covered

Accidental death and dismemberment (AD&D) insurance benefits are not payable for loss or death that results from:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Service in the armed forces of any country or international authority for more than 30 days. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;

- Any incident related to:
  - Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; however this exclusion will not apply to a loss sustained by you as a pilot or a crew member if you were hired by JPMorgan Chase as a pilot or crew member and the loss is sustained while you are acting in that capacity;
  - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self preservation;
  - Travel in an aircraft or device used:
    - For testing or experimental purposes;
    - By or for any military authority; or
    - For travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
  - Any drug, medication or sedative, unless it is:
    - Taken or used as prescribed by a Physician; or
    - An "over the counter" drug, medication or sedative taken as directed;
  - Alcohol in combination with any drug, medication, or sedative; or
  - Poison, gas, or fumes; or
- War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

This list is subject to change at any time.

Exclusion for Intoxication

The Plan will not pay AD&D benefits for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

When Benefits Are Paid

Your employee accidental death and dismemberment (AD&D) benefit is paid to your beneficiary upon your death. If you suffer a covered loss other than death, your benefit will be paid to you. Dependent AD&D benefits are paid to you in the event of a covered person's death or other covered loss. Applicable benefits are paid after MetLife receives notice of the covered loss (e.g., certified death certificate, or accident report).

Porting Your Coverage

You may port up to $2 million of your employee AD&D coverage with 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.
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.

Business Travel Accident Insurance

Business Travel Accident (BTA) Insurance, provided under an insurance policy with the AIG-National Union Fire Insurance Company of Pittsburgh, PA, is designed to protect you in the event of accidental death or serious covered injury caused by an accident that occurs while traveling on approved business for the company. In addition, this insurance covers you if accidental death or a serious covered injury occurs as a result of a criminal act of violence directed at you on JPMorgan Chase's premises or as a result of a criminal act of violence against you while you're traveling on company business.

Note: Your spouse/domestic partner and children are also covered if they accompany you or are on their way to accompany you on an authorized, company-paid business trip while you are covered under the Plan.

Business Travel Accident Insurance pays the full benefit amount in the event of an accidental death. A portion of the benefit amount is payable in the event of certain injuries.

Employee Coverage

JPMorgan Chase automatically provides you with business travel accident insurance equal to six times your annual salary, with a minimum benefit of $50,000 and a maximum of $3 million, at no cost to you. However, if you're paid on an hourly basis, annual salary is based on the monthly average of amounts paid to you by JPMorgan Chase as hourly wages and/or commissions during the previous 36 months. The monthly average is then multiplied by 12 to determine your annual salary. Annual salary excludes any overtime earnings, incentive compensation, or other extra compensation arrangements.

You are covered for business travel accident insurance benefits until your last day of active employment at JPMorgan Chase.

Dependent Coverage

Business Travel Accident Insurance includes coverage for your spouse/domestic partner and/or children if they accompany or are on their way to accompany you on an authorized, company-paid business trip while you are covered under the Plan.

- Your spouse/domestic partner coverage is covered for a maximum benefit of $150,000; and
- Your children are covered for $20,000 per child in the event of death or dismemberment.

How BTA Insurance Pays Benefits

Business Travel Accident Insurance pays full or partial benefits depending on the extent of loss, as shown in the chart below.

Type of Loss	Benefit Amount Payable
Life	100%
Quadriplegia	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and the sight of one eye	100%
One foot and the sight of one eye	100%
Speech and hearing in both ears	100%
Paraplegia	75% of the full amount
Hemiplegia	50% of the full amount

Type of Loss	Benefit Amount Payable
One hand or one foot	50% of the full amount
Sight of one eye	50% of the full amount
Speech or hearing in both ears	50% of the full amount
Hearing in one ear	25% of the full amount
Thumb and index finger of same hand	25% of the full amount

Benefits are also payable in the event of severe burns. Business Travel Accident Insurance pays a percentage of the full benefit amount depending on the extent of the burn injury.

Additional Plan Benefits

Business Travel Accident Insurance may provide additional benefits to you and to your spouse/domestic partner and/or children in the event of a covered accident. These additional benefits include, but are not limited to:

- **Seat Belt and Air Bag Benefit:** If you (or a covered family member) is in an accident that causes death while operating or riding as a passenger in an automobile while wearing a properly fastened, original, factory-installed seat belt, an additional seat belt benefit is payable if an accidental death benefit is payable under the Business Travel Accident Insurance Plan. The seat belt benefit is equal to the lesser of $50,000 or 10% of the maximum BTA Insurance benefit for the covered individual. An additional air bag benefit is also payable if the seat belt benefit is payable and if at the time of the accident the covered individual is positioned in a seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact. The additional air bag benefit is equal to the lesser of $25,000 or 5% of the maximum BTA Insurance benefit for the covered individual.
- **Felonious Assault Benefit:** Coverage for an additional $5,000 in the event of death as the result of a felonious assault while on a business trip or while you are at work on JPMorgan Chase's premises.
- **Hospitalization Benefit:** If you, your spouse/domestic partner and/or child requires hospitalization as a result of a covered accident, an additional amount equal to the lessor of $5,000 or 5% of the applicable benefit amount is payable.
- **Common Accident Benefit:** In the event that both you and your spouse/domestic partner die in the same accident, the maximum benefit amount for your spouse/domestic partner will increase from $150,000 to the amount equal to your maximum benefit.
- **Rehabilitation Benefit:** In the event of dismemberment or paralysis from a covered accident, this feature pays an additional amount, up to a maximum payment of $50,000, for rehabilitation expenses in connection with the injury.
- **Trauma and Bereavement Counseling Benefit:** In the event of your, your spouse's/domestic partner's, or your child's injury or death, this feature pays up to $250 per session for trauma or bereavement counseling for up to 20 sessions.
- **Emergency Evacuation:** If you (or your spouse/domestic partner or children) are outside a 100 mile radius from your place of primary residence and suffer an injury or emergency sickness that warrants emergency evacuation, this feature will pay the reasonable expense (up to $5,000,000) for such evacuation. The expense must not exceed the usual charge for similar transportation in the location where the expense is incurred and must not include charges that would not have been made if no insurance existed.
- Additional benefits, including psychological therapy, day care, and tuition benefits, are described in the insurance policy for the Plan.

What Is *Not* Covered

Business travel accident insurance benefits are not payable for loss or death that results from:

- Suicide or any attempt at suicide, or intentional self-inflicted injury or attempt at intentionally self-inflicted injury;
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a passenger, pilot, operator or crew member, unless specifically provided by this policy
- Declared or undeclared war, or any act of declared or undeclared war unless specifically provided by this policy
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these;
- Infection of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- Full-Time active duty in the Armed Forces, National Guard or organized reserve corps of any country or international authority;
- Commission of or attempt to commit a felony
- Normal commuting between your residence and place of employment

This list is subject to change at any time.

Claiming Benefits

The following information explains when and how to file claims for Life and Accident Insurance Plans benefits.

When Benefits Are Paid

- **Basic Life Insurance** benefits are paid to your beneficiary when Metropolitan Life Insurance Company (MetLife), the claims administrator, receives satisfactory evidence of your death (e.g., a certified death certificate).
- **Supplemental term life insurance** benefits are paid to your beneficiary when Metropolitan Life Insurance Company (MetLife), the claims administrator, receives satisfactory evidence of your death (e.g., a certified death certificate). Dependent supplemental term life insurance benefits are paid to you in the event of a covered person's death when MetLife receives satisfactory evidence of the covered person's death.
- **Accidental death and dismemberment (AD&D) insurance** benefits are paid to your beneficiary when Metropolitan Life Insurance Company (MetLife), the claims administrator, receives satisfactory evidence of your death (e.g., a certified death certificate). If you suffer a covered loss other than death, your benefit will be paid to you when MetLife receives proof of your loss (e.g., medical reports or accident/police reports). Dependent AD&D benefits are paid to you in the event of a covered person's death or other covered loss when MetLife receives proof of the death/loss.
- **Business travel accident** benefits are paid to your beneficiary when AIG-National Union Fire Insurance Company of Pittsburgh, PA receives satisfactory evidence of your accidental death. If you suffer a covered loss other than death, your benefit will be paid to you when AIG-National Union Fire Insurance Company of Pittsburgh, PA receives proof of your loss.

How Benefits Are Paid by MetLife

Benefit payments by MetLife on behalf of the Plans are made in the method chosen by the beneficiary, and can include:

- A Total Control Account (TCA), which is an interest bearing account similar to a checking account that MetLife would open for you to hold your claim proceeds. MetLife pays the full amount owed to you by placing the proceeds into the TCA and providing you with a book of drafts. You can use the draft as you would use checks.
- A check that MetLife mails to you; or
- An Electronic Funds Transfer (EFT) where MetLife would transfer the funds directly to a bank account provided by you via electronic funds transfer. This requires completion of an EFT form.

AIG makes payments for the Business Travel Accident Plan.

How to File Claims

If you or your beneficiary need to file a claim for Life and Accident Insurance Plans benefits, please contact HR Answers and speak with a Service Representative (please see the table entitled “Questions” under the “Life and Accident Insurance” section on page 303 for information). If you or a covered dependent dies, a certified copy of the death certificate is required before death benefits can be paid. You will also be required to provide satisfactory evidence of a covered loss under the AD&D Insurance Plan.

Important Claims Addresses

To discuss payment options, claims procedures, or other Plan details, please use the appropriate address and phone numbers from the following chart:

Claims Administrators’ Contact Information

Claims Administrator	Address and Telephone Number
Basic Life Insurance	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166-0188 (800) 673-9582 8 a.m. to 8 p.m. Eastern Time Monday – Friday
SurvivorSupport® Financial Counseling Services	The Ayco Company, LP P.O. Box 15073 Albany, NY 12212-5073 (800) 235-3417 8 a.m. to 5 p.m. Eastern Time Monday – Friday; appointments may also be scheduled outside of normal business hours
Identity (ID) Theft Assistance Program	AXA Assistance 122 S. Michigan Avenue Suite 1100 Chicago, IL 60603 (800) 454-3679 24 hours a day, 365 days a year www.metlife.com/travelassist

Claims Administrator	Address and Telephone Number
Travel Assistance and Emergency Evacuation Services	AXA Assistance 122 S. Michigan Avenue Suite 1100 Chicago, IL 60603 (800) 454-3679 or outside the United States, call collect at (312) 935-3783 24 hours a day, 365 days a year www.metlife.com/travelassist
Funeral Concierge Services	Dignity Memorial 1929 Allen Parkway Houston, TX 77019 (866) 853-0954 24 hours a day, 365 days a year www.finalwishesplanning.com
LifeWorks Funeral Planning Services	LifeWorks (888) 319-7819 24 hours a day, 365 days a year
Business Travel Accident Insurance	AIG-National Union Insurance Fire Company of Pittsburgh, PA Accident & Health Claims Department 17200 West 119 Street Shawnee Mission, Kansas 66225 (800) 551-0824 8 a.m. to 5 p.m. Central time Monday – Friday If needed, the FAX number is: (866) 893-8574.
Supplemental Term Life Insurance	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166-0188 (888) 673-9582 8 a.m. to 8 p.m. Eastern Time Monday – Friday
Accidental Death and Dismemberment (AD&D) Insurance	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166-0188 (888) 673-9582 8 a.m. to 8 p.m. Eastern Time Monday – Friday

Appealing a Claim

If a claim for payment under the JPMorgan Chase Life and Accident Insurance Plans is denied, either in whole or in part, you or your beneficiary can appeal the denial by following the appropriate procedures described in the *Plan Administration* section.

Defined Terms

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

Actively-at-Work	Actively-at-Work means you are performing all the duties that pertain to your work on a regular basis at the place where they're normally performed or where they're required to be performed by JPMorgan Chase. A person who works at home must be able to report to a place of employment outside the home. You must be actively-at-work for your new or newly approved increase in coverage to take effect. The actively-at-work provision also applies if your coverage is subject to evidence of insurability. The insurance carriers for each of these Plans may have additional actively-at-work requirements that are specific to their Plan. For more information, please contact the insurance carriers directly.
After-Tax Contributions	After-tax contributions that are taken from your pay after federal and, in most cases, state and local income taxes have been withheld.
Annual Earnings	(For the Business Travel Accident Insurance Plan only) Annual earnings means your annual wage or salary from JPMorgan Chase as of the date of the accident, including the monthly average times 12 of any amounts paid during the preceding 36 months as hourly wages and/or commissions, but excluding any overtime earnings, bonuses, or other extra compensation arrangements.
Beneficiary	Your beneficiary is the person, people, estate, or entity you name to receive benefits from the insurance plan if you die.
Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Life and Accident Insurance Plans. The claims administrator for each benefit is noted at the beginning of the description of each Plan. JPMorgan Chase is not involved in deciding appeals for any benefits claim denied under the Life and Accident Insurance Plans. All fiduciary responsibility and decisions regarding a claim for a denied benefit under the Plans rest solely with the claims administrator.
Eligible Compensation	(For accidental death and dismemberment coverage) Generally, your Eligible Compensation is your annual base salary/regular pay plus applicable job differential pay (e.g., shift pay). It does not include any annual incentive, overtime, special recognition, or other incentive awards you might receive. In certain situations, your Eligible Compensation may include other cash earnings (e.g., commissions, draws, and overrides) paid under certain non-annual incentive plans that provide compensation in lieu of base salary. For the benefits plans described here, your Eligible Compensation is updated as changes occur throughout the year (including while you are on a leave of absence). **Please Note:** Various JPMorgan Chase plans have different definitions of Eligible Compensation. Separate definitions may apply to employees in certain sales positions who are paid on a draw-and-commission basis.
Eligible Dependents	Under the Life and Accident Insurance Plans, your eligible dependents can include your spouse or domestic partner and your children (including children of your domestic partner). Please see "Eligible Dependents" in the *Health Care Participation* section for more information.
Evidence of Insurability	(Does not apply to the Business Travel Accident Insurance Plan or AD&D Plan) Evidence of insurability (EOI) is information that must be provided to Metropolitan Life Insurance Company (MetLife), the claims administrator for the Supplemental Term Life Insurance Plan, before you can be approved for certain levels of coverage. Please see "Evidence of Insurability" on page 319 for more information.

Imputed Income	(Applies to the Basic Life Insurance Plan only) Imputed income is the value of company-provided basic life insurance above $50,000, which must be reported as income to the Internal Revenue Service (IRS). Imputed income becomes part of your taxable income reported on your W-2.
Loss	For details on what qualifies as a loss under each plan, see: ▪ For Accidental Death & Dismemberment, “How the Plan Pays Benefits” on page 321. ▪ For Business Travel Accident, “How BTA Insurance Pays Benefits” on page 326.
Qualified Change in Status	(For the Life and Accident Insurance Plans) 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. The benefits you elect will be effective the date of the event if you make the elections timely. Any changes you make during the year must be consistent with your QSC. Please see “Changing Your Coverage Midyear” on page 313 for more information.
Total Annual Cash Compensation	(For basic and supplemental term life insurance) 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.

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.

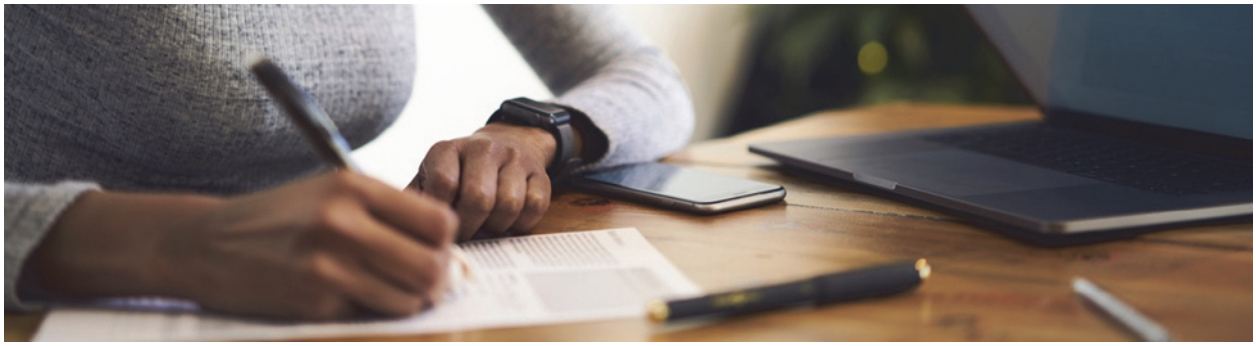
For Life and Accident Insurance Plans: If you continue to work for JPMorgan Chase after you reach age 65, you may continue to participate in the Life and Accident Insurance Plans, as long as you are actively employed and meet all eligibility requirements.

- 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.



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.

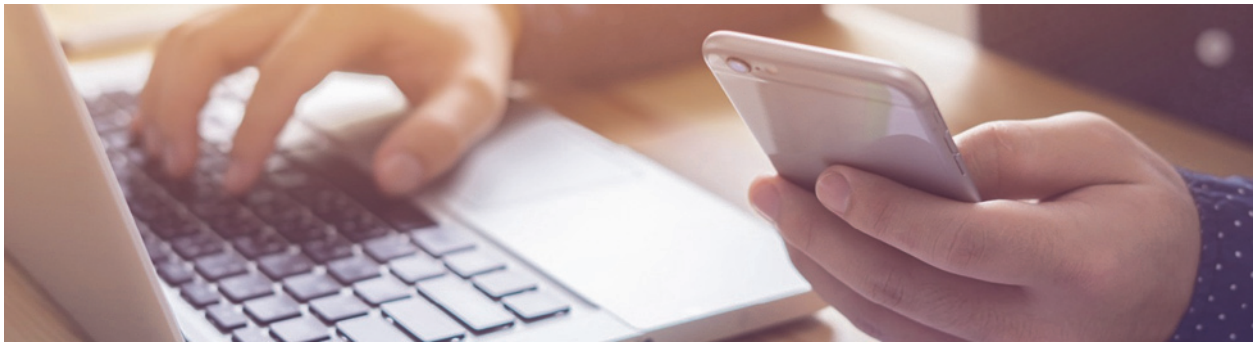
If you fail to disclose the amount of your recovery from a third party to the JPMorgan Chase plans, the plans shall be entitled to deduct the full amount of the benefits the plans paid on your behalf from any future benefits payable under the plans.

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