The Medical Plan

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

Our Medical Plan is built on the principle of a shared commitment to health. JPMorgan Chase provides valuable benefits, funding, and a suite of features designed to help you get and pay for the treatment you need, manage your health care expenses, and most importantly, take care of yourself. In addition to providing coverage in the event of illness, the Medical Plan offers full coverage for eligible preventive care and eligible preventive generic prescription drugs, along with an integrated Wellness Program to help you and your family stay healthy and a Medical Reimbursement Account (MRA) to help you pay for eligible out-of-pocket costs. You can earn funds for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in wellness activities.

Your commitment is required, too. Your role is to take responsibility for the controllable aspects of your health and your spending on health care. You can do this by staying informed about healthy lifestyle choices, getting preventive care, carefully selecting your doctors and hospitals, and understanding your treatment options and their costs before receiving services.

This Summary Plan Description explains the details of the Medical Plan, including how to use the Plan and how and when benefits are paid.
## Questions?

For live help through a customer service representative from your health care company, call the number on the back of your ID card:

<table>
<thead>
<tr>
<th>Company</th>
<th>Number</th>
<th>Hours</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigna</td>
<td>800-790-3086; 24/7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>800-272-8970</td>
<td>8 a.m. to 8 p.m. all time zones, Monday - Friday</td>
<td></td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>866-209-6093; 24/7</td>
<td></td>
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<tr>
<td></td>
<td>or email: <a href="mailto:customerservice@caremark.com">customerservice@caremark.com</a></td>
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</tr>
</tbody>
</table>

For questions about enrollment and eligibility, contact the **Benefits Call Center**:

- **Quick Path**: Enter your Standard ID or Social Security number; press 1; enter your PIN; press 1.

If calling from outside the United States:

- 1-212-552-5100 (GDP# 352-5100)

Service Representatives are available Monday through Friday, from 8 a.m. to 7 p.m. Eastern Time, except certain U.S. holidays.

You can also obtain answers to your questions 24 hours a day, seven days a week online at **My Health**. **My Health** provides one-stop access to all your medical plan, prescription drug, wellness programs, and Medical Reimbursement Account information on a personalized basis. Simply use your Single Sign-On password to access other sites from **My Health**. Go to **My Health** and click “My medical plan website” or “My prescription drug plan.”

**From work:** **My Health** from the intranet

**From home:** 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 user name and password.

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**Update: Your Guide to Benefits at JPMorgan Chase**

This document is your summary plan description of the JPMorgan Chase Medical Plan. The U.S. Department of Labor requires JPMorgan Chase to routinely provide benefits plan summaries to plan participants. Please retain this information for your records. This document also constitutes the plan document for the Medical Plan.

This document does not include all of the details contained in the applicable insurance contracts. If there is a discrepancy between the applicable insurance contracts and this document, the insurance contracts will control.
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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.
## Important Terms

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

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before-Tax Contributions</td>
<td>Contributions that are taken from your pay before federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before Social Security taxes are withheld. This lowers your taxable income and your income tax liability. This reduction to taxable income will not affect any other pay-related benefits, such as basic life insurance, long-term disability insurance, and your Retirement Plan benefits. So, your other benefits will continue to be based on your full, unreduced benefits pay. Keep in mind that before-tax contributions do not count as earnings for Social Security purposes. Therefore, your future Social Security benefit could be slightly reduced if your total earnings for the year are less than the Social Security wage base ($117,000 in 2014). However, this reduction is nominal and may be outweighed by the immediate tax savings resulting from using before-tax dollars to pay for your benefits.</td>
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<tr>
<td>Claims Administrator</td>
<td>The company that provides certain claims administration services for the Medical Plan. If you elect coverage in Option 1 or Option 2, your claims administrator is your health care company (Cigna or UnitedHealthcare, depending on your election).</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>The way you share costs for certain covered health care services, generally after you pay any applicable deductible under Option 1 and Option 2 and the Medicare Indemnity Options and for preferred and non-preferred brand-name drugs under the Prescription Drug Plan. For medically necessary covered in-network services, Option 1 and Option 2 pay a percentage of providers’ negotiated fees and you pay the remainder. For medically necessary covered out-of-network services, Option 1 and Option 2 pay a percentage of the reasonable and customary (R&amp;C) charges for services and you pay the remainder. In the Medicare Indemnity Options, the Plan pays a percentage of the reasonable and customary (R&amp;C) charges for services and you pay the remainder. In all the Medical Plan options you are responsible for paying any additional amount above R&amp;C charges. The coinsurance percentage you pay depends on the type of covered service.</td>
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<tr>
<td>Coinsurance Maximum</td>
<td>The coinsurance maximum is a &quot;safety net&quot; that protects you from having to pay high expenses in the event of a serious medical situation. The coinsurance maximum is the most you would need to pay in a calendar year in addition to the deductible for medically necessary covered services under Option 1 and Option 2 and the Medicare Indemnity Options. Once the coinsurance maximum is reached, the Medical Plan will pay 100% of negotiated rates for medically necessary covered in-network care and 100% of reasonable and customary (R&amp;C) charges for medically necessary covered out-of-network services for the rest of the year. Under Option 1 and Option 2, amounts that you pay toward your medical deductible, amounts above R&amp;C charges for out-of-network care, and your deductible, copayments, and coinsurance for prescription drugs do not count toward your medical coinsurance maximum.</td>
</tr>
<tr>
<td><strong>Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)</strong></td>
<td>A federal law that allows you and/or your covered dependents to continue Medical Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise end. The Plan Administration section of this Guide provides details on COBRA coverage.</td>
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</table>
| **Coordination of Benefits** | The rules that determine how benefits are paid when a patient is covered by more than one group plan. Rules include:  
  - Which plan assumes primary liability;  
  - The obligations of the secondary claims administrator or claims payer; and  
  - How the two plans ensure that the patient is not reimbursed for more than the actual charges incurred.  
  In general, the following coordination of benefits rules apply:  
  - As a JPMorgan Chase employee, your JPMorgan Chase coverage is considered primary for you.  
  - For your spouse/domestic partner or child covered as an active employee and/or retiree of another employer, that employer’s coverage is considered primary for him or her.  
  - For children covered as dependents under two plans, the primary plan is the plan of the parent whose birthday falls earlier in the year (based on month and day only, not year).  
  Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee) or covered by Medicare.  
  If you or a dependent are eligible for Medicare due to disability or end-stage renal disease, please see “Coordination with Medicare” on page 95 for more information. |
| **Copay or Copayment** | The fixed dollar amount you pay for certain medications under the prescription drug coverage feature of Option 1 and Option 2 and the Medicare Indemnity Options. For example, copayments apply for generic drugs. |
| **Covered Expenses** | The in-network negotiated fees or reasonable and customary (R&C) charges for medically necessary covered services or supplies that qualify for full or partial reimbursement under Option 1 and Option 2 and the Medicare Indemnity Options. |
| **Covered Services** | While the plan provides coverage for numerous services and supplies, there are limitations on what’s covered. For example, experimental treatments, most cosmetic surgery expenses, and inpatient private duty nursing are not covered under the Medical Plan. Medical procedures are generally reimbursable by the JPMorgan Chase Medical Plan only if they meet the definition of “Medically Necessary” (see “Medically Necessary” on page 9). |
| **Custodial Care** | Medical or non-medical services that do not seek to cure, are provided during periods when the medical condition of the patient is not changing, or do not require continued administration by medical personnel. An example of custodial care is assistance in the activities of daily living. |
**Deductible**

The amount you pay up front each calendar year for covered expenses before Option 1 and Option 2 and the Medicare Indemnity Options generally begin to pay benefits for many expenses. Amounts in excess of reasonable and customary (R&C) charges and ineligible charges do not count toward the deductible. A separate deductible applies for brand-name prescription drugs purchased at a retail pharmacy.

**Domestic Partner**

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

- You and your domestic partner must:
  - Be age 18 or older; and
  - Not be legally married to, or the domestic partner of, anyone else; and
  - Have lived together for at least the last six months, are currently living together, and have a serious, committed romantic relationship; and
  - Be financially interdependent (share responsibility for household expenses); and
  - Not be related to each other in a way that would prohibit legal marriage.

**OR**

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

You must certify that your domestic partner meets the eligibility rules as defined under the plan before coverage can begin. You may also be asked to certify that your domestic partner and/or your domestic partner’s children qualify as tax dependent(s) as determined by the IRC to avoid any applicable imputed income. Please see “Domestic Partners” on page 17 for more information.

**Eligible Dependents**

Under the Medical Plan, your eligible dependents can include your spouse or domestic partner and your children. Please see the above definition of “Domestic Partner” and the “Your Eligible Dependents” section on page 16 for more information.

**Experimental, Investigational, or Unproven Services**

Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the claims administrator makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The claims administrator, in its judgment, may determine an
experimental, investigational, or unproven service to be covered under the Medical Plan for treating a “life-threatening” sickness or condition if the claims administrator determines that a service:

- Is safe with promising effectiveness;
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

**Please Note:** For the purpose of this definition, the term “life-threatening” is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.

If services are denied because they are deemed to be experimental, investigational, or unproven, and the service is then considered an approved service by the claims administrator within six months of the date of service, you may resubmit your claim for payment.

<table>
<thead>
<tr>
<th><strong>Explanation of Benefits (EOB)</strong></th>
<th>A statement that the claims administrator prepares, which documents your claims and provides a description of benefits paid and not paid under the Medical Plan and through any related Medical Reimbursement Account and/or Health Care Spending Account.</th>
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<tbody>
<tr>
<td><strong>Home Health Care</strong></td>
<td>An alternative to inpatient hospitalization during a patient’s recovery period. If the attending physician believes that part-time care will suffice in treating the sickness or injury, the physician can prescribe a schedule of services to be provided by a state-licensed home health care agency. This schedule may include administration of medication, a regimen of physical therapy, suctioning or cleansing of a surgical incision, or the supervision of intravenous therapy.</td>
</tr>
<tr>
<td><strong>Hospice Care Program</strong></td>
<td>A program that tends to the needs of a terminally ill patient as an alternative to traditional health care, while meeting medically necessary and acceptable standards of quality and sound principles of health care administration. The program must be a written plan of hospice care for a covered person, and it must be approved by the appropriate claims administrator.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>An institution legally licensed as a hospital — other than a facility owned or operated by the United States Government — that’s engaged primarily in providing bed patients with diagnosis and treatment under the supervision of licensed physicians. The hospital must have 24-hour-a-day registered graduate nursing services and facilities for major surgery. Institutions that don’t meet this definition don’t qualify as hospitals.</td>
</tr>
<tr>
<td><strong>Hospital Notification</strong></td>
<td>Under Option 1 and Option 2 of the Medical Plan, you should notify the claims administrator in advance of a non-emergency hospital admission or if a maternity stay exceeds the guidelines. However, you will not be penalized under the plan if you do not notify the claims administrator.</td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td>Describes a covered service that is performed by a physician, hospital, lab, or other health care professional who is part of a health care company’s network and who has agreed to pre-negotiated fees, as in Option 1 and Option 2 of the Medical Plan. When a service is performed in-network, benefits are generally paid at a higher level than they are when a service is performed out-of-network.</td>
</tr>
<tr>
<td><strong>Medical Reimbursement Account (MRA)</strong></td>
<td>Also known as a “Health Reimbursement Account (HRA),” the Medical Reimbursement Account (MRA) is a tax-free account established on your behalf at your health care company when you enroll in Option 1 or Option 2 of the Medical Plan. You (and your covered spouse/domestic...</td>
</tr>
</tbody>
</table>
partner) can earn Wellness Funds for your MRA by completing Initial Wellness Activities and Additional Wellness Activities. You can use the funds in your MRA to pay for your out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments).

**Medically Necessary**

Health care services and supplies that are determined by the claims administrator to be medically appropriate and:

- Necessary to meet the basic health needs of the covered person;
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his or her physician; and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising effectiveness:
    - For treating a life-threatening sickness or condition;
    - In a clinically controlled research setting; and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

**Please Note:** For the purpose of this definition, the term “life-threatening” is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or condition does not mean that it is a medically necessary service or supply as defined above. The definition of “medically necessary” used here relates only to coverage and may differ from the way in which a physician engaged in the practice of medicine may define “medically necessary.”

Finally, to be considered necessary, a service or supply cannot be educational or experimental in nature in terms of generally accepted medical standards.

**Medicare**

Medicare is Health Insurance for the Aged and Disabled provisions of Title XVIII of the Social Security Act of the United States, as enacted or later amended. Coverage is available to most U.S. residents age 65 and older, those with a disability for at least 29 months, and those with end-stage renal disease (ESRD). Generally, Medicare is the primary coverage for individuals who are age 65 and older, unless those individuals are actively working.

**Multiple Surgical Procedure Reduction Policy**

Under Option 1 and Option 2 of the Medical Plan, surgical procedures that are performed on the same date of service are subject to the multiple surgical procedure reduction policy. On an in-network basis, 100% of the negotiated charges are reimbursable for the primary/major procedure, 50% of negotiated charges are reimbursable for the secondary procedure, and 50% of negotiated charges are reimbursable.
<table>
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<tr>
<th>Concept</th>
<th>Description</th>
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<tbody>
<tr>
<td>Out-of-network</td>
<td>Describes a covered service that is performed by a physician, hospital, lab, or other health care professional who is not part of a health care company’s network and who has not agreed to pre-negotiated fees, as in Option 1 and Option 2 of the Medical Plan. When a service is performed out-of-network, benefits are generally paid at a lower level than they are when a service is performed in-network and are limited to reasonable and customary charges.</td>
</tr>
<tr>
<td>Out-of-pocket Expense</td>
<td>The amount you pay for eligible expenses when you receive treatment. This includes your deductible, coinsurance, and copayments.</td>
</tr>
<tr>
<td>Out-of-pocket Maximum</td>
<td>Under the prescription drug coverage feature of Option 1 and Option 2 and the Medicare Indemnity Options, the maximum amount you would have to pay each year in copayments and coinsurance for prescription drugs. The out-of-pocket maximum does not include the deductible. After you reach the out-of-pocket maximum, the Plan would pay 100% of the cost of covered prescription drugs for the remainder of the year.</td>
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<tr>
<td>Primary Care Physician (PCP)</td>
<td>Under Option 1 and Option 2 and the Medicare Indemnity Options, the network physician who provides or coordinates all the care you receive. Under Option 1 and Option 2, primary care physicians include doctors who practice family medicine, internal medicine*, obstetrics/gynecology, and pediatrics. Care provided by an in-network primary care physician is covered at 90% of the pre-negotiated fee and is not subject to the deductible. *Internists must be contracted with Cigna or UnitedHealthcare as Primary Care Physicians. (A list of doctors who are designated as Primary Care Physicians is available on Cigna or UnitedHealthcare’s websites through My Health.)</td>
</tr>
<tr>
<td>Primary Plan</td>
<td>The plan that provides initial coverage to the participant. If the participant is covered under both a JPMorgan Chase Medical Plan option and another plan, the rules of the primary plan govern when determining the coordination of benefits between the two plans. Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee) or covered by Medicare. These rules do not apply to any private insurance you may have. Please see “If You Are Covered by More Than One Medical Plan” on page 94 for more information.</td>
</tr>
<tr>
<td>Qualified Change in Status</td>
<td>The JPMorgan Chase benefits you elect during each annual benefits enrollment period will generally stay in effect throughout the plan year, unless you elect otherwise due to a qualified change in status (such as</td>
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The Medical Plan

Effective 1/1/14

marriage, divorce, the birth or adoption of a child, etc.) within 31 days of the qualifying event for benefits to be effective the date of the event. If you miss the 31-day deadline, coverage for certain benefits (i.e., medical, dental, vision, and the Health Care Spending Account) will be effective as of the date you contact the Benefits Call Center, and in order to have retroactive coverage, you may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact the Benefits Call Center. Otherwise, you will not be able to make the change in coverage until the following annual benefits enrollment period.

Any changes you make during the year must be consistent with your qualified change in status. Please see “Qualified Change in Status” on page 24 for more information.

**Please Note:** Regardless of whether you experience a qualified change in status, you cannot change your health care company during the year under Option 1 or Option 2 of the Medical Plan.

| Reasonable and Customary (R&C) Charges | Also known as “eligible expenses,” the actual charges that are considered for payment when you receive medically necessary care for covered services from an out-of-network provider under Option 1 and Option 2 and the Medicare Indemnity Options. R&C means the prevailing charge for most providers in the same or a similar geographic area for the same or similar service or supply. These charges are subject to change at any time without notice. Reimbursement is based on the lower of this amount and the provider’s actual charge. If your provider charges more than the R&C charges considered under the Options, you’ll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered covered expenses. Therefore, they don’t count toward your deductible, benefit limits, or coinsurance maximums. |
| Regional Cost Category | The category that is assigned to a state or region based on the cost of health care for that region in relation to the national average. The Regional Cost Category is used to determine your Medical Plan contributions and is based on your home address. |
| Self-Insured | JPMorgan Chase is responsible for the payment of medical claims under the Medical Plan’s Option 1 and Option 2 and the Medicare Indemnity Options and under the Prescription Drug Plan. These Options are self-insured. |
| Skilled Nursing Facility | An institution that primarily provides skilled nursing care and related services for people who require medical or nursing care and that rehabilitates injured, disabled, or sick people. |
| Spouse | Any person to whom you are legally married as recognized by U.S. federal law. |
| Tobacco-User Surcharge | Refers to additional Medical Plan contribution costs for employees and covered spouses/domestic partners who use tobacco products. Eligible employees and covered spouses/domestic partners who do not use tobacco products pay less for coverage under the Medical Plan than those who use tobacco products. A “tobacco user” (for a plan year) is any person who has used any type of tobacco products (e.g., cigarettes, cigars, pipes, chewing tobacco, snuff, or a pipe) regardless of the frequency or location (this includes daily, occasionally, socially, at-home only, etc.) in the 12 months preceding January 1 of the plan year. Tobacco users may be able to qualify for lower non-tobacco user rates by completing a tobacco cessation program (see “Tobacco Cessation Program” on page 110). |
| **Total Annual Cash Compensation** | Your rate of base salary plus applicable job differential pay (e.g., shift pay) as of each August 1, plus any cash earnings from any incentive plans (e.g., annual bonus, commissions, draws, overrides, and special recognition payments or incentives) that are paid to or deferred by you for the previous 12-month period ending each July 31. Overtime is not included. For purposes of determining the Medical Plan contribution pay tier that applies to you, your Total Annual Cash Compensation 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, Total Annual Cash Compensation will be equal to base salary plus job differentials. Separate definitions may apply to employees in certain positions who are paid on a draw-and-commission basis. If this situation applies to you, you will be notified. Total Annual Cash Compensation is used for purposes of determining your Medical Plan contribution pay tier and in-network coinsurance maximum. |
| **Visit** | An encounter with a provider involving direct patient contact. Some benefit provisions limit the number of covered visits. Unless a visit is defined for a particular benefit provision (such as home health care), each procedure code billed counts as a visit toward the limit. The length of a visit may vary by procedure code. |
Some Quick Facts

<table>
<thead>
<tr>
<th>My Health</th>
<th><strong>My Health</strong> is your central online resource for finding quality in-network providers and for accessing health care tools, information regarding the Medical Plan, and other resources available to you to improve your health. Visit <strong>My Health</strong> to find links to the Cigna, UnitedHealthcare, and CVS Caremark websites, where you can check claims status, Explanations of Benefits (EOBs), your Medical Reimbursement Account balances, and in-network provider directories, in addition to accessing treatment cost estimators and tips on health and wellness.</th>
</tr>
</thead>
</table>
| Your Medical Plan Options | **Option 1 and Option 2** of the Medical Plan, each offered through Cigna and UnitedHealthcare, are “Consumer Driven Health Plan” options. Both options cover the same medically necessary services and supplies, including prescription drugs. However, Option 1 has higher payroll contributions but lower deductibles and coinsurance maximums, while Option 2 has lower payroll contributions but higher deductibles and coinsurance maximums. 

Option 1 and Option 2 benefits are offered through a network of participating health care providers (for example, doctors, hospitals, labs, and outpatient facilities that belong to Cigna’s and UnitedHealthcare’s networks). You can visit any provider each time you need care, even if they’re not in the network. However, the most cost-effective care will always be available through in-network providers who have agreed to accept pre-negotiated rates.

- Eligible in-network preventive care (including physical exams and recommended preventive screenings) and eligible preventive generic drugs are covered at 100% with no deductible, coinsurance, or copayments. In-network primary care office visits are covered at 90% with no deductible.
- When you receive other medical services, you’ll need to satisfy an annual deductible – a set amount that you pay out-of-pocket – before the Plan shares in the cost for care. There are separate deductibles for in- and out-of-network care and for prescription drugs.
- After you satisfy the deductible, the Plan pays a percentage (generally 80% in-network and 60% out-of-network) of the cost. Your share – called coinsurance, the amount you and the plan share for certain expenses – after the deductible is typically 20% of the cost of in-network care and 40% of the cost for out-of-network care. The amount of coinsurance you have to pay each year is limited by separate annual in-network and out-of-network coinsurance maximums, which act as a financial “safety net.” In-network charges do not apply toward the out-of-network deductible or coinsurance maximum – and vice versa.
- After you meet the out-of-network deductible, benefits for out-of-network care are limited to reasonable and customary (R&C) charges. These charges are based on average claims data in your area and are determined by your health care company to be appropriate fees. Out-of-network charges are typically higher than the pre-negotiated rates for in-network care. You are responsible for paying any amount above R&C charges.
- Prescription drug benefits are part of your coverage. Prescription drug coverage has a different plan design than other Medical Plan features and is subject to a separate deductible and a separate safety net in the form of per-prescription maximums and an annual out-of-pocket maximum.
- Option 1 and Option 2 include a Medical Reimbursement Account (MRA). The MRA is a company-funded account that you can use to help pay for your covered out-of-pocket medical and prescription drug expenses (deductibles, coinsurance,
and copayments). You can earn Wellness Funds for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in certain wellness activities.

### Your Health Care Company
Coverage under Option 1 and Option 2 is administered by Cigna and UnitedHealthcare (UHC). In addition to choosing Option 1 or Option 2 when you enroll in the Medical Plan, you select which health care company you would like to administer your option.

Both Cigna and UHC are large, established companies that offer broad nationwide provider networks. They also offer strong, well-established clinical programs and provide tools and resources to help you research and understand your health treatment alternatives.

### Your Coverage Level
You can choose to cover:
- Yourself only;
- Yourself and your spouse/domestic partner; or Yourself and your child(ren); or
- Your family (yourself, your spouse/domestic partner, and your children).

### Contribution Rates
Contribution rates vary by the types of dependent whom you choose to cover – e.g., a spouse/domestic partner vs. a child. You will be charged for up to a maximum of four children, regardless of how many additional children you choose to cover (you can cover all of your children, as long as they meet eligibility requirements). Contributions will also vary based on your Total Annual Cash Compensation, geographical location, the option you select, and your and your covered spouse’s/domestic partner’s tobacco user status. The amount you pay does not differ depending on whether you choose UnitedHealthcare or Cigna as your health care company.

### Covered Services
Covered services will generally include:
- Hospitalization;
- Surgical procedures;
- Physician’s office visits;
- Lab services/X-rays;
- Emergency room services;
- Maternity care;
- Mental health and substance abuse care; and
- Prescription drugs.

The Medical Plan also covers various preventive care services. Services and procedures must be considered medically necessary in order to be covered.
Participating in the Medical Plan

The general guidelines for participating in the JPMorgan Chase Medical Plan are described in this section.

Eligibility

Your participation in the JPMorgan Chase Medical Plan is optional. In general, you are eligible to participate if you are:

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

Please Note: An individual classified or employed in a work status other than as a common law salaried employee by his/her employer, such as an:

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

is not eligible to participate in the plan regardless of whether an administrative or judicial proceeding subsequently determines this individual to have instead been a common law salaried employee.

Medical Plan Options

You can choose your medical coverage from among the following options, depending on your zip code.

- Medical Plan Option 1;
- Medical Plan Option 2; or
- No Coverage.

Payroll Contribution Rates

Contribution rates vary by the types of dependent whom you elect to cover – e.g., a spouse/domestic partner vs. a child. You will be charged for a maximum of four children, regardless of how many additional children you choose to cover (you can cover all of your children, as long as they meet eligibility requirements). Contributions will also vary based on your Total Annual Cash Compensation, geographical location, the option you select, and your and your covered spouse’s/domestic partner’s tobacco user status.

Coverage Categories

The annual deductible and coinsurance maximum under your Medical Plan option are determined based on your coverage category election as follows:

- Employee only;
- Employee plus spouse/domestic partner or Employee plus child(ren); or
- Family (employee plus spouse/domestic partner plus child(ren)).
The coinsurance maximum also depends on your Total Annual Cash Compensation, as explained in “The Annual Coinsurance Maximum” on page 35.

**Important Note on Dependent Eligibility**

You are responsible for understanding the dependent eligibility rules and abiding by them. Each year during annual benefits enrollment, you must review your covered dependents and confirm that they continue to meet the eligibility requirements. It is important that you review both the dependent eligibility rules and the status of your dependents on file, and make any necessary adjustments during your designated enrollment period or within 31 days of a qualified change in status (e.g., birth of a child, gain or loss of other coverage, etc.). JPMorgan Chase reserves the right to conduct eligibility verifications on dependents at any time. If you fail to provide satisfactory proof (when requested) that your covered dependents meet the current eligibility requirements, you could face penalties ranging from **loss of coverage for your dependents** to **termination of employment**.

Within 30 days of adding a new dependent, an envelope will be sent to your home address requesting materials to verify your dependent’s eligibility (i.e., birth certificate, marriage license, etc.). You must supply acceptable supporting documents within 60 days. If you fail to provide satisfactory proof that your dependent(s) meet the current eligibility requirements, your dependent’s coverage will be terminated retroactively to the enrollment date and you will be responsible for any claims approved and paid.

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

**Your Eligible Dependents**

In addition to covering yourself under the Medical Plan, you can also cover your eligible dependents, but generally only under the same option you choose for yourself. (Please see “Special Medical Plan Options If You’re Disabled and Eligible for Medicare” on page 67 and the “Determining Primary Coverage” and “Coordination with Medicare” sections on pages 94-95 for details on coverage provisions for individuals who are eligible for Medicare.)

Your eligible dependents under the Medical Plan — and under certain other plans as referenced in those plan sections of this Guide — include:

- Your spouse or domestic partner (see “Domestic Partners” on page 17 for more information); and

- Your and/or your spouse’s/domestic partner’s children up to the last day the month in which they reach age 26, regardless of student or marital status, financial dependence on parents, residency with parents, or eligibility for coverage under another health plan. In order to cover your domestic partner’s children, you must elect coverage for your domestic partner.

**Please Note:** You may continue coverage beyond age 26 for an unmarried child who is unable to support himself or herself due to a mental or physical disability that began before age 26 and who depends fully on you for financial support.

**Spouse**

The term “spouse” refers to any person to whom you are legally married as recognized by U.S. federal law.
If JPMorgan Chase employs your spouse, domestic partner, or child, he or she can be covered as an employee or as your dependent, but not as both. If you want to cover your eligible child(ren), you or your spouse/domestic partner may provide this coverage.

**Children**

“Children” include your natural children; stepchildren (children of your current spouse); children of your domestic partner (if your domestic partner is also covered); legally adopted children; foster children; children under your legal guardianship (as established by a court order) whom you claim on your income tax return as dependents or for whom you provide more than 50% of their financial support; a child under age 18 who lives with you and for whom (1) adoption proceedings have already begun, and (2) whom you have the legal obligation to support (in whole or in part); and children who are alternate recipients under a Qualified Medical Child Support Order (QMCSO), as required by law. **Remember:** To cover the children of your domestic partner under the JPMorgan Chase Health Care & Insurance Plans, your domestic partner must also be enrolled.

**Please Note:** If you are covering the child of a domestic partner who is *not* a tax dependent, imputed income for that child will be applied.

**Domestic Partners**

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

For the purposes of the Medical Plan, you and your domestic partner must:

- Be age 18 or older; **and**
- Not be legally married to, or the domestic partner of, anyone else; **and**
- Have lived together for at least the last six months, are currently living together, and have a serious, committed romantic relationship; **and**
- Be financially interdependent (share responsibility for household expenses); **and**
- Not be related to each other in a way that would prohibit legal marriage.

**OR**

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

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

**Please Note:** See page 21 for information on extra tax withholding if you elect domestic partner coverage and on special "gross up" pay that compensates for such withholding. Information regarding domestic partner coverage and the various tax consequences can be found on **My Health**.
Cost of Coverage

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

JPMorgan Chase uses a “flat-dollar subsidy” approach to determine each employee’s contribution toward the cost of medical coverage. This means that JPMorgan Chase will generally contribute the same dollar amount (or “subsidy”) to the cost of your coverage, regardless of the Medical Plan option you choose.

The amount you pay depends on the level of your Total Annual Cash Compensation, the Medical Plan option you choose, your regional cost category, the number and type of eligible dependents you cover, and your and/or your covered spouse’s/domestic partner’s tobacco user status. The amount you pay does not differ depending on whether you choose UnitedHealthcare or Cigna as your health care company.

You will have a higher cost for coverage if your Total Annual Cash Compensation is higher, you elect Option 1, you cover more dependents, you and/or your covered spouse/domestic partner are a tobacco user, and/or costs in your geographic area are higher than average.

Total Annual Cash Compensation

Under the Medical Plan, Total Annual Cash Compensation is used to determine your Medical Plan contribution pay tier and the coinsurance maximum under Option 1 and Option 2.

Your Total Annual Cash Compensation is your rate of base salary plus applicable job differential pay (e.g., shift pay) as of each August 1, plus any cash earnings from any incentive plans (e.g., annual bonus, commissions, draws, overrides, and special recognition payments or incentives) that are paid to or deferred by you for the previous 12-month period ending each July 31. Overtime is not included. For purposes of determining the Medical Plan contribution pay tier that applies to you, your Total Annual Cash Compensation 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, Total Annual Cash Compensation will be equal to base salary plus job differentials.

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

Please Note: Your Total Annual Cash Compensation is measured as of August 1 and remains unchanged for purposes of determining Medical Plan contributions and the coinsurance maximum for the next calendar year.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Total Annual Cash Compensation (excluding overtime)</th>
<th>Employee Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Less than $35,000</td>
<td>Least</td>
</tr>
<tr>
<td>2</td>
<td>$35,000–$59,999</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$60,000–$79,999</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>$80,000–$149,999</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$150,000–$249,999</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>$250,000–$349,999</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>$350,000 and above</td>
<td>Most</td>
</tr>
</tbody>
</table>
Medical Option

Employee contributions will also vary because Option 1 and Option 2 of the Medical Plan provide different levels of coverage.

Here’s how the two Medical Plan options compare:

- **Option 1** – *Higher* employee contributions; *lower* deductibles and coinsurance maximums
- **Option 2** – *Lower* employee contributions; *higher* deductibles and coinsurance maximums

Covered Dependents

Your costs will vary based on the type and number of family members you cover. You pay for each family member (spouse/domestic partner and children) whom you cover; however, if you cover more than four children you will only be charged for covering four children.

Your payroll contributions, the annual deductible, and the coinsurance maximum for which you are responsible are determined by your coverage category:

- Employee Only;
- Employee Plus Spouse/Domestic Partner, or Employee Plus Child(ren);
- Employee Plus Spouse/Domestic Partner Plus Child(ren).

Tobacco User Status

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

**Please Note:** In your first calendar year of employment, 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 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, go to My Health > Take Action > Tobacco cessation.

### How Tobacco User Is Defined

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

### Regional Cost Categories

Costs for medical care differ across the United States. To ensure equity in how the Medical Plan options are priced, JPMorgan Chase applies the concept of geographic cost differences to the Medical Plan. Under the plan, each state or region is assigned to a “Regional Cost Category” based on the cost of health care for that region in relation to the national average.

The Regional Cost Category for your home state or region will be a factor in determining your Medical Plan contributions, along with the Medical Plan option you choose, your Total Annual Cash Compensation, the number and type of eligible dependents you cover, and the tobacco user status for you and your covered spouse/domestic partner.

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

<table>
<thead>
<tr>
<th>Lowest Cost</th>
<th>Regional Cost Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Colorado; Evansville and Jeffersonville, Indiana; Kansas; Kentucky; Missouri; Nebraska; New York (excluding Metro New York); Austin and San Antonio, Texas; Utah; Washington</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Cost Category 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona; Arkansas; California; Delaware; Georgia; Illinois (excluding Chicago); Iowa; Maryland; Nevada; North Carolina; Oklahoma; Oregon; Pennsylvania; South Carolina; Virginia; Washington, D.C.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Cost Category 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama; Alaska; Florida; Hawaii; Idaho; Chicago, Illinois; Gary, Indiana; Maine; Massachusetts; Michigan; Minnesota; Mississippi; Montana; New Hampshire; New Mexico; North Dakota; Ohio; South Dakota; Tennessee; Dallas, Texas; Vermont; Wyoming</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Cost Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut; Louisiana; New Jersey; Metro New York; Houston, Texas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Cost Category 5:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana (excluding Evansville, Gary, and Jeffersonville); West Virginia; Wisconsin</td>
</tr>
</tbody>
</table>
When Contributions Begin

Your contributions toward the cost of coverage start when your coverage begins. Your contributions are automatically deducted from your pay in equal installments (unless retroactive payments are required).

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.

Tax Treatment of Domestic Partner Coverage/
Gross-Up Policy

If you’re covering a domestic partner as described in “Your Eligible Dependents” on page 16, there are tax implications of which you should be aware. JPMorgan Chase is required to report the entire value of the medical coverage for a “Domestic Partner” as taxable (or “imputed”) income to you and to withhold for federal, state, and FICA taxes on the imputed income. The imputed income includes the amount that both you and JPMorgan Chase contribute towards the cost of coverage.

To offset the additional federal and state tax that is payable in order to cover a domestic partner, employees who cover same-sex domestic partners receive special “gross up” pay to compensate for the cost of the additional taxes. You will receive recurring payments, each of which represents an offset for federal (including FICA) and state taxes, if applicable, that you paid on benefits in the prior pay period. You can identify these payments on your pay statement under Earnings, “Benefit Tax Offset – GUDP.”

Because these payments will be taxable payments, the payments include an additional amount to help adjust for the taxes that you will pay on the payments themselves. They are based on estimated federal (25%) and state tax rates and include a FICA adjustment for individuals whose prior-year wages do not exceed the FICA wage limit for the prior year.

Please Note: If you certify that your domestic partner and/or your domestic partner’s children are your tax dependents, you will not receive the benefit tax offset payment described above, as you will not be subject to taxation of imputed income on the tax dependent’s coverage.

How to Enroll

Participation in the Medical Plan is optional.

<table>
<thead>
<tr>
<th>If You:</th>
<th>What You Need to Do to Enroll:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are an Employee</td>
<td>During an annual benefits enrollment period, you can make your elections through the Benefits Web Center on My Health or through the Benefits Call Center. At the beginning of each enrollment period, you’ll receive instructions on how to enroll. To access the Benefits Web Center, go to My Health &gt; Other Benefits &gt; Benefits Web Center. 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 change in status. Please see “Qualified Change in Status” on page 24.</td>
</tr>
</tbody>
</table>

(Table continued next page)
<table>
<thead>
<tr>
<th>If You:</th>
<th>What You Need to Do to Enroll:</th>
</tr>
</thead>
</table>
| 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 the Benefits Call Center 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, you may receive information regarding benefits enrollment after accepting a position with JPMorgan Chase but before your hire date. Your coverage will begin on the first of the month following your hire date, as long as you enroll prior to your hire date or within 31 days after your hire date.  

If you are a part-time employee, you will receive your enrollment materials within 31 days before becoming eligible for coverage. You need to enroll within 31 days before your eligibility date.  

You can access your benefits enrollment materials online at My Health > New hire benefits enrollment. To access the Benefits Web Center, go to My Health > Other Benefits > Benefits Web Center. |
| Have a Change in Work Status or Qualified Change in Status | 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 change in status, you’ll have 31 days from the date of the change in status (including the birth or adoption of a child, etc.) to make your new choices through the Benefits Web Center on My Health or through the Benefits Call Center. To access the Benefits Web Center, go to My Health > Other Benefits > Benefits Web Center. Please see “Qualified Change in Status” on page 24. |
## If You Do Not Enroll

<table>
<thead>
<tr>
<th>If You:</th>
<th>What Happens If You Do Not Enroll:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are an Employee</td>
<td>If you’re already participating in the Medical Plan and do not change your elections or cancel coverage during the annual benefits enrollment period, you’ll generally keep the same coverage for the following plan year that you had before the annual benefits enrollment period (if available) or you will be assigned coverage by JPMorgan Chase. However, you’ll be subject to any changes in the plan and coverage costs.</td>
</tr>
<tr>
<td>Are a Newly Hired or Newly Eligible Employee</td>
<td>If you’re a new hire or newly eligible employee and do not enroll before the end of the designated 31-day enrollment period, coverage for certain benefits will be effective as of the date you contact the Benefits Call Center, and in order to have retroactive coverage, you may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact the Benefits Call Center. Otherwise, you will not be able to make the change in coverage until the following annual benefits enrollment period. Please see “Qualified Change in Status” on page 24.</td>
</tr>
<tr>
<td>Have a Qualified Change in Status</td>
<td>If you have a qualified change in status that allows you to enroll in the Medical Plan mid-year and you do not enroll within the designated 31-day period (including the birth or adoption of a child, etc.), coverage for certain benefits will be effective as of the date you contact the Benefits Call Center and in order to have retroactive coverage, you may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact the Benefits Call Center. Otherwise, you will not be able to make the change in coverage until the following annual benefits enrollment period. Please see “Qualified Change in Status” on page 24.</td>
</tr>
</tbody>
</table>

## When Coverage Begins

<table>
<thead>
<tr>
<th>If You:</th>
<th>When the Coverage You Elect Begins:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are an Employee</td>
<td>The coverage you elect during the annual benefits enrollment period takes effect at the beginning of the following plan year (January 1).</td>
</tr>
<tr>
<td>Are a Newly Hired or Newly Eligible Employee</td>
<td>The coverage you elect as a new hire takes effect as follows:</td>
</tr>
<tr>
<td></td>
<td>• If you are a full-time employee, coverage begins on the first of the month following your date of hire.</td>
</tr>
<tr>
<td></td>
<td>• If you are a part-time employee regularly scheduled to work at least 20 but less than 40 hours per week, coverage begins on the first of the month following 60 days from your date of hire.</td>
</tr>
</tbody>
</table>

(Table continued next page)
<table>
<thead>
<tr>
<th>If You:</th>
<th>When the Coverage You Elect Begins:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a Change in Work Status or</td>
<td>The coverage you elect as a result of a qualifying event (such as marriage, divorce, or the birth or adoption of a child or a work-related event such as an adjustment to your regularly scheduled work hours that results in a change in eligibility) will take effect as of the day of the qualifying event, if you enroll within 31 days of the event and you have already met the plan’s eligibility requirements. If you miss the 31-day deadline, coverage for certain benefits will be effective as of the date you contact the Benefits Call Center, and in order to have retroactive coverage, you may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact the Benefits Call Center. Otherwise, you will not be able to make the change in coverage until the following annual benefits enrollment period. Please see “Qualified Change in Status” on page 24.</td>
</tr>
<tr>
<td>Qualified Change in Status</td>
<td></td>
</tr>
</tbody>
</table>

**Please Note:** All of the Medical Plan options cover pre-existing conditions. Your coverage begins as soon as you're eligible and enroll. If you miss the 31-day deadline, coverage for certain benefits will be effective as of the date you contact the Benefits Call Center and in order to have retroactive coverage, you may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact the Benefits Call Center. Otherwise, you will not be able to make the change in coverage until the following annual benefits enrollment period.

**Qualified Change in Status**

The Medical Plan elections you make during the annual benefits enrollment period 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 period if you have a qualified change in status. **Please Note:** Any changes you make during the year must be consistent with your qualified change in status.

If you have a qualified change in status and want to change your elections, please see the [Benefits Status Change Guide](#), which includes details on how to make changes. The Guide is available on [My Health > Benefits updates for new situations](#) and is also available on request through the Benefits Call Center.

You need to enroll through the Benefits Web Center on [My Health](#) or through the Benefits Call Center within 31 days of the qualifying event for benefits to be effective on the date of the event. To access the Benefits Web Center, go to [My Health > Other Benefits > Benefits Web Center](#). If you miss the 31-day deadline, coverage for certain benefits (i.e., medical, dental, vision, and the Health Care Spending Account) will be effective as of the date you contact the Benefits Call Center, and in order to have retroactive coverage, you may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact the Benefits Call Center. Otherwise, you will not be able to make the change in coverage until the following annual benefits enrollment period. Your deadline to report a qualifying event may be extended to 60 days if your newly eligible dependent dies prior to adding them to coverage. Please contact the Benefits Call Center if this situation applies to you.
**Please Note:** Documentation of dependent eligibility will be required when adding a dependent 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 an "Important Note on Dependent Eligibility" on page 16.

If you have questions during the year about qualifying events and what the allowed benefit changes are, please visit My Health, or contact the Benefits Call Center and speak with a Service Representative.

Qualified changes in status for eligible dependents under the Medical Plan are listed in the following table. **Please Note:** A qualified change in status does not permit you to change your health care company during the year under Option 1 or Option 2 of the Medical Plan.

<table>
<thead>
<tr>
<th>Event</th>
<th>Medical Plan Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>You get married</td>
<td>Add coverage for yourself and/or your eligible dependents</td>
</tr>
<tr>
<td>You enter into a domestic partner relationship or civil union</td>
<td>Add coverage for yourself, your domestic partner, and any eligible children.</td>
</tr>
<tr>
<td>You have, adopt, or obtain legal guardianship of a child*</td>
<td>Add coverage for yourself and/or your eligible dependents</td>
</tr>
<tr>
<td>You and/or your covered dependents gain other benefits coverage*</td>
<td>Cancel coverage for yourself and/or your covered dependents who have gained other coverage</td>
</tr>
<tr>
<td>You and/or your eligible dependents lose other benefits coverage*</td>
<td>Add coverage for yourself and/or your eligible dependents who have lost other coverage</td>
</tr>
<tr>
<td>You get legally separated or divorced</td>
<td>Cancel coverage for your former spouse and/or children who are no longer eligible</td>
</tr>
<tr>
<td>You end a domestic partner relationship or civil union</td>
<td>Cancel coverage for your domestic partner and your domestic partner’s eligible children who are no longer eligible.</td>
</tr>
<tr>
<td>A child is no longer eligible*</td>
<td>Cancel coverage for your child</td>
</tr>
<tr>
<td>A covered family member dies*</td>
<td>Cancel coverage for your deceased dependent and any children who are no longer eligible</td>
</tr>
<tr>
<td>You move out of a Medical Plan option service area and your current option is no longer available</td>
<td>Change Medical Plan option for yourself and your covered dependents. <strong>(Please Note:</strong> 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.)</td>
</tr>
</tbody>
</table>

* Also applies to a domestic partner relationship.

**Please Note:** Your deadline to report a qualifying event may be extended to 60 days if your newly eligible dependent dies prior to adding them to your coverage. Please contact the Benefits Call Center if this situation applies to you.
# Option 1 and Option 2 of the Medical Plan

The JPMorgan Chase Medical Plan offers medical and prescription drug coverage under two “Consumer Driven Health Plan” options, Option 1 and Option 2, provided by Cigna and UnitedHealthcare, the health care companies that act as claims administrators for Option 1 and Option 2. Both options offer the same coverage for medically necessary services and supplies, including prescription drugs. The key differences between the two options are that Option 1 has higher payroll contributions and lower deductibles and coinsurance maximums, while Option 2 has lower payroll contributions and higher deductibles and coinsurance maximums.

When you enroll in Option 1 or Option 2 through Cigna or UnitedHealthcare, you will automatically be set up with a Medical Reimbursement Account (MRA). The MRA is a company-funded account that you can use to help pay for out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments). You can earn Wellness Funds for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in certain wellness activities.

This section provides a general overview of Option 1 and Option 2; detailed descriptions of covered expenses and how to use the MRA are in the following pages.

## With Option 1 and Option 2 of the Medical Plan...

- **Benefits are provided through a network of participating health care providers who have agreed to charge negotiated rates for their services.** You can visit any doctor, hospital, lab, or outpatient facility, even if they’re not in the network. However, because in-network providers have agreed to pre-negotiated rates, you’ll save money by staying in-network for your care.

- **Eligible in-network preventive medical care and eligible preventive generic drugs are covered at 100% with no deductible or coinsurance.** Please see the chart on beginning on page 40 for information about eligible preventive medical care and “Prescription Drug Coverage Under Option 1 and 2” on page 47 for information about eligible preventive generic drugs.

- **In-network primary care visits are covered at 90% of the negotiated cost with no deductible; you pay 10%.** Primary care doctors include family practitioners, internists*, pediatricians, and OB/GYNs. Visits to convenience care clinics, such as CVS Minute Clinic® and Walgreens Healthcare Clinic, are also considered primary care visits.

*Internists must be contracted with Cigna or UHC as a Primary Care Physician (PCP). Go to Cigna or UnitedHealthcare’s websites through **My Health** to search for PCPs/primary care.

- **When you receive other medical care, you’ll need to satisfy an annual deductible before the Medical Plan begins to pay benefits.**

- **After you satisfy the annual deductible, you and the Medical Plan share the cost of expenses through coinsurance.** You pay either 20% (in-network) or 40% (out-of-network) of the negotiated rate for covered in-network care or of reasonable and customary (R&C) charges for covered out-of-network care (you are responsible for paying for amounts above R&C charges for covered out-of-network care). The Plan pays the remaining 80% (in-network) or 60% (out-of-network). The amount of coinsurance you have to pay each year is limited by separate in- and out-of-network annual coinsurance maximums, which act as a financial “safety net.”

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### Important Note About Providers Leaving Networks

If your doctor leaves a network, it does **not** qualify as an event that allows you to change coverage during the year. Each year during the fall annual enrollment period, you may want to check with your provider to ensure that he or she plans to continue to participate in the network of your health care company.
• **Prescription drugs benefits** are part of your coverage and are administered by CVS Caremark. Prescription drug coverage has a separate deductible, copayments and coinsurance, and a separate “safety net” in the form of per-prescription maximums and an annual out-of-pocket maximum.

• **You will automatically have a Medical Reimbursement Account (MRA) set up for you.** The MRA is a company-funded tax-free account that you can use to help pay for your covered out-of-pocket medical and prescription drug expenses, such as deductibles, coinsurance, and copayments. You can earn Wellness Funds for your MRA when you (and in some cases, your covered spouse/domestic partner) participate in certain wellness activities.

• **If you see an in-network provider you will generally not have to pay anything at the point of service and you will not have to file a claim.** Your provider will typically submit your claim electronically to your health care company using the information on your ID card.

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**The Medical Reimbursement Account (MRA)**

Option 1 and Option 2 of the Medical Plan include a Medical Reimbursement Account (MRA). This tax-free account will automatically be established on your behalf at your health care company, Cigna or UnitedHealthcare. Your MRA is completely company-funded; you are not permitted to make contributions. You can earn funds for your MRA when you take action for your health by completing certain wellness activities, as described in the next section.

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

Unused funds left in your MRA at year-end carry over to be used in future years, as long as:

- you remain a JPMorgan Chase employee enrolled in Option 1 or Option 2 of the Medical Plan; or
- you leave JPMorgan Chase and qualify for retirement benefits or you elect to continue your medical coverage through COBRA (see “What Happens to Your MRA if You Leave JPMorgan Chase” on 32).

If you are an active employee and waive coverage in Option 1 or Option 2, any unused MRA funds will be placed on hold for you by your health care company and will be available to you if you re-enroll in Option 1 or Option 2 in a subsequent year.

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To Check Your MRA Balance
Go to My Health > My MRA Balance.
How to Earn Wellness Funds for Your MRA

You can earn up to $1,000 ($1,400 if your covered spouse/domestic partner also participates) in Wellness Funds for your MRA by completing certain wellness activities. The following chart summarizes the opportunities for 2014 to earn Wellness Funds; details about the wellness activities listed below are described in “The Wellness Program Under Option 1 and Option 2” on page 55.

<table>
<thead>
<tr>
<th>Wellness Activity</th>
<th>Amount of MRA Funds That Can Be Earned by:</th>
<th>Special Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You</td>
<td>Your Covered Spouse/Domestic Partner</td>
</tr>
<tr>
<td>Initial Wellness Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biometric Wellness Screening (see page 55 for description)</td>
<td>$300</td>
<td>$100</td>
</tr>
</tbody>
</table>

Please Note: The Wellness Funding amounts and activities shown in the chart above may vary in future years.
### Wellness Activity

<table>
<thead>
<tr>
<th>Wellness Activity</th>
<th>Amount of MRA Funds That Can Be Earned by:</th>
<th>Special Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You</td>
<td>Your Covered Spouse/Domestic Partner</td>
</tr>
<tr>
<td><strong>Online Wellness Assessment (see page 55 for description)</strong></td>
<td>$300</td>
<td>$100</td>
</tr>
<tr>
<td>Complete this 15-minute questionnaire at your health care company’s website after you have obtained a Wellness Screening. Go to My Health &gt; Take Action &gt; Wellness Assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Wellness Activities</strong></td>
<td>$200</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>$200</td>
<td>$100</td>
</tr>
<tr>
<td>Get a physical, cervical or prostate cancer screening, mammogram, or colonoscopy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Achieve a healthy Body Mass Index (BMI) &lt; 25 OR make progress toward a healthy BMI</strong></td>
<td>$200</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Health Coaching Programs (telephonic or online)</strong></td>
<td>$200</td>
<td>$100</td>
</tr>
<tr>
<td>Stress and weight management, nutrition, maternity support, condition management, and/or treatment decision support – see “The Wellness Program Under Option 1 and Option 2” on page 55 for detailed information.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If it is unreasonably difficult, due to a medical condition, for you to achieve the standards for the reward under this program, contact Corporate Wellness at us.wellness@jpmchase.com and the Wellness staff will work with you to develop another way to qualify for the reward.

**Please Note:** The Wellness Funding amounts and activities shown in the chart above may vary in future years.

(Table continued next page)
<table>
<thead>
<tr>
<th>Wellness Activity</th>
<th>Amount of MRA Funds That Can Be Earned by</th>
<th>Special Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You</td>
<td>Your Covered Spouse/Domestic Partner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Wellness Activities, continued from previous page</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participate in a Local Community Physical Activity Event</td>
<td>$200</td>
<td>Not applicable</td>
</tr>
<tr>
<td>through Good Works, or participate in the JPMorgan Chase Corporate Challenge*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centers of Excellence (COE)</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>(for Bariatric and Organ Transplant Surgery)</td>
<td></td>
<td>If you and/or your covered spouse/domestic partner receive bariatric surgery or organ transplant surgery through one of your health care company’s designated Centers of Excellence and complete all program requirements by December 31, including a follow-up call.</td>
</tr>
<tr>
<td>Please see page 45 for additional information.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If it is unreasonably difficult, due to a medical condition, for you to achieve the standards for the reward under this program, contact Corporate Wellness at us.wellness@jpmchase.com and the Wellness staff will work with you to develop another way to qualify for the reward.

Please Note: The Wellness Funding amounts and activities shown in the chart above may vary in future years.

**MRA Payment Elections**

During annual enrollment or when you first enroll in Option 1 or Option 2, you must choose how claims will be paid from your MRA when you have a covered expense: through **Automatic Claim Payment** or a **Debit Card**. Your choice will also apply to your Health Care Spending Account (HCSA), if you elect to participate in that plan. (For information about the Health Care Spending Account, please see the Spending Accounts section of this Guide.) Your election will remain in effect for future plan years unless you make a change during a subsequent annual enrollment period (the annual enrollment period is the only time during the year that you can change your MRA payment election). If you do not make an election when you first enroll in the Medical Plan, you will be enrolled in the Automatic Claim Payment method.

Your MRA payment election determines how in-network claims are processed by your health care company. If an out-of-network provider agrees to submit a claim to your health care company on your behalf, your election would also apply to the processing of that claim. The claims payment process takes into account whether there is money in your MRA (and/or HCSA, if applicable) available to pay for all or part of your share of the covered medical or prescription drug expense.

The following “What to Do at the Point of Service” section contains detailed instructions regarding payments at in-network and out-of-network providers.
What to Do at the Point of Service

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

If You See an In-network Provider

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

<table>
<thead>
<tr>
<th>If You Elected or Were Assigned Automatic Claim Payment</th>
<th>If You Elected the Debit Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your provider will submit a claim to Cigna or UnitedHealthcare, as applicable. Your health care company will pay your provider for the Plan’s share of the expense. If the claim is not for eligible preventive care and you therefore owe a portion of the expense, your health care company will see if funds are available – first from your MRA and then from your HCSA, if applicable.</td>
<td>Your provider will submit a claim to Cigna or UnitedHealthcare, as applicable. Your health care company will pay your provider for the Plan’s share of the expense. If the claim is not for eligible preventive care and you therefore owe a portion of the expense, your doctor will bill you for your share. The amount your doctor bills you should match the information shown on your Explanation of Benefits (for Cigna participants) or Health Statement (for UHC participants). The amount in the “What I Owe” field on the Cigna EOB or the “Total You Owe” field on the UHC Health Statement should match the amount of your provider’s bill. You can decide whether to use your debit card to pay your bill or pay out-of-pocket.</td>
</tr>
<tr>
<td>First, your health care company will use the funds in your MRA to pay your provider directly.</td>
<td></td>
</tr>
<tr>
<td>Once your MRA has been exhausted, your health care company will use your HCSA balance, if any, to pay your provider directly.</td>
<td></td>
</tr>
<tr>
<td>Once your MRA and HCSA, if applicable, have been depleted, your provider will bill you for the remaining balance that you owe. You should pay the bill after comparing it to your Explanation of Benefits (for Cigna members) or Health Statement (for UnitedHealthcare members). The amount in the “What I Owe” field on the Cigna EOB or the “Total You Owe” field on the UHC Health Statement should match the amount of your provider’s bill.</td>
<td>If you pay out-of-pocket, you may request reimbursement from your MRA/HCSA, if applicable, at a later date by submitting the MRA and/or HCSA Claim Form to your health care company. You will need to provide a receipt if you file for reimbursement from your MRA/HCSA (see “Filing a Claim for Reimbursement under Option 1 and Option 2” on page 61).</td>
</tr>
</tbody>
</table>

Please Note: Not all providers accept the debit card as a form of payment. In those instances, you will need to pay out-of-pocket and then submit a MRA and/or HCSA Claim Form to your health care company (see “Filing a Claim for Reimbursement under Option 1 and Option 2” on page 61).
If Your In-network Provider Asks You to Pay at the Point of Service

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

If this happens, you should show your provider your ID card and explain that your health care company needs to review the claim first to see what you owe. If you are still required to pay at the time of service, you should do so and get a receipt from your provider. For instructions on how to file for reimbursement, see “If You Saw an In-Network Provider and Paid Out-of-Pocket” in the “Filing A Claim for Reimbursement Under Option 1 and Option 2” section on page 61.

If You See an Out-of-network Provider

When you visit an out-of-network provider, you should always show the provider your ID card and ask if they will submit the claim for you. If they agree to do so, your claim will be processed as explained in the “If You See an In-network Provider” section on page 31 (your health care company will see if funds are available – first from your MRA and then from your HCSA, if applicable).

If an out-of-network provider will not file a claim for you, you will need to pay for the service at the time of your visit and submit a Medical Claim Form to your health care company to be reimbursed for the plan’s share of the expense. You can also be reimbursed from your MRA/HCSA, if applicable, for your out-of-pocket share of the expense. Please see “If You Saw an Out-of-Network Provider and Paid Out-of-Pocket” in the “Filing A Claim for Reimbursement Under Option 1 and Option 2” section on page 61 for instructions.

At the Pharmacy

Please see the “The MRA and Your Prescription Drug Expenses” on page 51 for information on how your MRA is automatically applied to your share of the cost for prescription drugs.

What Happens to Your MRA If You Leave JPMorgan Chase

If you leave JPMorgan Chase with a balance in your MRA account, you can use the balance for covered out-of-pocket medical and prescription drug expenses incurred prior to the end of the month in which you leave. You will forfeit any remaining MRA funds. However, your account balance will be available if:

- **you elect COBRA medical coverage.** While you remain enrolled in COBRA medical coverage you can use the remaining balance in your MRA to pay for your out-of-pocket costs related to covered medical and prescription drug expenses. You can also continue to earn Wellness Funds for your MRA as if you were an active employee (see “How to Earn Wellness Funds for Your MRA on page 28); or

- **you qualify for retirement benefits** (i.e., leave JPMorgan Chase at age 55 or older with at least 15 years of service, or at age 50 or older with at least 20 years of service in the case of severance). If you retire from JPMorgan Chase you can continue to access your MRA regardless of what medical coverage you have in retirement, whether it is through COBRA, the JPMorgan Chase Retiree Medical Plan, or another plan. If you are enrolled in COBRA or in the JPMorgan Chase Retiree Medical Plan, the MRA can be used to pay for covered out-of-pocket medical and prescription drug expenses. If you are covered by another plan, the
expenses eligible for reimbursement from the MRA will be determined by the expenses covered by that plan.

Please Note: Your MRA funds can be used to pay for covered out-of-pocket medical and prescription drug costs incurred while you were enrolled in the JPMorgan Chase Medical Plan as an employee, even if you do not qualify to retain your MRA after you leave the company as described above.

If you continue your Medical Plan coverage under COBRA, you can continue to earn Wellness Funds to increase the value of your MRA. If you retire and elect coverage under the Retiree Medical Plan, you will not be able to earn additional funds to increase your MRA balance.

Costs for Your MRA If You Elect COBRA or as a Retiree

If you elect COBRA or if you are a retiree and you elect coverage under the JPMorgan Chase Retiree Medical Plan, no administrative fees will be deducted from your MRA and you may use automatic claim reimbursement or the debit card to pay for expenses from your MRA. If you are a retiree and you do not elect COBRA coverage or the Retiree Medical Plan, monthly administrative fees will be deducted from your account and you will need to file a MRA and/or HCSA Claim Form for reimbursement of your covered out-of-pocket medical and prescription drug expenses (see “Filing a Claim for Reimbursement Under Option 1 and Option 2” on page 61).

Please see the Plan Administration section of this Guide for more information on COBRA.

Eligible MRA Expenses

You can use the funds in your MRA to pay for covered out-of-pocket medical and prescription drug expenses (deductibles, coinsurance, and copayments) under the Medical Plan. Please see “What is Covered Under All Medical Plan Options” on page 80 for a list of covered expenses.

Expenses that are not covered under the Medical Plan are not eligible to be reimbursed by the MRA. Please see “What Is Not Covered Under the Medical Plan Options” on page 91 for a list of excluded expenses. Please Note: While the MRA cannot be used to pay for expenses that are not considered covered expenses under the Medical Plan, such as charges above reasonable and customary levels for out-of-network care, or for dental or vision expenses, you can be reimbursed for these expenses from a Health Care Spending Account, if you choose to participate in that Plan. Please see the Spending Accounts section of this Guide for more information.
How Option 1 and Option 2 Pay Benefits

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

Prescription drugs are also covered the same way under Option 1 and Option 2. For a description of coverage for prescription drugs, please see page 47.

The Annual Deductible

Under Option 1 and Option 2 certain expenses are subject to an annual deductible. The annual deductible is the amount you must pay “up front” each calendar year before the Plan begins to pay benefits for most covered expenses.

Under Option 1 and Option 2, eligible preventive care that is received from in-network providers is covered in full without having to satisfy the deductible and in-network primary care is covered at 90% without having to satisfy the deductible (for more information on what is considered “eligible preventive care” and “primary care,” please see the chart beginning on page 40).

Out-of-network care has a higher deductible that is separate from the in-network deductible. Amounts in excess of reasonable and customary (R&C) charges do not count toward the out-of-network deductible.

If you elect coverage for yourself, you must pay up front for all eligible expenses (except for preventive care and primary care) until you meet the per-person deductible. After you meet the per-person deductible, the Plan will begin to pay its coinsurance rate for covered expenses (please see the chart beginning on page 40 for the Plan’s coinsurance for various expenses).

If you cover dependents, all eligible expenses paid by you and/or your covered dependents combine to meet the deductible amount for the coverage level. However, no individual must satisfy more than the per-person deductible amount. This means that once an individual’s expenses meet the per-person deductible, the Plan will begin to pay benefits for that person, even if the family has not yet met the full deductible for the coverage category. Please see “The Per-person Deductible and Coinsurance Maximum Provision” on page 37.

The table on the following page shows the annual deductibles for the different coverage levels under each option.
The Medical Plan

Effective 1/1/14

The Annual Coinsurance Maximum

Under Option 1 and Option 2, the annual coinsurance maximum is the maximum amount you must pay in coinsurance in a plan year toward eligible expenses. The coinsurance maximum does not include the deductible and there are separate coinsurance maximums for in-network and out-of-network charges.

The coinsurance maximum functions as your “financial safety net.” It prevents you from having to pay very high health care expenses in the event of a serious medical situation. Once the coinsurance maximum is reached, the Medical Plan will pay 100% of negotiated fees for covered in-network care and 100% of the reasonable and customary charges for covered out-of-network services for the rest of the year.

Amounts that you pay toward your medical deductible and amounts above reasonable and customary charges for out-of-network care do not count toward your coinsurance maximum. In addition, prescription drug benefits are subject to a separate out-of-pocket maximum, as explained on pages 48-49.

The coinsurance maximum varies based on coverage level and Total Annual Cash Compensation (see definition on page 12), which provides greater financial protection for lower-paid employees, as shown in the table on the following page.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Employee (Also functions as a “per-person” deductible under the other coverage levels.)</td>
<td>$1,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Employee + spouse/domestic partner or Employee + child(ren)</td>
<td>$2,250</td>
<td>$3,750</td>
</tr>
<tr>
<td>Family (employee + spouse/domestic partner + child(ren))</td>
<td>$3,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
### Option 1 and Option 2 In- and Out-of-Network Coinsurance Maximums

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$750</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family (employee +</td>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td>spouse/domestic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>partner or Employee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ child(ren)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Annual Cash</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation: $60,000-149,999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$1,250</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family (employee +</td>
<td>$2,500</td>
<td></td>
</tr>
<tr>
<td>spouse/domestic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>partner + Employee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ child(ren)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Annual Cash</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation: $150,000+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Employee (Also functions as a “per-person” coinsurance maximum under the other coverage levels.)
- Employee + spouse/domestic partner or Employee + child(ren)
- Family (employee + spouse/domestic partner + child(ren))
The Per-person Deductible and Coinsurance Maximum Provision

If you elect coverage for yourself, you must pay all deductible/coinsurance expenses until the per-person deductible/coinsurance maximum is met. After you meet the per-person deductible/coinsurance maximum, you will pay no further deductible/coinsurance expenses for the year.

If you cover dependents, the “per person” rule allows any single person (e.g., the employee or a covered spouse/domestic partner or child) within a coverage level to reach the individual deductible or coinsurance maximum, after which the deductible or coinsurance maximum is satisfied for the year for that person.

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

An Example: Amounts Applied Toward In-Network Family Coinsurance Maximum for Medical Plan Option 1 After Deductibles Were Met
(Total Annual Cash Compensation < $60,000)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>On behalf of you</td>
<td>$750</td>
</tr>
<tr>
<td>On behalf of your spouse/domestic partner</td>
<td>$100</td>
</tr>
<tr>
<td>On behalf of one child</td>
<td>$50</td>
</tr>
<tr>
<td>On behalf of a second child</td>
<td>$50</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$950</td>
</tr>
</tbody>
</table>

In this example, one person has met the $750 per-person coinsurance maximum (you), and combined coinsurance costs for the family have reached $950. Any charges for eligible medically necessary covered services for your care would therefore be reimbursable at 100% for the remainder of the year, even though the family as a whole has not yet met the family coinsurance maximum for the Total Annual Cash Compensation < $60,000 tier ($1,500).
Maximum Lifetime Benefits

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

However, there is a **$20,000** lifetime infertility services maximum (**$30,000** if you and/or your covered spouse/domestic partner receive your care in a Center of Excellence, as explained on page 45). There is also a lifetime limit of 365 days for in- or out-of-network care in a skilled nursing facility. The infertility services and skilled nursing facility lifetime maximum benefits apply to both in-network and out-of-network care.

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

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

- Medical Plan Option 1;
- Medical Plan Option 2; and
- The Medicare Indemnity Options.

You do not gain a new benefit maximum if you switch your coverage between options or health care companies. In addition, any benefits that were applied to a lifetime maximum provision under prior medical plans of JPMorgan Chase (such as the Point of Service High/Low and the Consumer Driven Health Option) and medical plans of a heritage organization that was acquired by JPMorgan Chase will also be applied to the lifetime benefit maximums of the JPMorgan Chase Medical Plan.
Choosing Between In- and Out-of-Network Care

Under Option 1 and Option 2 of the Medical Plan you can choose to see any provider, but you'll pay less when you receive your care through your health care company's network of physicians and facilities because network providers have agreed to charge negotiated discounted fees for their services. In addition, the Plan pays a higher rate of coinsurance for in-network care, so your share of charges, if any, is less for in-network care. Lastly, the deductible is lower for in-network care than it is for out-of-network care, so you have to incur less expense before the Medical Plan begins to pay coinsurance for covered expenses.

When you receive in-network care:

- You usually don't have to file any claim forms; your network provider will usually file claims for you.
- Your out-of-pocket expenses will be lower compared to your expenses for the same type of care on an out-of-network basis. In-network doctors have agreed with Cigna and UnitedHealthcare to charge pre-negotiated fees that are on average 50% lower than the fees charged by doctors outside the network.

When you receive out-of-network care:

- You may need to file a claim form to receive out-of-network benefits. Please see “Filing a Claim for Reimbursement Under Option 1 and Option 2” on page 61 for more information.
- Your out-of-pocket costs for medically necessary covered services generally will be higher than if you received in-network care.

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

Coinsurance Paid by Option 1 and Option 2 for Covered Benefits

The table on the following page shows the coinsurance percentage paid by the Medical Plan on an in-network and out-of-network basis for covered expenses. Please also see "What is Covered Under All Options" on page 80 for a more detailed list of covered expenses under the Medical Plan.

Please Note

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

For example, assume you visit an in-network facility for surgery and are treated by an out-of-network anesthesiologist whose charge is $500. The plan will reimburse you 80% of $500 ($400); you will be responsible for payment of the remaining $100. Fees for services provided by any other out-of-network specialists who attend to you while you are confined in an in-network facility will be paid at the out-of-network level of benefits. Services performed in an out-of-network facility will be paid at the out-of-network level of benefits.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Plan’s Coinsurance Percentage for In-Network Care</th>
<th>Plan’s Coinsurance Percentage for Out-of-Network Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Preventive Care**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please Note: A medical service will only be covered at 100% if it is coded as preventive. Before receiving any service, you should check with your physician to be sure the procedure is considered, and will be submitted to your health care company, as preventive medical care rather than as a diagnostic service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physical exams</td>
<td>100% before deductible**</td>
<td>60% coverage after deductible**</td>
</tr>
<tr>
<td>Immunizations (routine adult and child) (includes immunizations related to travel)</td>
<td>100% before deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Routine Gynecological Exams and Pap Smears</td>
<td>100% before deductible, one exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines</td>
<td>60% coverage after deductible, one exam and Pap smear per year (includes related laboratory fees); check with your provider for age guidelines</td>
</tr>
<tr>
<td>Routine screenings provided during pregnancy (e.g., gestational diabetes and bacteriuria screenings, as well as items such as certain breast pumps)</td>
<td>100% before deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Routine Mammography, Prostate Specific Antigen (PSA) Test, and Digital Rectal Exam</td>
<td>100% before deductible, age 40 and over: one exam per year</td>
<td>60% coverage after deductible, age 40 and over: one exam per year</td>
</tr>
<tr>
<td>Fecal Occult Blood Test</td>
<td>100% before deductible, age 50 and over: one test per year</td>
<td>60% coverage after deductible, age 50 and over: one test per year</td>
</tr>
</tbody>
</table>

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

** Your health care company determines the preventive care services covered at 100% under the plan based on guidelines and clinical recommendations for the general population developed by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorgan Chase does not make this determination. For a list of preventive services that are covered at 100%, go to your health care company’s website at My Health > My medical plan website.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Plan’s Coinsurance Percentage for In-Network Care</th>
<th>Plan’s Coinsurance Percentage for Out-of-Network Care*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Preventive Care services (continued)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Sigmoidoscopy/Colonoscopy</td>
<td>100% before deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>age 50 and over: one baseline screening and one follow-up screening every 5 years</td>
<td>age 50 and over: one baseline screening and one follow-up screening every 5 years</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Office Visits</td>
<td>90% coverage before deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>(to family practitioners, internists, pediatricians, OB/GYNs, and convenience care clinics). Internists must be contracted with Cigna or UHC as a Primary Care Physician (PCP). Go to Cigna or UnitedHealthcare’s websites through My Health to search for PCPs/primary care. (includes tests, injection drugs, supplies, and other services authorized by the plan and provided during the visit and billed by the Primary Care Physician)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist’s Office Visits</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>(includes tests, injection drugs, supplies, and other services authorized by the plan and provided during the visit, consultations, specialist referrals, and second surgical opinions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays and Labs</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>(when performed to diagnose a medical problem or treat an illness or injury)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

** Your health care company determines the preventive care services covered at 100% under the plan based on guidelines and clinical recommendations for the general population developed by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorgan Chase does not make this determination. For a list of preventive services that are covered at 100%, go to your health care company’s website at My Health > My medical plan website.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Plan’s Coinsurance Percentage for In-Network Care</th>
<th>Plan’s Coinsurance Percentage for Out-of-Network Care*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% coverage after deductible; coverage requires you to contact your health care company and receive precertification <strong>before</strong> obtaining services</td>
<td>60% coverage after deductible; coverage requires you to contact your health care company and receive precertification <strong>before</strong> obtaining services</td>
</tr>
<tr>
<td><strong>Outpatient Services (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td>80% coverage after deductible; coverage requires you to contact your health care company and receive precertification <strong>before</strong> obtaining services</td>
<td>60% coverage after deductible; coverage requires you to contact your health care company and receive precertification <strong>before</strong> obtaining services</td>
</tr>
<tr>
<td></td>
<td>($includes diagnostic procedures, in-vitro fertilization, artificial insemination, etc., limited to combined in-network and out-of-network maximum of $20,000/lifetime for each covered employee and/or spouse/domestic partner ***)</td>
<td>($includes diagnostic procedures, in-vitro fertilization, artificial insemination, etc., limited to combined in-network and out-of-network maximum of $20,000/lifetime for each covered employee and/or spouse/domestic partner ***)</td>
</tr>
<tr>
<td></td>
<td>($30,000 lifetime maximum if you and/or your covered spouse/domestic partner use a Center of Excellence for your treatment, as described on page 45)</td>
<td>($30,000 lifetime maximum if you and/or your covered spouse/domestic partner use a Center of Excellence for your treatment, as described on page 45)</td>
</tr>
<tr>
<td>Routine eye exams</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Speech, Physical, or Occupational Therapy</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>(combined in-network and out-of-network limit of 40 visits/calendar year per therapy type***)</td>
<td>(combined in-network and out-of-network limit of 40 visits/calendar year per therapy type***)</td>
</tr>
<tr>
<td>Spinal Treatment/Chiropractic Care</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>(coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year***)</td>
<td>(coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year***)</td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
</tbody>
</table>

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

**Combined in-network and out-of-network. All out-of-network expenses are subject to reasonable and customary (R&C) charges. You are responsible for paying any charges above the R&C amount. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Plan’s Coinsurance Percentage for In-Network Care</th>
<th>Plan’s Coinsurance Percentage for Out-of-Network Care*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurobiological Disorders - mental health services for autism spectrum disorders (includes intensive behavior therapy, such as Applied Behavior Analysis (ABA) for autism spectrum disorders)</td>
<td>80% coverage after deductible, must contact your health care company to obtain precertification before receiving services</td>
<td>60% coverage after deductible, must contact your health care company to obtain precertification before receiving services</td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Acupuncture Services</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Inpatient Services (pre-certification recommended, please see “Hospital Notification” on page 45)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Hospital Care (based on hospital’s standard rate for semi-private or common rooms, except for isolation of communicable diseases)</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
</tbody>
</table>

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

*** Combined in-network and out-of-network. All out-of-network expenses are subject to reasonable and customary (R&C) charges. You are responsible for paying any charges above the R&C amount. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Plan’s Coinsurance Percentage for In-Network Care</th>
<th>Plan’s Coinsurance Percentage for Out-of-Network Care*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Services (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurobiological Disorders - mental health services for autism spectrum disorders (includes intensive behavior therapy, such as Applied Behavior Analysis (ABA) for autism spectrum disorders)</td>
<td>80% coverage after deductible, must contact your health care company to obtain precertification before receiving services</td>
<td>60% coverage after deductible, must contact your health care company to obtain precertification before receiving services</td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80% coverage after deductible</td>
<td>80% coverage after deductible; Note: the in-network deductible applies, rather than the out-of-network deductible</td>
</tr>
<tr>
<td>(for sudden and serious medical conditions approved by your health care company as required for emergency care – also see “If You Need Emergency Care” on page 45)</td>
<td>80% coverage after deductible; 60% coverage after deductible for non-emergencies</td>
<td>80% coverage after deductible for true emergencies (Note: the in-network deductible applies for true emergencies, rather than the out-of-network deductible); 60% coverage after deductible for non-emergencies</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>80% coverage after deductible</td>
<td>80% after deductible; Note: the in-network deductible applies, rather than the out-of-network deductible</td>
</tr>
<tr>
<td>(for sudden and serious medical conditions approved by your health care company as required for emergency care – also see “If You Need Emergency Care” on page 45)</td>
<td>80% coverage after deductible; 60% coverage after deductible for non-emergencies</td>
<td>80% after deductible; Note: the in-network deductible applies, rather than the out-of-network deductible</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>80% coverage after deductible</td>
<td>80% after deductible; Note: the in-network deductible applies, rather than the out-of-network deductible</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Plan’s Coinsurance Percentage for In-Network Care</th>
<th>Plan’s Coinsurance Percentage for Out-of-Network Care*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care <em>(may require pre-certification; limited to combined in-network and out-of-network maximum of 200 visits/calendar year; one visit = four hours)</em></td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment and Prosthetics <em>(includes glucose monitors, insulin pumps and related pump supplies)</em></td>
<td>80% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Please see “Prescription Drug Coverage Under Option 1 and 2” on page 47.</td>
<td></td>
</tr>
</tbody>
</table>

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

### Hospital Notification

You should contact your health care company at least 48 hours before all scheduled hospital admissions. In the event of an emergency, you can make this notification within 48 hours after your admission. You should also contact your health care company if a maternity stay will exceed 48 hours for the mother and/or newborn child following a vaginal delivery, or 96 hours for the mother and/or newborn child following a cesarean section delivery.

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

### If You Need Emergency Care

If you have a medical emergency that’s sudden, urgent, and life-threatening, you should go to the nearest physician, hospital emergency room, or other urgent care facility. Your emergency care will be covered at 80% (assuming you have met the in-network annual deductible) under both Option 1 and Option 2 as long as:

- You, the physician, or a member of your family calls your health care company within 48 hours after the emergency; and
- Your health care company approves the care as being required for a true emergency.

If your health care company determines that you did not have a true emergency, the Plan will pay benefits at 60% rather than 80% after meeting the deductible.

### Centers of Excellence (COE)

Organ transplants, bariatric surgery, and infertility treatment are complex procedures and services that require quality care. As a result, Option 1 and Option 2 have in-network hospitals that have been designated as Centers of Excellence because of the high quality care they consistently provide for these...
procedures and services. The Medical Plan contains incentives designed to encourage use of such facilities.

Provided you complete your Initial Wellness Activities (the Wellness Screening and Wellness Assessment, as described in the chart beginning on page 28) you will receive $1,000 in additional MRA funding for transplant and bariatric surgery when you and/or a covered spouse/domestic partner use an approved Center of Excellence and consult with your health care company ahead before the procedure. In addition, you may be eligible to receive reimbursement for your travel and lodging expenses if your Center of Excellence is more than 50 miles away from your home.

Your infertility benefit maximum will be increased from $20,000 to $30,000 if you and/or a covered spouse/domestic partner choose a Center of Excellence for your treatment.

Please Note: In order to receive benefits for infertility treatment services or bariatric surgery, you must contact your health care company and receive precertification before obtaining services.

To locate a Center of Excellence, visit your health care company’s website at My Health > My medical plan website or call your health care company (please see page 2 for contact information).

Nurseline

You can call Cigna and UnitedHealthcare and speak to a registered nurse at any time. You can get help with health advice 24 hours a day, 7 days a week – even on weekends and holidays. There are no limitations on how many times you might use the Nurseline. Examples include:

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

Contact your health care company to learn more:

- **Cigna**: Call 1-800-790-3086 and say, “24-Hour Health Information Line.”
- **UnitedHealthcare**: Call 1-800-272-8970 and say, “Speak with a nurse.”
Prescription Drug Coverage Under Option 1 and Option 2

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

How Prescription Drug Coverage Works

Prescription drug benefits are based on discounted prices that are available at network pharmacies. If you use an out-of-network pharmacy that does not accept your prescription drug ID card, you will pay more than you have to and you will need to file a claim for reimbursement. Highlights of prescription drug coverage are listed below; detailed information follows.

- **Free preventive generic drugs.** Eligible preventive generic medications are covered at 100% with no deductible or copayments at network pharmacies.

  Preventive drugs are medications that can help prevent the onset of a condition if you are at risk or help you manage your health if you have a condition. Examples of preventive generic drugs include atorvastatin — which is the generic for Lipitor®—to help lower cholesterol, and alendronate — the generic for Fosamax®—to help prevent osteoporosis. Generic prescription contraceptives are also fully covered with no deductible (as are brand-name contraceptive drugs for which a generic is not available), for example Ortho Evra®, Depo-Provera®, and Loestrin® 24 Fe.

CVS Caremark determines which drugs are considered “preventive generic” drugs. To see a list of drugs in this category, visit CVS Caremark’s website at My Health > My prescription drug plan.

- **$10 copayment for generic drugs.** You pay $10 for other generic drugs (generic drugs not considered preventive) purchased at a network pharmacy. Generic drugs are not subject to a deductible. If the cost of a generic drug is less than the $10 copayment, you’ll pay the lower amount.

- **Annual retail deductible for brand-name drugs.** An annual deductible of $50 per individual (with a maximum of $150 per family) applies to brand-name prescriptions filled at retail pharmacies. There is no deductible for generic drugs or for 90-day supplies of maintenance drugs purchased at a CVS pharmacy or by mail.

- **Coinsurance for “brand-name” drugs.** After you satisfy the retail deductible, you and the Plan share the cost of brand-name drugs through coinsurance.

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

FOR HELP WITH PRESCRIPTION DRUG COVERAGE

You can reach a Caremark Customer Service Representative 24 hours a day, seven days a week at 1-866-209-6093. In addition, once you are enrolled you can visit Caremark’s website at My Health > My prescription drug plan. The site allows you to:

- View the JPMorgan Chase drug lists;
- View your personal prescription drug history;
- Estimate drug costs and identify prescription drug cost saving opportunities;
- Order/refill/check the status of mail order prescriptions;
- Look for network retail pharmacies;
- Research drug information;
- Set up personal e-mail reminders for refills; and
- Print temporary Caremark ID cards.

A NOTE ABOUT GENERIC VS. BRAND NAME DRUGS

In the coming years, many popular brand-name drugs (such as Celebrex and Nexium) are expected to have a generic version available. Shortly after generic alternatives are introduced, the equivalent brand-name drug will move from preferred to non-preferred status, resulting in a higher cost to you to purchase the brand-name drug. You should talk to your doctor to determine whether a generic alternative is suitable.
• **Per-prescription maximum.** The amount you pay for brand-name drugs is capped by a per-prescription maximum, a safety net that protects against the cost of very expensive drugs. If the coinsurance amount is greater than the per-prescription maximum, you will pay only the amount of the maximum.

• **Cost savings for long-term maintenance medications.** Maintenance Choice® offers advantageous pricing when you receive 90-day supplies of maintenance medication by mail or pick up your prescription at CVS pharmacies, where the same discounts are available. There is no deductible for maintenance medications received through Maintenance Choice®.

• **Annual out-of-pocket maximum.** The annual out-of-pocket maximum is the overall "safety net" of your prescription drug coverage. The maximum caps your annual cost for covered prescriptions to $2,000 per person (up to a maximum of $6,000 for family coverage). Once an individual reaches this limit (or once the family meets the family limit), that individual (or family) does not have to pay anything further for covered drugs for the calendar year, regardless of coverage level.

  The out-of-pocket maximum covers all copayments and coinsurance for covered drugs. It does not include the annual deductible for retail prescriptions or costs for non-covered drugs. **Please Note:** The prescription drug out-of-pocket maximum is separate from the Medical Plan’s coinsurance maximum.

• **If you have money in your Medical Reimbursement Account (MRA),** those funds are available to offset your share of the cost of your medication. If you have elected or were assigned Automatic Claim Payment, at the time of purchase, your MRA funds will automatically be used to offset your out-of-pocket cost after CVS Caremark pays its share of the cost of your medication. If you elected the Debit Card, you may pay your out-of-pocket costs by using the card or your own funds.

### How Prescription Drug Benefits Are Paid Under Option 1 and Option 2

<table>
<thead>
<tr>
<th>Preventive Generic Drugs*</th>
<th>100% coverage without a deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Pharmacy Benefit (for a 30-day supply)</strong></td>
<td>The Retail Pharmacy benefit covers a 30-day supply of medication purchased from a network pharmacy.</td>
</tr>
<tr>
<td><strong>Annual Retail Deductible (waived for generic drugs)</strong></td>
<td>Employee only (also serves as a per-person maximum**): $ 50</td>
</tr>
<tr>
<td></td>
<td>Employee + spouse/domestic partner or Employee + child(ren): $100</td>
</tr>
<tr>
<td></td>
<td>Family (employee + spouse/domestic partner + child(ren)): $150</td>
</tr>
</tbody>
</table>

* CVS Caremark determines which drugs are considered “preventive generic,” “preferred,” "non-preferred,” and “maintenance” drugs. To see a list of drugs in these categories, visit CVS Caremark’s website at My Health > My prescription drug plan.

** For both the retail deductible and the annual out-of-pocket maximum, the "per person" rule allows the employee or any covered dependent(s) [e.g., spouse/domestic partner or child(ren)] to reach an individual deductible or out-of-pocket maximum, after which the deductible or out-of-pocket maximum is satisfied for the year for that person. Covered individuals who have not met the deductible or out-of-pocket maximum may combine to meet the remainder of the deductible or out-of-pocket maximum for that particular coverage level. If no one person has met the individual deductible or out-of-pocket maximum, the expenses of all covered individuals can combine to meet the deductible or out-of-pocket maximum for that coverage level.
## How Prescription Drug Benefits Are Paid Under Option 1 and Option 2

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<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic copayment</td>
<td>$10 or the actual cost of the drug if less than $10; not subject to the deductible</td>
<td>$10 or the actual cost of the drug if less than $10; not subject to the deductible</td>
</tr>
<tr>
<td>Preferred brand-name</td>
<td>You pay 30% after the deductible, up to a $100 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $100 maximum)</td>
<td>You pay 30% after the deductible, up to a $100 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $100 maximum)</td>
</tr>
<tr>
<td>coinsurance/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>per-prescription maximum*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand-name</td>
<td>You pay 45% after the deductible, up to a $150 maximum per-prescription payment (the Plan pays 55% coinsurance plus costs above the $150 maximum)</td>
<td>You pay 45% after the deductible, up to a $150 maximum per-prescription payment (the Plan pays 55% coinsurance plus costs above the $150 maximum)</td>
</tr>
<tr>
<td>coinsurance/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>per-prescription maximum*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Maintenance Choice® (for a 90-day supply; opt-out available)

The Maintenance Choice® program covers 90-day supplies of maintenance medication. There is no deductible for maintenance medications.

Maintenance Choice® allows you to: 1) send your 90-day prescription to CVS Caremark and have your medicine delivered by mail to your home; or 2) fill your 90-day prescription at any CVS pharmacy. You can also “opt out” of Maintenance Choice®, but your costs will generally be lowest if you get a 90-day supply by mail or at a CVS pharmacy. Please see “Details about Maintenance Choice®” following this table.

| Generic copayment                          | You pay $20 or actual cost of the drug if less than $20 |
| Preferred brand-name coinsurance/ per-prescription maximum* | You pay 30%, up to a $250 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $250 maximum) |
| Non-preferred brand-name coinsurance/ per-prescription maximum * | You pay 45%, up to a $375 maximum per-prescription payment (the Plan pays 55% coinsurance plus costs above the $375 maximum) |

### Annual Out-of-Pocket Maximum (covers copayment/coinsurance expenses for prescription drugs; does not include the retail deductible)

| Employee only (also serves as a per-person maximum**): | $2,000 |
| Employee + spouse/domestic partner or Employee + child(ren): | $4,000 |
| Family (employee + spouse/domestic partner + child(ren)): | $6,000 |

* CVS Caremark determines which drugs are considered “preventive generic,” “preferred,” “non-preferred,” and “maintenance” drugs. To see a list of drugs in these categories, visit CVS Caremark’s website at My Health > My prescription drug plan.

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

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

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

To see a list of maintenance drugs and to compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS network pharmacy, visit CVS Caremark’s website at My Health > My prescription drug plan.

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

You may also “opt out” of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy (see “Opting Out of Maintenance Choice®” in the next section).

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

A CVS Caremark Mail Order Form is available at My Health > My prescription drug plan. Mail your prescriptions with your completed order form to:

CVS Caremark
P.O. Box 94467
Palatine, IL 60094-4467

Opting Out of Maintenance Choice®

You will generally pay the lowest price for maintenance medications if you use Maintenance Choice® to obtain a 90-day supply by mail or at a CVS pharmacy. However, you may “opt out” of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy. You will be subject to the annual retail deductible, and, for 90-day supplies of medication, your per-prescription maximum will be higher, as shown in the table on the following page.
Comparing Per-prescription Maximums under Maintenance Choice® to Opting Out of Maintenance Choice®

<table>
<thead>
<tr>
<th></th>
<th>Maintenance Choice® (Obtain through mail or at a CVS pharmacy)</th>
<th>Opt Out (Obtain prescription at a non-CVS network pharmacy)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic 90-day supply</td>
<td>$20</td>
<td>$30</td>
</tr>
<tr>
<td>Preferred brand-name 90-day supply</td>
<td>$250</td>
<td>$300</td>
</tr>
<tr>
<td>Non-preferred brand-name 90-day supply</td>
<td>$375</td>
<td>$450</td>
</tr>
</tbody>
</table>

*Or a 30-day supply at a CVS pharmacy.

To compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS network pharmacy, visit CVS Caremark’s website at My Health > My prescription drug plan.

In order to fill your maintenance medication prescription at a non-CVS network pharmacy, you must first opt out of Maintenance Choice® by calling CVS Caremark at 1-866-209-6093. If you order maintenance medications through a non-CVS network pharmacy without calling CVS Caremark first, you will pay the full cost of the medication. **Please Note:** Your “opt out” status will apply to all maintenance medications that you fill through the Plan.

**The MRA and Your Prescription Drug Expenses**

You must pay for your share of prescription drug expenses at the time of purchase. The payment process differs according to whether you elected or were assigned Automatic Claim Payment or whether you elected the Debit Card method of payment for your MRA/HCSA.

<table>
<thead>
<tr>
<th>If You Elected or Were Assigned Automatic Claim Payment</th>
<th>If You Elected the Debit Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your network pharmacy will submit the claim to CVS Caremark. After CVS Caremark pays its share of the cost, your health care company will pay your share of the expense first from your MRA and then from your HCSA, if applicable. <strong>Your MRA balance will be used first to cover your share of the cost,</strong> you won’t need to pay anything.</td>
<td>Your network pharmacy will submit the claim to CVS Caremark. After CVS Caremark pays its share of the cost, you can then decide whether to use your debit card to pay your share of the cost or pay out-of-pocket at the pharmacy. If you use your debit card, the card would first use funds from your MRA and then from your HCSA, if applicable, to pay the pharmacy. You should keep your receipt in case you are asked to substantiate your expense.</td>
</tr>
<tr>
<td><strong>If your MRA has been exhausted,</strong> your health care company will use your HCSA balance, if any, to pay the pharmacy; you won’t need to pay anything if the HCSA covers your remaining amount due. <strong>If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost,</strong> your health care company will inform your pharmacy. You will need to pay the amount you owe out-of-pocket at the time of your pharmacy visit.</td>
<td><strong>If your MRA and HCSA, if applicable, do not have enough money to cover your share of the cost,</strong> your health care company will inform your pharmacy. You will need to pay the amount you owe out-of-pocket at the time of your pharmacy visit. If you choose not to use your debit card and instead pay out-of-pocket, you may request reimbursement for your share of the expense from your MRA/HCSA, if applicable, at a later date. You will need to provide a receipt if you file for reimbursement from your MRA/HCSA (see “If You Paid Out-of-Pocket for a Prescription Drug” in the “Filing a Claim for Reimbursement Under Option 1 and Option 2” section on page 61).</td>
</tr>
</tbody>
</table>

Effective 1/1/14
Out-of-Network Pharmacy Benefits/
Filing a Claim If You Do Not Show Your ID Card at a Network Pharmacy

If you purchase your prescription drugs through a non-network pharmacy or do not show your CVS Caremark ID card at a network pharmacy, you will have to pay for the prescription drug and then file a CVS Caremark Claim Form to be reimbursed for the plan’s share of the expense. If you have funds in your MRA/HCSA, as applicable, you can be reimbursed for your share of the expense by filing a MRA and/or HCSA Claim Form (see “If You Paid Out-of-Pocket for a Prescription Drug” in the “Filing a Claim for Reimbursement Under Option 1 and Option 2” section on page 61.)

What Prescription Drugs are Covered and Not Covered

The following chart shows common prescription drugs and their coverage status. Please Note: This list does not show every drug covered under the Plan. For the most current information and a full list of covered medications, visit CVS Caremark’s website at My Health > My prescription drug plan.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne Medications (such as Retin-A, Differin, Tazorac, Tretinoin, Avita)</td>
<td>Covered through age 35; then prior authorization required</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Covered – Generic prescription contraceptives are fully covered without a deductible, as are brand-name prescription contraceptives for which a generic is not available, such as Ortho Evra®, Depo-Provera®, and Loestrin® 24 Fe*</td>
</tr>
<tr>
<td></td>
<td>*Please Note: If a generic prescription becomes available for a brand-name contraceptive, the generic form of the contraceptive will be fully covered without a deductible, while the brand-name version of the contraceptive would be covered according to the provisions for other brand-name medications (see chart on page 52).</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Covered – except alcohol wipes and glucose monitors</td>
</tr>
<tr>
<td>Diet Medications (anorexiants and anti-obesity)</td>
<td>Covered but requires prior authorization</td>
</tr>
<tr>
<td>Infertility Drugs (exclusive of treatment)</td>
<td>Covered up to a $10,000 lifetime maximum (combined Retail Pharmacy Benefit and Maintenance Choice® Program) per person – the lifetime maximum includes infertility drug benefits received under Option 1 and Option 2, the Medicare Indemnity Option, and all prior JPMorgan Chase medical plans</td>
</tr>
<tr>
<td>Legend Vitamins</td>
<td>Covered</td>
</tr>
<tr>
<td>Male Impotency Drugs</td>
<td>Covered at 8 units per 30 days (24 units per 90 days through Maintenance Choice®)</td>
</tr>
</tbody>
</table>

(Table continued next page)
<table>
<thead>
<tr>
<th>Drug</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Tobacco Cessation Products</td>
<td>Covered</td>
</tr>
<tr>
<td>Proton Pump Inhibitors (PPIs) (such as Prilosec, Tagamet, and Nexium)</td>
<td>Covered subject to preauthorization, as described in the “Coverage for Proton Pump Inhibitors” section following this table</td>
</tr>
<tr>
<td>Respiratory Therapy Supplies</td>
<td>Covered — except nebulizers</td>
</tr>
<tr>
<td>Solodyn</td>
<td>Covered but requires prior authorization</td>
</tr>
<tr>
<td>Allergy Serums</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Blood Plasma/ Blood Transfusion Agents</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Botox and Myoblock</td>
<td>Not Covered for cosmetic purposes; requires prior authorization for other uses</td>
</tr>
<tr>
<td>Cosmetic Products (such as depigmenting agents, hair growth stimulants, hair removal agents)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mifeprax</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Sedating Antihistamines (NSAs) (such as Clarinex and Allegra)*</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Nutritional Supplements (injectable or oral)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Over-the-counter drugs</td>
<td>Not Covered (but still may be less expensive than related prescription drugs)</td>
</tr>
<tr>
<td>Renova</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rx devices other than respiratory (such as elastic bandages and supports, GI-GUostomy and irrigation supplies, other Rx devices)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vaccines/Toxoids</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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

**Coverage for Proton Pump Inhibitors**

If you are prescribed a brand-name proton pump inhibitor (PPI) prescription medication, you must have previously tried a generic proton pump inhibitor in order to receive coverage for the brand name PPI. You should talk to your doctor to see if a generic alternative is appropriate for you. If your physician has a medical reason for you to take a brand name PPI prescription medication rather than a generic alternative, your physician will need to contact CVS Caremark at 1-877-203-0003 for pre-authorization and a determination will be
made. If the brand name prescription is not authorized and you opt not to obtain the generic alternative available, you will be responsible for the entire cost of the prescription under the terms of the JPMorgan Chase Prescription Drug Plan.

**Coverage for Specialty Drugs**

Certain conditions such as anemia, asthma, growth hormone deficiency, hepatitis C, infertility, multiple sclerosis, and rheumatoid arthritis may be treated with specialty drugs. These are typically drugs that are self-injectable, require special handling, or are oral chemotherapy drugs. CVS Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides specialty drugs directly to covered individuals along with supplies, equipment, and care coordination.

Certain specialty drugs require further clinical review and prior authorization before coverage will be approved. The “Special Pharmacy Drug List” can be found on CVS Caremark’s website at My Health > My prescription drug plan. The CVS Caremark Specialty Preferred Drug Program evaluates the appropriateness of drug therapy with specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. This clinical program helps ensure patient safety, efficacy, and optimal therapeutic benefit.

If you submit a prescription for a specialty drug that requires preauthorization, CVS Caremark will undertake a review. The provider who prescribed the medication will be required to call 1-866-814-5506 as part of the review process. After the review is complete, you and your physician will receive a letter confirming whether coverage has been approved (usually within 48 hours after CVS Caremark receives the information it needs).

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

If coverage is approved, you’ll pay your normal copay or coinsurance amount for your prescription. If coverage is not approved, you have the right to appeal (please see the Plan Administration section of this Guide.)

You may contact CVS CaremarkConnect toll-free at 1-800-237-2767, 24 hours a day, seven days a week, to arrange for expedited, confidential delivery of your specialty drug to the location of your choice. You will also have access to a pharmacist-led or nurse-led CareTeam that can provide customized care, counseling on how to best manage your condition(s), patient education, and evaluation to assess your progress and to discuss your concerns.
The Wellness Program Under Option 1 and Option 2

As part of Option 1 and Option 2, JPMorgan Chase provides a Wellness Program to give you and your family more ways to get and stay healthy. The program, which is administered by your health care company—Cigna or UnitedHealthcare—provides tailored, personal support to help you make educated health care decisions when you need treatment.

The Wellness Funds component of the program gives you the opportunity to earn funds for your Medical Reimbursement Account (MRA) when you take certain actions. You can also earn Wellness Funds for your MRA when your covered spouse/domestic partner participates in certain wellness activities. Activities that qualify for Wellness Funds are noted below in the shaded “Wellness Funds Opportunity” boxes and are also described in the “Medical Reimbursement Account” section beginning on page 27.

You can access all the Wellness Program offerings easily through My Health or by calling your health care company:

<table>
<thead>
<tr>
<th>Questions?</th>
<th>To Access My Health:</th>
</tr>
</thead>
</table>
| Call your health care company to find out more about the wellness resources that they offer: | • From work: My Health from the intranet  
• From home: myhealth.jpmorganchase.com |
| • Cigna: 1-800-790-3086 or go to Cigna’s website through My Health > My medical plan website | 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. |
| • UnitedHealthcare: 1-800-272-8970 or go to UnitedHealthcare’s website through My Health > My medical plan website | |

The Wellness Screening and Wellness Assessment

A biometric Wellness Screening provides overall key indicators of your health. The Wellness Screening measures your blood pressure, blood sugar, cholesterol, triglycerides, and body mass index (BMI) numbers. You can get a Wellness Screening at no charge at a JPMorgan Chase Health & Wellness Center, at a participating lab, or at your in-network health care provider’s office. Go to My Health > Take Action > Wellness Screenings to schedule a Wellness Screening at an onsite Health & Wellness Center or at a participating lab or to download paperwork to bring to your in-network health care provider.

The Wellness Assessment is a simple, online health and lifestyle questionnaire that takes about 15 minutes to complete on your health care company’s website. Go to My Health > Take Action > Wellness Assessment.

Together, the Wellness Screening and Wellness Assessment provide important indicators of your current health and potential health risks — you’ll learn what you’re doing well and what you can do to improve your health, like get a health coach, participate in a weight management program, or take advantage of other support that JPMorgan Chase offers.
Wellness Funds Opportunity: If you complete a Wellness Screening and Wellness Assessment by February 28, 2014, you can earn Initial Wellness Funds for your 2014 MRA: $300 for completing the Wellness Screening and another $300 for completing the Wellness Assessment.* You can also earn Wellness Funds for your 2014 MRA when your covered spouse/domestic partner participates. You can earn $100 when your covered spouse/domestic partner completes the Wellness Screening and $100 when your covered spouse/domestic partner completes the Wellness Assessment, as long as the activities are completed by February 28, 2014. Both activities must be completed in order to be eligible to earn Additional Wellness Funds for your 2014 MRA by completing Additional Wellness Activities. See the “Wellness Funds” chart beginning on page 28 for a summary of the 2014 MRA funds earning opportunities.

* If you completed a Wellness Screening and Wellness Assessment in 2013, those activities will count for earning the 2014 Initial Wellness Funds. If your benefits eligibility date is after January 1, 2014, you have until December 31, 2014 to complete the Initial Wellness Activities in order to earn Initial Wellness Funds for your MRA.

Preventive Care

The Medical Plan covers eligible in-network preventive care at 100% with no deductible, coinsurance, or copayments. Out-of-network preventive care is also covered (please see the chart on beginning on page 40 for information about eligible preventive medical care). You and/or your covered spouse/domestic partner can also earn Additional Wellness funds for completing any of the following preventive care services:

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

Wellness Funds Opportunity: If you have completed the Wellness Screening and Wellness Assessment, you can earn $200 in Additional Wellness Funds for your 2014 MRA for completing one preventive care service. If your covered spouse/domestic partner has completed the Wellness Screening and Wellness Assessment, you can also earn $100 in Additional Wellness Funds for your 2014 MRA if they complete one preventive care service. See the “Wellness Funds” chart beginning on page 28 for a summary of the 2014 MRA funds earning opportunities.
Healthy BMI/Progress Toward Healthy BMI*

Body mass index (BMI) is one of the numbers that is measured in the Wellness Screening. BMI can be an indicator of overall health.

**Wellness Funds Opportunity:** If you have completed the Wellness Screening and Wellness Assessment, you can earn $200 in Additional Wellness Funds for your 2014 MRA for having a healthy BMI under 25 or for making progress toward a healthier score. If your covered spouse/domestic partner has completed the Wellness Screening and Wellness Assessment, you can also earn $100 in Additional Wellness Funds for your 2014 MRA if your covered spouse/domestic partner either has a healthy BMI or makes progress toward a healthier score.

**Please Note:** A BMI under 25 from 2013 counts for 2014. Progress is generally measured as a 5% weight reduction or a 2 point reduction in BMI. At least one screening must be received in 2014 for progress to be measured. Contact your health care company for more details.

*If it is unreasonably difficult, due to a medical condition, for you to achieve the standards for the reward under this program, contact Corporate Wellness at us.wellness@jpmchase.com and the Wellness staff will work with you to develop another way to qualify for the reward.

Local Community Physical Activity Event*

You can earn Additional Wellness Funds by participating in a local community physical activity event. **Please Note:** This is an employee-only opportunity; your covered spouse/domestic partner cannot earn Additional Wellness Funds by participating.

**Wellness Funds Opportunity:** If you have completed the Wellness Screening and Wellness Assessment, you can earn $200 in Additional Wellness Funds for your 2014 MRA by participating in a local physical activity event through Good Works (visit the Good Works website to learn about opportunities) or by participating in the JPMorgan Chase Corporate Challenge.

*If it is unreasonably difficult, due to a medical condition, for you to achieve the standards for the reward under this program, contact Corporate Wellness at us.wellness@jpmchase.com and the Wellness staff will work with you to develop another way to qualify for the reward.
Health Coaching

Cigna and UnitedHealthcare offer access to health coaches who can answer questions about your Wellness Screening and/or Wellness Assessment, as well as help you set and achieve your health goals, assess treatment options, navigate the Wellness Program, and remind you about prescription refills and preventive tests. You have your choice of receiving telephonic or online support.

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

- Asthma
- Congestive heart failure
- COPD, emphysema, and chronic bronchitis
- Coronary artery disease
- Depression and anxiety
- Diabetes/pre-diabetes
- Healthy eating
- High blood pressure
- High cholesterol
- Maternity support
- Physical activity
- Stress management
- Weight management

Please refer to the Cigna and UnitedHealthcare websites through My Health > My medical plan website for a more comprehensive list of the topics they address through their telephonic and online programs.

Contact your health care company to learn more:

- **Cigna:** Call 1-800-790-3086 and say, “Your Cigna Health Coaching Team.” The Cigna Health Coaching Team is available 9 a.m. to 9 p.m. Eastern Time on Monday through Friday and from 9 a.m. to 5 p.m. Eastern Time on Saturday.

- **UnitedHealthcare** – call 1-800-272-8970 and say, “Speak with a nurse.” The UnitedHealthcare Health Coaching Team is available 8 a.m. to 11 p.m. Eastern Time on Monday through Thursday, 8 a.m. to 8 p.m. Eastern Time on Friday, and from 9 a.m. to 2 p.m. Eastern Time on Saturday.

**Wellness Funds Opportunity:** If you have completed the Wellness Screening and Wellness Assessment, you can earn up to $200 in Additional Wellness Funds for your 2014 MRA for each health coaching program, to a maximum award of $400 for completing two programs.* If your covered spouse/domestic partner has completed the Wellness Screening and Wellness Assessment, you can also earn up to $100 in Additional Wellness Funds for your 2014 MRA for each health coaching program that your covered spouse/domestic partner completes, to a maximum award of $200 if your covered spouse/domestic partner completes two programs.* See the “Wellness Funds” chart beginning on page 28 for a summary of the 2014 MRA funds earning opportunities.

*Please Note: You and your covered spouse/domestic partner may each earn only one reward for participating in an online coaching program.
**Condition Management**

The Condition Management program provides you with personal support from a registered nurse to help you find practical ways to manage chronic conditions.

- **Cigna:** Condition Management offers support for acute myocardial infarction, angina, anxiety, asthma, bipolar disorder, congestive heart failure, coronary artery disease, COPD, depression, diabetes, heart disease, low back pain, metabolic syndrome, osteoarthritis, and peripheral artery disease.

- **UnitedHealthcare:** Condition Management offers support for asthma, coronary artery disease, COPD, diabetes, and heart failure.

Contact your health care company to learn more:

- **Cigna:** Call 1-800-790-3086 and say, “Your Cigna Health Coaching Team.” The Cigna Health Coaching Team is available 9 a.m. to 9 p.m. Eastern Time on Monday through Friday and from 9 a.m. to 5 p.m. Eastern Time on Saturday.

- **UnitedHealthcare:** Call 1-800-272-8970 and say, “Speak with a nurse.” The UnitedHealthcare Health Coaching Team is available 8 a.m. to 11 p.m. Eastern Time on Monday through Thursday, 8 a.m. to 8 p.m. Eastern Time on Friday, and from 9 a.m. to 2 p.m. Eastern Time on Saturday.

**Wellness Funds Opportunity:** If you have completed the Wellness Screening and Wellness Assessment, you can earn up to $200 in Additional Wellness Funds for your 2014 MRA for participating in a Condition Management program, to a maximum award of $400 for participating in two Condition Management programs. If your covered spouse/domestic partner has completed the Wellness Screening and Wellness Assessment, you can also earn up to $100 in Additional Wellness Funds for your 2014 MRA for each program that your covered spouse/domestic partner completes, to a maximum award of $200 if your covered spouse/domestic partner completes two programs. See the “Wellness Funds” chart beginning on page 28 for a summary of the 2014 MRA funds earning opportunities.

**Treatment Decision Support**

The Treatment Decision Support program offers access to registered nurses who can help you deal with conditions that have multiple treatment options, such as breast cancer and prostate cancer. The Treatment Decision Support program provides detailed information to help you choose the best treatment option(s) along with names of high quality, cost-effective physicians near you and questions to ask your doctor.

- **Cigna:** Treatment Decision Support offers support for benign uterine conditions, breast cancer, coronary artery disease, hip osteoarthritis/replacement, knee osteoarthritis/replacement, low back pain, and prostate cancer.

- **UnitedHealthcare:** Treatment Decision Support offers support for angina, benign prostate disease, breast cancer, dysfunctional uterine bleeding, endometriosis, fibroids, hip replacement, knee replacement, low back pain, and prostate cancer.
Contact your health care company to learn more:

- **Cigna:** Call 1-800-790-3086 and say, “Your Cigna Health Coaching Team.” The Cigna Health Coaching Team is available 9 a.m. to 9 p.m. Eastern Time on Monday through Friday and from 9 a.m. to 5 p.m. Eastern Time on Saturday.

- **UnitedHealthcare** – call 1-800-272-8970 and say, “Speak with a nurse.” The UnitedHealthcare Health Coaching Team is available 8 a.m. to 11 p.m. Eastern Time on Monday through Thursday, 8 a.m. to 8 p.m. Eastern Time on Friday, and from 9 a.m. to 2 p.m. Eastern Time on Saturday.

**Wellness Funds Opportunity:** If you have completed the Wellness Screening and Wellness Assessment, you can earn up to $200 in Additional Wellness Funds for your 2014 MRA for participating in Treatment Decision Support, to a maximum award of $400 for participating in two programs. If your covered spouse/domestic partner has completed the Wellness Screening and Wellness Assessment, you can also earn up to $100 in Additional Wellness Funds for your 2014 MRA for each program that your covered spouse/domestic partner completes, to a maximum award of $200 for completing two programs. See the “Wellness Funds” chart beginning on page 28 for a summary of the 2014 MRA funds earning opportunities.

**Maternity Support Program**

The Maternity Support Program provides expectant mothers with help throughout their pregnancy. If you or a covered spouse/domestic partner are pregnant and enroll in the program within the first trimester of a pregnancy, you and your covered spouse/domestic partner can earn Additional Wellness Funds.

Contact your health care company to learn more:

- **Cigna:** Call 1-800-790-3086 and say, “Maternity Support.” The Maternity Support unit is available 8 a.m. to 6 p.m. Eastern Time, Monday through Friday.

- **UnitedHealthcare:** Call 1-888-246-7389 between 9 a.m. and 9 p.m. Eastern Time, Monday through Friday, or visit the Health Pregnancy program website on myuhc.com through My Health > My medical plan website.

**Wellness Funds Opportunity:** If you have completed the Wellness Screening and Wellness Assessment and you enroll in the Maternity Support Program by the end of your first trimester or within 31 days of your benefits effective date, you can earn $200 in Additional Wellness Funds for your MRA. If your covered spouse/domestic partner has completed the Wellness Screening and Wellness Assessment and enrolls in the Maternity Support Program by the end of his/her first trimester or within 31 days of his/her benefits effective date, you can earn $100 in Additional Wellness Funds for your 2014 MRA. All program requirements, including a postpartum call, must be completed to earn the Additional Wellness Funds. See the “Wellness Funds” chart beginning on page 28 for a summary of the 2014 MRA funds earning opportunities.
Filing a Claim for Reimbursement Under Option 1 and Option 2

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

How to file a claim and determine which claim form to use depends on the services you received and whether you paid out-of-pocket, as detailed below. Always keep your receipt for any out-of-pocket expense for which you intend to file for reimbursement. Instructions for accessing claim forms, if necessary, and mailing addresses are in “How to Submit a Claim” on page 62.

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

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

• If you elected or were defaulted to Automatic Claim Payment, you will typically be reimbursed automatically by your health care provider. However, if reimbursement is not made automatically, you will need to call your provider when you receive your Explanation of Benefits (for Cigna participants) or Health Statement (for UnitedHealthcare participants). The EOB/Health Statement will show that your health care company made payment to your provider. You should explain to the provider’s billing office that they have been paid twice: once by you at the time of service and again when the Plan paid them from your MRA/HCSA. (On the Cigna EOB, the “What My Accounts Paid” section shows the amount paid; on the UHC Health Statement, this information is in the “Your Financial Account Claims” section). If you need additional assistance you can call your health care company at the number on the back of your ID card or the JPMorgan Chase Health Advocate for help in getting reimbursed for amounts paid out-of-pocket (see “If You Have Questions About A Claim” on page 64).

• If you elected the Debit Card, use the MRA and/or HCSA Claim Form to request reimbursement from your accounts (see “How to Submit a Claim” on the next page).

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

Out-of-network providers may require payment at the point of service. In these circumstances you should submit a Medical Claim Form to your health care company (see “How to Submit a Claim” on the next page) to be reimbursed for the plan’s share of the expense. Be sure not to sign the box on the Medical Claim Form that authorizes your health care company to make payment directly to your provider, as the payment should be made to you.

Your health care company will process your claim to determine your and the Plan’s responsibility, based on whether you have satisfied your deductible and the amount of coinsurance applicable.
• If you elected or were defaulted to Automatic Claim Payment, in addition to processing the claim to determine the amount the plan should have paid, your health care company will determine what amount can be paid directly to you by available MRA funds first, and then from your HCSA, if applicable.

• If you elected the Debit Card, you will receive an EOB (for Cigna participants) and/or Health Statement (for UnitedHealthcare participants) showing the amount paid by the plan. You can then submit a MRA and/or HCSA Claim Form to request reimbursement if you paid with your personal funds (see “How to Submit a Claim” below).

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

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

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

If You Paid Out-of-Pocket because Your MRA/HCSA was Depleted (but You Have Since Earned MRA Funding)

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

How to Submit a Claim

The Medical Claim Form and the MRA and/or HCSA Claim Form are available on My Health. Go to: My Health > Benefits, Health & Wellness Resources > Claim forms.

Please Note: You can elect to have your MRA reimbursement directly deposited into an account of your choice by accessing your health care plan option at My Health > My medical plan website.

You need to file your claim by December 31 of the year following the one in which you received the service or purchased the prescription. For example, if you incur an expense on July 1, 2014, you must file your claim for reimbursement by December 31, 2015. If you fail to meet this deadline, your claim will be denied. Be sure to attach itemized receipts to your claim form, and keep copies for your records.
Mail your claim form to the address printed on the forms:

**Medical Claim Forms**

*Cigna:*

Cigna
P.O. Box 182223
Chattanooga, TN 37422-7223
Customer Service: 1-800-790-3086

*UnitedHealthcare:*

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800
Customer Service: 1-800-272-8970

**Remember:** If you have already paid your medical provider, be sure not to sign the box on the Medical Claim Form that authorizes your health care company to make payment directly to your provider, as the payment should go to you.

Generally, Medical Claim Forms are processed in 10-12 business days and mailed with an Explanation of Benefits (for Cigna) or Health Statement (for UnitedHealthcare). Payment (if any) is sent about two weeks after the claim is processed.

**MRA and/or HCSA Claim Forms**

*Cigna:*

Cigna
P.O. Box 182223
Chattanooga, TN 37422-7223
Customer Service: 1-800-790-3086

*UnitedHealthcare:*

UnitedHealthcare
Health Care Account Service Center
P.O. Box 981506
El Paso, TX 79998-1506
Customer Service: 1-800-331-0480

**CVS Caremark Claim Forms**

The CVS Caremark Claim Form is available at My Health > My prescription drug plan. Please mail your completed claim form to:

CVS Caremark Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196
Member Services: 1-866-209-6093

Generally prescription claims are processed weekly and mailed with payment (if any) in about two to three weeks.
If You Change Health Care Companies During Annual Benefits Enrollment

If you change health care companies during the annual benefits enrollment period, you will also be changing the company that administers your MRA and HCSA.

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

If You Have Questions About a Claim

You can check the status of your claim by accessing your health care option at My Health > My medical plan website or My prescription drug plan. You can also call your health care company at the number on the back of your ID card.

If you are experiencing difficulty with a claim, the JPMorgan Chase Health Advocate can also help you resolve benefit claim issues. To contact Health Advocate, Inc., call 1-866-611-8298 Monday through Friday, 8:00 a.m. to 9:00 p.m. Eastern Time.

Appealing A Claim

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

Please Note: The information in this section is generally not applicable to employees unless you (or a covered dependent) become entitled to Medicare because of a qualifying disability.

Medicare is a federal health insurance program designed to assist eligible individuals in paying for some of their medical care. Medicare comprises Part A and Part B (together known as “Original Medicare”) and Part D.

- **Medicare Part A (Hospital Insurance).** Medicare Part A helps cover approved expenses for basic inpatient care (e.g., semi-private room, general nursing), care in a skilled nursing facility, home health care, and hospice care. In most cases, there’s no monthly premium for Part A. That's because most people pay Medicare taxes while they are working, which covers the cost of participating in Part A.

- **Medicare Part B (Medical Insurance).** Medicare Part B helps cover expenses for doctor’s services, outpatient care, and other medical services that aren’t covered by Medicare Part A, such as diagnostic tests, ambulatory surgery centers, and second surgical opinions. Participating in Medicare Part B is optional. You must pay a monthly premium to receive Medicare Part B benefits. The 2014 monthly premium for Medicare Part B is based on your marital status and income (premiums are subject to change on an annual basis).

- **Medicare Part D (Medicare Prescription Drug Program).** Effective January 1, 2006, a Medicare Prescription Drug Program (Medicare Part D) was added to the Original Medicare program (Part A for hospital insurance and Part B for medical insurance). Under Medicare Part D, people with Medicare can purchase coverage for prescription drugs — a benefit that had not been part of Original Medicare.

Under Medicare Part D, Medicare prescription drug plans are offered by private health insurance companies, not by the federal government. These plans work much like other types of medical insurance. In other words, you pay a monthly premium and then pay a share of the cost of each prescription drug. The premiums vary based on the plan you choose and your geographic area. Premiums are expected to increase annually.

In addition to the annual premium, Medicare prescription drug plans have some or all of the following features:

- Annual deductibles (the amount you pay before the plan starts paying benefits);
- Coinsurance/copayment requirements (the percentage or amount you pay for prescription drugs after you meet your annual deductible);
- Coverage gaps (a range of prescription drug expenses, aside from an up-front deductible, that may not be covered under the plan);
- Formularies (a “preferred” drug list, typically with better coverage than drugs excluded from the formulary); and
- Participating pharmacies.

Important Reminder
Covered services and benefits levels under Medicare are subject to change by the federal government. Contact your local Social Security office to obtain the most recent information on Medicare costs and coverage.
Medicare has outlined a “standard” way that Medicare prescription drug plans cover prescription drug expenses. However, it’s important to understand that private health insurance companies offering Medicare prescription drug plans can deviate from the “standard” benefit — as long as their benefits are at least as good as the “standard.” This means that depending on where you live, the Medicare prescription drug plans in your area may vary by the monthly premiums you pay, the types of prescription drugs covered, how much you have to pay out of pocket, and which pharmacies you can use.
Special Medical Plan Options
If You’re Disabled and Eligible for Medicare

If you are a JPMorgan Chase employee enrolled in the Medical Plan and you become entitled to Medicare because of a qualifying disability, Medicare becomes the primary source of your medical coverage 29 months after the disability determination date. In addition, you would become eligible to participate in the same Medical Plan options that are available to JPMorgan Chase Medicare-eligible retirees. These include the:

- Medicare Indemnity High Option;
- Medicare Indemnity Low Option; and
- Medicare Advantage Health Maintenance Organization (HMO) Option, if available in your location.

In general, you and your dependents must be enrolled in the same Medical Plan option. However, you and your dependents may be covered under separate Medical Plan options if you are eligible for Medicare and your covered dependents are not. This is called “split coverage.” However, at all other times everyone must be covered under the same option. (Please see “Determining Primary Coverage” and “Coordination with Medicare” on pages 94-95 for more information.)

If you are eligible for the Medicare options listed above, you will be contacted after you notify JPMorgan Chase of your Medicare status.

Medicare Indemnity High Option

With this option, you must first meet an annual deductible, then the plan pays 90% of medically necessary covered expenses (up to Medicare-allowable charges), subject to certain annual and lifetime maximums. You can choose to use any physician you like. Please see the “How the Medicare Indemnity Options Pay Benefits” chart on page 69 to compare the key provisions of the two Medicare Indemnity Options.

Medicare Indemnity Low Option

This option differs from the Medicare Indemnity High Option in the amount of your contributions, deductibles, coinsurance percentage, coinsurance maximums, and your payments for covered services. Under the Medicare Indemnity Low Option, your contributions for coverage are lower than under the Medicare Indemnity High Option. However, you have higher deductibles and coinsurance maximums, and the plan reimburses a lower percentage of eligible expenses.

After you pay the deductible, the plan pays 85% of medically necessary covered expenses (up to Medicare-allowable charges), subject to certain annual and lifetime maximums. You can use any physician you like and still receive benefits. Please see the “How the Medicare Indemnity Options Pay Benefits” chart on page 69 to compare the key provisions of the two Medicare Indemnity Options.
Medicare Indemnity High and Low Options

Here are some highlights of the Medicare Indemnity High and Low Options:

- You can use any doctor you like at any time and still receive benefits for covered services.
- Generally, benefits begin after you meet an annual deductible.
- Preventive care benefits are covered at 100% without a deductible.
- You must notify the claims administrator before a non-emergency hospital admission.
- There are limits on your annual out-of-pocket expenses.
- If you are disabled and become eligible for Medicare, Medicare becomes the primary payer of benefits. This means that Medicare pays benefits first. Then, the JPMorgan Chase Medical Plan pays the difference between what Medicare paid and what the JPMorgan Chase Medical Plan would have paid if it were the only coverage available (in other words, if Medicare did not exist). JPMorgan Chase will pay second even if your provider does not participate in Medicare. This means that JPMorgan Chase will determine how much it will pay based on what Medicare would have paid, even if Medicare did not pay any of the cost. Please see “Determining Primary Coverage” and “Coordination with Medicare” on pages 94-95 for more information.

In addition:

- **Under the Medicare Indemnity Low Option:** Your contributions for coverage are lower than under the Medicare Indemnity High Option. However, you have higher deductibles and coinsurance maximums, and the plan reimburses a lower percentage of eligible expenses.

An Important Note on the Medical Plan’s Lifetime Maximums

The Medical Plan’s lifetime maximums for infertility services and skilled nursing facility care reflect services received across the following plans:

- Medical Plan Option 1;
- Medical Plan Option 2; and
- Medicare Indemnity Options.

You do not gain a new maximum if you switch your coverage between options. In addition, any benefits that were applied to a lifetime maximum provision under prior medical plans of JPMorgan Chase (such as the Point of Service High/Low and the Consumer Driven Health Option) and medical plans of a heritage organization that was acquired by JPMorgan Chase will also be applied to the lifetime benefit maximums of the JPMorgan Chase Medical Plan.
### How the Medicare Indemnity Options Pay Benefits

The Medicare Indemnity High and Low Options pay benefits as follows:

<table>
<thead>
<tr>
<th>Benefit Provision</th>
<th>Medicare Indemnity High Option</th>
<th>Medicare Indemnity Low Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$ 500 Individual only</td>
<td>$1,500 Individual only</td>
</tr>
<tr>
<td></td>
<td>$1,000 Individual + spouse/domestic partner or Individual + child(ren):</td>
<td>$3,000 Individual + spouse/domestic partner or Individual + child(ren):</td>
</tr>
<tr>
<td></td>
<td>$1,500 Family (individual + spouse/domestic partner + child(ren))</td>
<td>$4,500 Family (individual + spouse/domestic partner + child(ren))</td>
</tr>
<tr>
<td>Coinsurance Percentage</td>
<td>90%</td>
<td>85%</td>
</tr>
<tr>
<td>Annual Coinsurance</td>
<td>$2,500 Individual only</td>
<td>$ 5,000 Individual only</td>
</tr>
<tr>
<td>Maximum</td>
<td>$5,000 Individual + spouse/domestic partner or Individual + child(ren):</td>
<td>$10,000 Individual + spouse/domestic partner or Individual + child(ren):</td>
</tr>
<tr>
<td></td>
<td>$7,500 Family (individual + spouse/domestic partner + child(ren))</td>
<td>$15,000 Family (Individual + spouse/domestic partner + child(ren))</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive Care Exams</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Well-Child Care and Well Adult Care</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Doctor’s Office Visits</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>(Includes tests, supplies, and other services authorized by the plan and provided during the visit, consultations, specialist referrals, and second surgical opinions.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays and Labs</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>(When performed to diagnose a medical problem or treat an illness or injury.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Mammograms</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>(Check with claims administrator for age and frequency limitations.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>(Includes diagnostic procedures, in-vitro fertilization, artificial insemination, etc.; limited to maximum of $20,000/lifetime for each covered individual.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All percentages above generally apply to reasonable and customary (R&C) charges and Medicare allowable charges. You are responsible for 100% of all expenses above R&C and for all charges that are not allowable by Medicare.
<table>
<thead>
<tr>
<th>Benefit Provision</th>
<th>Medicare Indemnity High Option</th>
<th>Medicare Indemnity Low Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Services (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech, Physical, or Occupational Therapy (Limited to a maximum of 60 visits/calendar year per therapy type.)</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Chiropractic Care (coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to a maximum of 20 visits/calendar year.)</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Substance Use Disorders Services</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Hospital Care</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility (Limited to maximum of 120 days/lifetime for each covered individual.)</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Substance Use Disorder Services</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (For sudden and serious medical conditions approved by claims administrators as required for emergency care.)</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Home Health Care (may require pre-certification; limited to maximum of 200 visits/calendar year; one visit = four hours.)</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment and Prosthetics (includes glucose monitors, insulin pumps and related pump supplies)</td>
<td>90% coverage after deductible</td>
<td>85% coverage after deductible</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Please see “Prescription Drug Coverage under the Medicare Indemnity Options” on page 71.</td>
<td>Please see “Prescription Drug Coverage under the Medicare Indemnity Options” on page 71.</td>
</tr>
</tbody>
</table>

All percentages above generally apply to reasonable and customary (R&C) charges and Medicare allowable charges. You are responsible for 100% of all expenses above R&C and for all charges that are not allowable by Medicare.
Other Provisions
You should also review “What Is Covered Under All Medical Plan Options” on page 80 to review what the Medicare Indemnity Plans cover.

Prescription Drug Coverage Under the Medicare Indemnity Options
Your prescription drug coverage under the Medicare Indemnity Options is administered by CVS Caremark. Prescription drug coverage has a different plan design from the Medicare Indemnity Options, with a separate deductible, copayments, and coinsurance, and a separate “safety net” in the form of per-prescription maximums and a prescription drug annual out-of-pocket maximum. You will receive a separate identification (ID) card from CVS Caremark in addition to your Medical Plan ID card.

How Prescription Drug Coverage Works
Prescription drug benefits are based on discounted prices that are available at network pharmacies. If you use an out-of-network pharmacy that does not accept your prescription drug ID card, you will pay more than you have to and you will need to file a claim for reimbursement. Highlights of prescription drug coverage under the Medicare Indemnity Options are listed below; detailed information follows.

- **Annual retail deductible.** An annual deductible of $50 per individual (with a maximum of $150 per family) applies to prescriptions filled at retail pharmacies. There is no deductible for generic drugs or for 90-day supplies of maintenance drugs purchased at a CVS pharmacy or by mail.

- **$10 copayment for generic drugs.** You pay $10 for generic drugs purchased at a network pharmacy. Generic drugs are not subject to a deductible. If the cost of a generic drug is less than the $10 copayment, you’ll pay the lower amount.

- **Coinsurance for “brand-name” drugs.** After you satisfy the retail deductible, you and the Plan share the cost of brand-name drugs through coinsurance.

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

- **Per-prescription maximum.** The amount you pay for brand-name drugs is capped by a per-prescription maximum, a safety net that protects against the cost of very expensive drugs. If the coinsurance amount you would pay for a drug is greater than the per-prescription maximum, you will pay only the amount of the maximum.

- **Cost savings for long-term maintenance medications.** The Maintenance Choice® program offers advantageous pricing when you receive 90-day supplies of maintenance medication by mail or pick up your prescription at CVS pharmacies, where the same discounts are available. There is no deductible for maintenance medications received through Maintenance Choice®.

FOR HELP WITH PRESCRIPTION DRUG COVERAGE
You can reach a Caremark Customer Service Representative 24 hours a day, seven days a week at 1-866-209-6093. In addition, you can visit Caremark’s website at My Health > My Prescription Drug Plan. The site allows you to:
- View the JPMorgan Chase drug lists;
- View your personal prescription drug history;
- Estimate drug costs and identify prescription drug cost saving opportunities;
- Order/refill/check the status of mail order prescriptions;
- Look for network retail pharmacies;
- Research drug information;
- Set up personal e-mail reminders for refills; and
- Print temporary Caremark ID cards.

A NOTE ABOUT GENERIC VS. BRAND-NAME DRUGS
In the coming years, many popular brand-name drugs (such as Celebrex and Nexium) are expected to have a generic version available. After generic alternatives are introduced, the equivalent brand-name drug will move from preferred to non-preferred status, resulting in a higher cost to you to purchase the brand-name drug. You should talk to your doctor to determine whether a generic alternative is suitable.
• **Annual out-of-pocket maximum.** The annual out-of-pocket maximum is the overall “safety net” of your prescription drug coverage. The maximum caps your annual cost for covered prescriptions to $2,000 per person (up to a maximum of $6,000 for family coverage). Once an individual reaches this limit (or once the family meets the family limit), that individual (or family) does not have to pay anything further for covered drugs for the calendar year, regardless of coverage level.

The out-of-pocket maximum covers all copayments and coinsurance for covered drugs. It does not include the annual deductible for retail prescriptions or costs for non-covered drugs. **Please Note:** The prescription drug out-of-pocket maximum is separate from the Medical Plan’s coinsurance maximum.

### How Prescription Drug Benefits Are Paid Under the Medicare Indemnity Options

#### Retail Pharmacy Benefit (for a 30-day supply)
The Retail Pharmacy benefit covers a 30-day supply of medication purchased from a network pharmacy.

<table>
<thead>
<tr>
<th>Annual Retail Deductible</th>
<th>Individual only (also serves as a per-person maximum*): $50</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual + spouse/domestic partner or Individual + child(ren): $100</td>
</tr>
<tr>
<td></td>
<td>Family (individual + spouse/domestic partner + child(ren)): $150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Generic copayment</th>
<th>You pay $10 or the actual cost of the drug if less than $10 (there is no deductible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred brand-name coinsurance/ per-prescription maximum**</td>
<td>After you satisfy the deductible, you pay 30%, up to a $100 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $100 maximum)</td>
</tr>
<tr>
<td>Non-preferred brand-name coinsurance/ per-prescription maximum**</td>
<td>After you satisfy the deductible, you pay 45%, up to a $150 maximum per-prescription payment (the Plan pays 55% coinsurance plus costs above the $150 maximum)</td>
</tr>
</tbody>
</table>

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

**CVS Caremark determines which drugs are considered “preferred,” “non-preferred,” and “maintenance” drugs. To see a list of drugs in these categories, visit CVS Caremark’s website at My Health > My prescription drug plan.
How Prescription Drug Benefits Are Paid Under the Medicare Indemnity Options

**Maintenance Choice® (for a 90-day supply; opt-out available)**

The Maintenance Choice® program covers 90-day supplies of maintenance medication. There is no deductible for maintenance medications.

Maintenance Choice® allows you to: 1) send your 90-day prescription to CVS Caremark and have your medicine delivered by mail to your home; or 2) fill your 90-day prescription at any CVS pharmacy. You can also “opt out” of Maintenance Choice®, but your costs will generally be lowest if you get a 90-day supply by mail or at a CVS pharmacy. Please see “Details about Maintenance Choice®” following this table.

<table>
<thead>
<tr>
<th>Generic copayment</th>
<th>Preferred brand-name coinsurance/ per-prescription maximum**</th>
<th>Non-preferred brand-name coinsurance/ per-prescription maximum**</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay $20 or actual cost of the drug if less than $20</td>
<td>You pay 30%, up to a $250 maximum per-prescription payment (the Plan pays 70% coinsurance plus costs above the $250 maximum)</td>
<td>You pay 45%, up to a $375 maximum per-prescription payment (the Plan pays 55% coinsurance plus costs above the $375 maximum)</td>
</tr>
</tbody>
</table>

**Annual Out-of-Pocket Maximum for Prescription Drugs (covers copayment/coinsurance expenses for prescription drugs; does not include the retail deductible)**

| Individual only (also serves as a per-person maximum*) | $2,000 |
| Individual + spouse/domestic partner or Individual + child(ren) | $4,000 |
| Family (Individual + spouse/domestic partner + children) | $6,000 |

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

**CVS Caremark determines which drugs are considered “preferred,” “non-preferred,” and “maintenance” drugs. To see a list of drugs in these categories, visit CVS Caremark’s website at My Health > My prescription drug plan.

**Details about Maintenance Choice®**

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

- Asthma;
- Diabetes;
- High blood pressure; and
- High cholesterol.
To see a list of maintenance drugs and to compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS network pharmacy, visit CVS Caremark’s website at My Health > My prescription drug plan.

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

You may also “opt out” of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy (see “Opting Out of Maintenance Choice®” in the next section).

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

A CVS Caremark Mail Order Form is available at My Health > My prescription drug plan. Mail your prescriptions with your completed order form to:

CVS Caremark
P.O. Box 94467
Palatine, IL 60094-4467

**Opting Out of Maintenance Choice®**

You will generally pay the lowest price for maintenance medications if you use Maintenance Choice® to obtain a 90-day supply by mail or at a CVS pharmacy. However, you may “opt out” of Maintenance Choice® and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy.

You will be subject to the annual retail deductible, and, for 90-day supplies of medication, your per-prescription maximum will be higher, as shown in the table below.

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

<table>
<thead>
<tr>
<th></th>
<th>Maximum per-prescription charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance Choice®</td>
<td>(Obtain through mail or at a CVS pharmacy)</td>
</tr>
<tr>
<td><strong>Generic 90-day supply</strong></td>
<td>$20</td>
</tr>
<tr>
<td><strong>Preferred brand-name 90-day supply</strong></td>
<td>$250</td>
</tr>
<tr>
<td><strong>Non-preferred brand-name 90-day supply</strong></td>
<td>$375</td>
</tr>
</tbody>
</table>

*Or a 30-day supply at a CVS pharmacy.

To compare pricing for using Maintenance Choice® vs. purchasing the drug at a non-CVS network pharmacy, visit CVS Caremark’s website at My Health > My prescription drug plan.
In order to fill your maintenance medication prescription at a non-CVS network pharmacy, you must **first opt out of Maintenance Choice®** by calling CVS Caremark at 1-866-209-6093. If you order maintenance medications through a non-CVS network pharmacy without calling CVS Caremark first, you will pay the full cost of the medication. **Please Note:** Your “opt out” status will apply to all maintenance medications that you fill through the Plan.

### What Prescription Drugs are Covered and Not Covered

The following chart shows common prescription drugs and their coverage status. For the most current information and a full list of covered medications, visit CVS Caremark’s website at [My Health > My prescription drug plan](#).

<table>
<thead>
<tr>
<th>Drug</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne Medications (such as Retin-A, Differin, Tazorac, Tretinoin, Avita)</td>
<td>Covered through age 35; then prior authorization required</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Covered</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Covered – except alcohol wipes and glucose monitors</td>
</tr>
<tr>
<td>Diet Medications (anorexiants and anti-obesity)</td>
<td>Covered but requires prior authorization</td>
</tr>
<tr>
<td>Infertility Drugs (exclusive of treatment)</td>
<td>Covered up to a $10,000 lifetime maximum (combined Retail Pharmacy Benefit and Maintenance Choice® Program) per person – the lifetime maximum includes infertility drug benefits received under Option 1 and Option 2, the Medicare Indemnity Option, and all prior JPMorgan Chase medical plans</td>
</tr>
<tr>
<td>Legend Vitamins</td>
<td>Covered</td>
</tr>
<tr>
<td>Male Impotency Drugs</td>
<td>Covered at 8 units per 30 days (24 units per 90 days through Maintenance Choice®)</td>
</tr>
<tr>
<td>Prescription Tobacco Cessation Products</td>
<td>Covered</td>
</tr>
<tr>
<td>Proton Pump Inhibitors (PPIs) (such as Prilosec, Tagamet, and Nexium)</td>
<td>Covered subject to preauthorization, as described in the &quot;Coverage for Proton Pump Inhibitors&quot; section following this chart</td>
</tr>
<tr>
<td>Respiratory Therapy Supplies</td>
<td>Covered — except nebulizers</td>
</tr>
</tbody>
</table>

(Table continued next page)
<table>
<thead>
<tr>
<th>Drug</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Serums</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Blood Plasma/Blood Transfusion Agents</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Botox and Myoblock</td>
<td>Not Covered for cosmetic purposes; requires prior authorization for other uses</td>
</tr>
<tr>
<td>Cosmetic Products (such as depigmenting agents, hair growth stimulants, hair removal agents)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mifeprex</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Sedating Antihistamines (NSAs) (such as Clarinex and Allegra)*</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Nutritional Supplements (injectable or oral)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Over-the-counter drugs</td>
<td>Not Covered (but still may be less expensive than related prescription drugs)</td>
</tr>
<tr>
<td>Renova</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rx devices other than respiratory (such as elastic bandages and supports, GI-GU ostomy and irrigation supplies, other Rx devices)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vaccines/Toxoids</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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

**Coverage for Proton Pump Inhibitors**

If you are prescribed a brand-name proton pump inhibitor (PPI) prescription medication you must have previously tried a generic proton pump inhibitor in order to receive coverage for the brand-name PPI. You should talk to your doctor to see if a generic alternative is appropriate for you. If your physician has a medical reason for you to take a brand-name PPI prescription medication rather than a generic alternative, your physician will need to contact CVS Caremark at 1-877-203-0003 for pre-authorization and a determination will be made. If the brand-name prescription is not authorized and you opt not to obtain the generic alternative, you will be responsible for the entire cost of the prescription under the terms of the JPMorgan Chase Prescription Drug Plan.
**Coverage for Specialty Drugs**

Certain conditions such as anemia, asthma, growth hormone deficiency, hepatitis C, infertility, multiple sclerosis, and rheumatoid arthritis may be treated with specialty drugs. These are typically drugs that are self-injectable, require special handling, or are oral chemotherapy drugs. Caremark Specialty Pharmacy is a comprehensive pharmacy program that provides specialty drugs directly to covered individuals along with supplies, equipment, and care coordination.

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

If you submit a prescription for a specialty drug that requires preauthorization, CVS Caremark will undertake a review. The provider who prescribed the medication will be required to call 1-866-814-5506 as part of the review process. After the review is complete, you and your physician will receive a letter confirming whether coverage has been approved (usually within 48 hours after CVS Caremark receives the information it needs).

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

If coverage is approved, you’ll pay your normal copay or coinsurance amount for your prescription. If coverage is not approved, you have the right to appeal (please see the Plan Administration section of this Guide.)

You may contact CVS CaremarkConnect toll-free at 1-800-237-2767, 24 hours a day, seven days a week, to arrange for expedited, confidential delivery of your specialty drug to the location of your choice. You will also have access to a pharmacist-led or nurse-led CareTeam that can provide customized care, counseling on how to best manage your condition(s), patient education, and evaluation to assess your progress and to discuss your concerns.

**Medicare Advantage Plans (Medicare Part C)**

Medicare Advantage Plans (Medicare Part C) are managed care plans offered by private health insurance companies across the country. Most Medicare Advantage Plans are Medicare Health Maintenance Organizations (HMOs). This means they work much like regular HMOs — you must use the HMO’s network of providers to receive benefits (except in an emergency). However, in return, you can usually receive a higher level of benefits than under Original Medicare.

The federal government helps to fund Medicare Advantage Plans by paying a set amount of money to the health insurance companies that offer these types of plans for each participant who enrolls. Because of this funding, Medicare Advantage Plans cover the same services as Original Medicare, plus they sometimes offer enhanced benefits for vision, hearing, and prescription drugs.

You must be enrolled in Medicare Part A and paying Medicare Part B premiums to participate in a Medicare Advantage Plan. JPMorgan Chase offers Medicare Advantage HMOs to Medicare-eligible individuals in certain locations.
Filing a Claim for Reimbursement Under the Medicare Indemnity Options

This section explains how to file claims under the Medicare Indemnity Options for health care services and, if necessary, for prescription drug expenses.

Filing A Claim for a Health Care Service

When you see a health care provider, you can ask if they will submit your claim to your health care company. If your provider does not do so, you will need to file a claim to be reimbursed from the Medicare Indemnity Options for the Plan’s share of medical expenses. Use the UnitedHealthcare Medical Claim Form, which is available on My Health > Claim forms. Please mail your completed claim form to:

UnitedHealthcare
JPMorgan Chase Dedicated Service Center
P.O. Box 740800
Atlanta, GA 30374-0800
1-800-272-8970

If you have funds in your MRA/HCSA, you can be reimbursed for your out-of-pocket costs by filing a MRA and/or HCSA Claim Form. Please see “How to Submit the MRA and/or HCSA Claim Form” below.

Filing a Claim for Out-of-Network Pharmacy Benefits or If You Do Not Show Your ID Card at a Network Pharmacy

If you purchase your prescription drugs through a non-network pharmacy or do not show your CVS Caremark ID card at a network pharmacy, you will have to pay for the prescription drug and then file a CVS Caremark Claim Form to be reimbursed for the amount owed by the Prescription Drug Plan.

You will be reimbursed the same amount you would have been if you had purchased the drug at a participating pharmacy. You will pay the difference between what the non-network pharmacy charges and what the Plan reimburses.

The CVS Caremark Claim Form for reimbursement is available at My Health > My prescription drug plan. Please mail your completed claim form to:

CVS Caremark Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196
Member Services: 1-866-209-6093

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

If you have funds in your MRA/HCSA, you can be reimbursed for your out-of-pocket costs by filing a MRA and/or HCSA Claim Form. Please see “How to Submit the MRA and/or HCSA Claim Form” below.

How to Submit the MRA and/or HCSA Claim Form

If you have incurred out-of-pocket expense for a health care service or a prescription drug and you have funds in your MRA/HCSA, you can be reimbursed by filing a MRA and/or HCSA Claim Form. The MRA and/or HCSA Claim Form is available at My Health > Claim forms. Please Note: You must use the claim form for the health care company that administered the Plan option you were in before you became covered under the Medicare Indemnity Option.
For example, if your health care company was Cigna for Option 1 or Option 2, you would use the Cigna MRA and/or HCSA Claim Form, while if your health care company was UnitedHealthcare, you would use the UnitedHealthcare MRA and/or HCSA Claim Form. Mail your claim form to the address printed on the form:

**Cigna:**
Cigna  
P.O. Box 182223  
Chattanooga, TN 37422-7223  
Customer Service: 1-800-790-3086

**UnitedHealthcare:**
UnitedHealthcare  
Health Care Account Service Center  
P.O. Box 981506  
El Paso, TX 79998-1506  
Customer Service: 1-800-331-0480

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

**Appealing A Claim**

If a claim for reimbursement is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the *Plan Administration* section of this Guide.
What Is Covered Under All Medical Plan Options

Option 1 and Option 2 and the Medicare Indemnity Options cover a wide variety of services, as long as the services are medically necessary (please see the definition of "Medically Necessary" on page 9). However, covered services under each JPMorgan Chase Medical Plan option may differ from the lists below and/or be subject to limits or restrictions. For specific information on each option’s covered services, please contact the option’s claims administrator directly.

Quality Providers

Many of our Medical Plan options designate a select number of their participating providers to be “quality” providers. This is a special designation for physicians and other medical providers who have been proven to provide high-quality and cost-effective care. If you choose to use these providers, you may have better outcomes, lower medical costs, or both. Visit your health care company’s website at My Health > My medical plan website for more information.

Preventive Care Services

The preventive care services covered at 100% by the Medical Plan are determined by your health care company based on guidelines and clinical recommendations developed for the general population by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorgan Chase does not make this determination. For a list of preventive services that are covered at 100%, go to your health care company’s website at My Health > My medical plan website.

Option 1 and Option 2 and the Medicare Indemnity Options each cover the same preventive care services, although benefits levels may differ substantially. (Please check with your claims administrator for any age or frequency limitations. Please see contact information on page 2.) These services generally include:

- Routine care including:
  - PAP tests (one per year, includes related laboratory fees);
  - Prostate exams (age 40 and over, one exam per year);
  - Flexible sigmoidoscopy (age 50 and over, one baseline screening, and one follow-up screening every five years);
  - Screening colonoscopy (age 50 and over, one baseline screening and one follow-up screening every five years);
  - Fecal occult blood test (age 50 and over, one test per year);
  - Routine physical exams (office visit with appropriate laboratory and radiology services);
  - Mammography screenings (age 40 and over, one mammogram per year);
  - Routine screenings during pregnancy (e.g. for gestational diabetes and bacteriuria);
  - Breast pumps (please contact your health care company for details regarding which breast pumps are fully covered); and
— Well-child/adult care office visits (plus immunization and labs):
  o Birth to age 12 months: seven exams
  o Age 13-24 months: three exams
  o Age 25-36 months: three exams
  o Age 3 and over: one exam per year

This list is subject to change at any time.

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

Inpatient Hospital and Related Services

Option 1 and Option 2 and the Medicare Indemnity Options cover medically necessary inpatient hospital admissions for an unlimited number of days. Covered services include, but are not limited to the following services, subject to any limitations or requirements of the plan and based on medical necessity:

• Allergy testing and treatment, when provided as part of inpatient care for another covered condition;
• Anesthetics and their administration;
• Bariatric surgery, subject to claims administrator guidelines. Under Option 1 and Option 2, if you and/or your covered spouse/domestic partner use a Center of Excellence (COE) for your treatment you will receive $1,000 in additional MRA funding and you may be eligible for reimbursement of travel and lodging expenses if your treatment facility is more than 50 miles away from your home. In order to be eligible for the additional MRA funding, you must complete all program requirements, including completing the Initial Wellness Activities as described in the "How to Earn Wellness Funds for Your MRA" chart on page 28. To locate a Center of Excellence, visit your health care company’s website at My Health > My medical plan website. Please Note: In order to receive benefits for bariatric surgery, you must contact your health care company and receive precertification before obtaining services.
• Basic metabolic examinations;
• Cosmetic surgery when needed to:
  — Reconstruct or treat a functional defect of a congenital disorder or malfunction;
  — Treat an infection or disease;
  — Treat an injury or accident; or
  — Reconstruct a breast after mastectomy. Coverage for the following services is available under the Medical Plan in a manner determined in consultation with you and your physician:
    - Reconstruction of the breast on which the mastectomy was performed;
    - Surgery and reconstruction for the other breast to produce a symmetrical appearance; and
    - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.

Multiple Surgical Procedure Reduction Policy
Option 1 and Option 2 and the Medicare Indemnity Options limit the benefits you are eligible to receive if you have more than one surgical procedure performed at the same time. When you have multiple procedures performed at the same time, these options will pay:

• 100% of your medical option’s coinsurance percentage amount for the primary or major surgical procedure;
• 50% of your medical option’s coinsurance percentage amount for the secondary procedure; and
• If more than two procedures are performed, please check with your claims administrator for coverage details. Please see contact information on page 2.
• Diagnostic services, including:
  — EEG, EKG, and other diagnostic medical procedures;
  — Laboratory and pathology tests; and
  — Radiology services.
• Electrocardiographic and physiotherapeutic equipment usage;
• Hemodialysis for kidney failure;
• Intensive care unit service;
• Maternity care, including:
  — Any required care for an illness or injury that the newborn develops either before or after birth, as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames;
  — Care required due to miscarriage or ectopic pregnancy;
  — Coverage of eligible expenses if your covered child has a baby, but not including nursery or other expenses incurred by the newborn child;
  — Delivery by a certified, registered nurse or midwife in a birthing center;
  — Drugs, medications, and anesthesia;
  — Normal or cesarean section delivery;
  — Routine medical and hospital nursery care for your covered newborn child, as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames;
  — Circumcision by a licensed provider (for your covered newborn child), as long as you and your newborn are enrolled in the appropriate coverage category within prescribed enrollment time frames; and
  — A semi-private room. The period of hospitalization for childbirth (for either the mother or the covered newborn child) is up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. (However, your attending physician — after consulting with the mother — may decide to discharge the mother or newborn child earlier.)
• Mental health care/substance abuse care;
• Operative and surgical procedures by a licensed provider for the treatment of a disease or injury, including pre-operative preparation and post-operative care;
• Organ and tissue transplants including replacing a non-functioning or damaged organ or tissue with a working organ or tissue from another person. Covered services include physician and hospital costs, donor search, tests to establish donor suitability, organ harvesting and procurement, and anti-rejection drugs. Donor expenses related to the transplant procedure are covered if the transplant recipient is a covered member under this plan, but only to the extent that the donor expenses are not covered under another health insurance plan. In addition, if you are enrolled in Option 1 or Option 2 and your procedure is conducted at a designated Center of Excellence, you may be eligible for an additional $1,000 in MRA funds and reimbursement for travel and lodging expenses if your treatment facility is more than 50 miles away from your home. In order to be eligible for the additional MRA funding, you must complete all program requirements, including completing the Initial Wellness Activities as described in the “How to Earn Wellness Funds for Your

Please Note:
You must enroll a new dependent within 31 days of birth in order for coverage to be effective retroactive to the date of birth. Please see “Your Eligible Dependents” on page 16 and “Qualified Change in Status” on page 24 for more information.
MRA* chart on page 28. To locate a Center of Excellence, visit your health care company’s website at My Health > My medical plan website.

- Pre-admission testing when completed within seven days of hospital admission;
- Semi-private room and board; and
- Take-home drugs and medications.

The above list is subject to change at any time.

**Newborns’ and Mothers’ Health Protection Act**

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

**Women’s Health and Cancer Rights Act of 1998**

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

If you or your dependent(s) (including your spouse/domestic partner) are receiving benefits under the Medical Plan in connection with a mastectomy and you or your dependent(s) (including your spouse) elect breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and you or your covered dependent(s) (including your spouse/domestic partner) for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

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

**Outpatient Services**

Outpatient services under Option 1 and Option 2 and the Medicare Indemnity Options include, but are not limited to the following services, subject to any limitations or requirements of the plan and based on medical necessity:

- Acupuncture when used as a form of pain control and performed by a licensed provider (check with your claims administrator);
- Allergy testing and treatment;
- Chemotherapy and radiation treatments;
- Chiropractic care when medically necessary as determined by the claims administrator to diagnose or treat illness, injury, or disease. Coverage is limited to 20 visits per year and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
- Diagnostic services, including:
  — EEG, EKG, and other medical electronic procedures;
— Laboratory and pathology tests; and
— Radiology services.

• Education therapy, but only for participants with a diagnosis of diabetes mellitus;
• Eye exams for patients with diabetes (covered as a specialist office visit);
• Hemodialysis provided at a free-standing facility such as a dialysis center or your home, when ordered by a licensed provider;
• Licensed, general hospital emergency room use for treatment of an injury or sudden illness, including:
  — Emergency treatment rooms;
  — Laboratory and pathology tests;
  — Licensed providers’ services;
  — Supplies and medicines administered during the visit; and
  — Radiology services.
• Licensed provider-prescribed respiratory therapy approved by the claims administrator;
• Mental health care/substance abuse care;
• Occupational therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year;
• Outpatient surgery and related follow-up care;
• Physical therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year;
• Podiatric care when medically necessary as determined by the claims administrator to diagnose or treat illness, injury, or disease. Coverage ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain;
• Prenatal care;
• Speech therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year; and
• Temporomandibular joint syndrome (TMJ) medical treatment only; including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery up to $1,000 combined in-network and out-of-network maximum per year (appliances are not covered).

The above list is subject to change at any time.

Other Covered Services

Option 1 and Option 2 and the Medicare Indemnity Options cover a wide variety of other medically necessary services, although benefits levels may differ substantially. These services include, but are not limited to the following services, subject to any limitations or requirements of the Medical Plan and based on medical necessity:

• Compression stockings (two pair per calendar year for the following conditions only: diabetes, varicose veins, varicose ulcers, statis dermatitis, post-phlebitic syndrome, and lymphedema);
• Coverage abroad, as follows:

<table>
<thead>
<tr>
<th>Benefit Provision</th>
<th>Coverage under Option 1 and Option 2</th>
<th>Coverage under Medicare Indemnity High Option</th>
<th>Coverage under Medicare Indemnity Low Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment for a true emergency, e.g., sudden, serious chest pain</td>
<td>80% after in-network deductible</td>
<td>90% after deductible</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Treatment for an urgent situation that is not a true emergency, e.g., severely sore throat</td>
<td>80% after in-network deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>All other treatment, e.g., elective surgery scheduled several months in advance</td>
<td>60% after out-of-network deductible</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

If you receive treatment while traveling outside the United States, you will have to pay for the services up-front and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, please see "Filing a Claim for Reimbursement under Option 1 and Option 2" on page 61 or "Filing a Claim for Reimbursement under the Medicare Indemnity Options" on page 78. If you have any questions about benefits while traveling abroad, please call your health care company.

• Dental procedures resulting from a congenital or medical disorder or accidental injury (treatment must be received within 12 months of the accident). Includes surgical removal of wisdom teeth only if procedure is done in medical setting. Please Note: The charges must not be covered by the JPMorgan Chase Dental Plan.

• Gender Reassignment Surgery (GRS) – in order to be eligible, the participant must meet certain medically established guidelines for obtaining the surgery (Harry Benjamin guidelines) which require the participant to, among other things:
  o Be at least 18 years old;
  o Have a GID (Gender Identity Disorder) diagnosis;
  o Have been approved for hormone therapy;
  o Have at least one year’s real life experience living and working in desired gender; and
  o Have two letters endorsing surgery, including one from a mental health provider at the doctorate level.

Follow-up procedures such as breast augmentation surgery, electrolysis, and facial surgery will not be covered.

• Surgery must be preauthorized by the medical Plan Administrator whether in- or out-of-network.

• Hearing aids, as follows:
  - Under Option 1 and Option 2: reimbursement for up to $3,000 every 36 months; hearing aid must be prescribed by an in-network doctor and purchased from an in-network durable medical equipment vendor.
- Under the Medicare Indemnity Plans: reimbursement for up to $2,500 every 24 months for covered dependent children through age 12.

- Hearing aid evaluations and hearing tests;

- Home health care approved by the claims administrator. The attending physician must submit a detailed description of the medical necessity and scope of services provided to the claims administrator. The following are covered if ordered by the physician under the home health care plan and provided in the patient’s home. (Please check with your claims administrator for any age or frequency limitations. Please see page 2 for contact information.)

  — Medical supplies and laboratory services prescribed by a physician;

  — Nutrition counseling provided by or under the supervision of a registered dietitian;

  — Part-time or intermittent nursing care provided or supervised by a registered nurse (R.N.);

  — Part-time or intermittent home health services, primarily for the patient’s medical care; and

  — Physical, occupational, speech, or respiratory therapy by a licensed qualified therapist.

- Intensive behavior therapy, such as Applied Behavior Analysis (ABA) for Autism Spectrum Disorder, subject to precertification from your health care company and participation in your health care company’s Autism Care Management Program.

- Local ambulance service or air ambulance to the nearest hospital if medically necessary and confirmed by a licensed provider;

- Medical equipment and supplies including blood and blood plasma (unless donated on behalf of the patient); artificial limbs (excluding replacements); artificial eyes and larynx (including fitting); heart pacemaker; surgical dressings; casts; splints; trusses; orthopedic braces; crutches; wheelchair; walker; cane; insulin pump; Athner monitor; custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot; hospital bed; ventilator; iron lung; ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers and bags; and other items necessary to the treatment of an illness or injury that are not excluded under the plans. Prior authorization or pre-certification may be required for coverage of some medical equipment and supplies. The claims administrator may authorize purchase of an item if more cost-effective than rental.

- Medically necessary visits to licensed physicians, surgeons, and chiropractors, whether in the office or in your home;

- Nutritional support, including nutritional counseling (limited to three visits for diabetes and three visits for non-diabetes counseling, for a total of six visits) and durable medical equipment, to treat inborn errors of metabolism and/or to function as the majority source of nutrition*, as long as each of the following conditions are met:

  o Without enteral (feeding tube) feedings, the individual is unable to obtain sufficient nutrients to maintain appropriate weight by dietary and/or oral supplements;

  o The administration of enteral nutrition requires ongoing evaluation and management by a physician; and
The individual has one of the following conditions that is expected to be permanent or of indefinite duration:

- An anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel;
- Disease of the small bowel that impairs absorption of an oral diet; or
- A central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.

*When assessing the "majority source of nutrition," the following considerations apply:

- Enteral feeding constitutes over 50% of caloric nutritional intake as determined by clinical information submitted by the provider for review;
- Calories from parenteral (intravenous) nutrition should not be considered when assessing for the sole source of nutrition; i.e., transitioning to enteral feedings; and
- Parenteral feedings are covered when considered "medically necessary" and used when oral or enteral alone are not possible.

- Oxygen and supplies for its administration;
- Prosthetic devices and supplies, including fitting, adjustments, and repairs, if ordered by a licensed provider. Please check with the claims administrator for frequency or other limitations. (Please Note: Dentures, bridges, etc., are not considered medical prosthetic devices);
- Radiation, chemotherapy, and kidney dialysis;
- Rental or purchase of durable medical equipment as determined by the Claims Administrator, if ordered by a licensed provider. Please check with the claims administrator for frequency or other limitations.
- Services and supplies that are part of an alternate care proposal. This is a course of treatment developed and authorized by the claims administrator as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless specified otherwise, the provisions of the plan related to benefit amounts, maximum amounts, copayments, and deductible will apply to these services.
- Skilled nursing facility for up to 365 days per lifetime (combined in-network and out-of-network) under Option 1 and Option 2 and for up to 120 days per lifetime (combined in-network and out-of-network) under the Medicare Indemnity Options. The lifetime maximums reflect services received across Option 1 and Option 2, the Medicare Indemnity Options and under prior medical plans of JPMorgan Chase (such as the Point Service High/Low and the Consumer Driven Health Option) and the medical plans of a heritage organization that was acquired by JPMorgan Chase.
- Urgent care;
- Voluntary sterilization; and
- Wigs up to a $500 per year limit, for burns, chemotherapy or radiation, accidental injury, following a diagnosis of Alopecia, or for other medically necessary reasons.

The above list is subject to change at any time.
**Hospice Care**

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

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

Hospice services include:

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

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

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

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

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

The above list is subject to change at any time.
Infertility Treatment Procedures

There are special covered procedures that induce pregnancy but do not treat the underlying medical condition. They include (but are not limited to) artificial insemination and in-vitro fertilization. Infertility services are subject to a $20,000 combined lifetime maximum benefit for each covered individual (yourself and/or your spouse/domestic partner). This limit applies to all benefits received under Option 1 and Option 2 and the Medicare Indemnity Options and under prior medical plans of JPMorgan Chase (such as the Point Service High/Low and the Consumer Driven Health Option) and the medical plans of a heritage organization that was acquired by JPMorgan Chase and it applies regardless of whether the service was received in-network or out-of-network. This limit does not apply to the diagnosis of infertility and/or its cause. All procedures and access will be governed by the health care company’s protocols for determining appropriateness of care. Please also see “Infertility Drugs” in the “What Prescription Drugs are Covered” chart on page 52 for information on a $10,000 lifetime maximum on prescription drugs related to infertility treatment. Please contact your option’s claims administrator for specific details.

Please Note:

• In order to receive benefits for infertility services, you must contact your health care company and receive precertification before obtaining services.
• Under Option 1 and Option 2, if you and/or your covered spouse/domestic partner use a Center of Excellence (COE) for your treatment, your lifetime infertility benefit maximum will be increased to $30,000. You must complete all program requirements to earn the increase to the benefit maximum. To locate a Center of Excellence, visit your health care company’s website at My Health > My medical plan website.

Planning Treatments That May Cause Infertility

Covered individuals with a diagnosis of cancer who are planning cancer treatment, or medical treatment for any condition that is demonstrated to result in infertility, are considered to meet the definition of infertility. Planned cancer treatments include bilateral orchietomy, bilateral oophorectomy, hysterectomy, and chemotherapy or radiation therapy that is established in the medical literature to result in infertility. In order to use infertility benefits covered under the Plan, you must notify your health care company and meet the following eligibility criteria:

• Covered individuals or their partners must not have undergone a previous elective sterilization procedure, (e.g. hysterectomy, tubal ligation, vasectomy), with or without surgical reversal, regardless of post reversal results;
• Covered individuals must have had a day 3 FSH test in the prior 12 months if under age 35 or in the prior six months if age 35 or older;
• Day 3 FSH level of a female covered individual must not have been greater than 15 mIU/mL in any (past or current) menstrual cycle, regardless of the type of infertility services planned (Including donor egg, donor embryo or frozen embryo cycle); and
• Only those infertility services that have a reasonable likelihood of success are covered.
Coverage is limited to:

- collection of sperm;
- cryopreservation of sperm and eggs;
- ovulation induction and retrieval of eggs;
- in vitro fertilization; and
- embryo cryopreservation.

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

**Infertility Diagnostic Services**

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

**Coverage Limitations**

As mentioned earlier, certain covered services are limited to a specific number of visits or days of limitations, subject to applicable deductibles and coinsurance. These limitations are included in the coverage charts earlier in this section.

Please keep in mind that any benefits listed that have limitations on the number of visits or days of treatment are determined by medical necessity. In other words, the treatment must be medically necessary, even if the number of visits or days is within the prescribed limitations.
What Is Not Covered Under the Medical Plan Options

While Option 1 and Option 2 and the Medicare Indemnity Options cover a wide variety of medically necessary services, there are some expenses that are not covered. Some of these are listed below.

Expenses not covered include, but are not limited to:

- Care from a person who is a member of your family or your spouse’s/domestic partner’s family;
- Charges for the difference between a private and semi-private hospital room;
- Correction of weak, unstable, or flat feet; arch supports; corrective shoes; shoe orthotics (except for custom-molded shoe inserts prescribed to treat a condition, disease, or illness affecting the function of the foot); or treatment of corns, calluses, or chronic foot strain;
- Cosmetic surgery treatment, except to repair damage from accident or injury; treat a functional birth defect; reconstruct a breast after mastectomy and/or reconstruction of the non-affected breast to produce a symmetrical appearance; or treat an infection or disease;
- Custodial services, including custodial nursing care and group homes;
- Donor expenses with regard to infertility treatment;
- Educational therapy (except for members with a diagnosis of diabetes) and social or marital counseling;
- Expenses for which you’re not obligated to pay (for example, if a licensed provider or hospital waives an expense, the plan will not pay any benefit to you or a licensed provider);
- Expenses in excess of reasonable and customary (R&C) charges for out-of-network services;
- Expenses submitted later than December 31 of the year following the year in which services were provided;
- Experimental, investigational, or unproven services, devices, or supplies (see the definition of “Experimental, Investigational, or Unproven Services” on page 7);
- Hospital admissions and other services that began before the participant’s effective date of coverage under the Medical Plan;
- Inpatient private duty nursing;
- Non-medical charges for care in a nursing or convalescent home or long-term custodial care, even if prescribed by a licensed provider;
- Non-prescription contraceptive devices, unless medically necessary (prescription oral contraceptives are covered under the JPMorgan Chase Prescription Drug Plan);
- Non-surgical correction of temporomandibular joint (TMJ) syndrome, such as appliances or devices;
Nutritional support expenses including but not limited to:
  o regular grocery products (including over-the-counter infant formulas such as Similac, Nutramigen, and Enfamil) that meet the nutritional needs of the patient;
  o infant formula that is not specifically made to treat inborn errors of metabolism;
  o medical food products that:
    ▪ are prescribed without a diagnosis requiring such food;
    ▪ are used for convenience purposes;
    ▪ have no proven therapeutic benefit without an underlying disease, condition, or disorder;
    ▪ are used as a substitute for acceptable standard dietary interventions;
    ▪ are used exclusively for nutritional supplementation; and
    ▪ are required due to food allergies.
  o nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals.

Personal hospital services, such as television, telephone, etc.;

Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments if required solely for purposes of school, sports or camp, career or employment, insurance, marriage, or adoption;

Refractive eye examinations for new lenses or the cost of eyeglasses or contacts. This does not apply to the first pair of contact lenses or the first pair of eyeglasses following either cataract surgery or a diagnosis of Keratoconus;

Refractive eye surgery including, but not limited to, Lasik or Radial Keratotomy;

Reproductive education and prevention classes;

Reversals of sterilization;

Routine dental care (please see the Dental Plan section of this Guide for information about services covered under the JPMorgan Chase Dental Plan);

Routine eye exams (please see the Vision Plan section of this Guide for information about services covered under the JPMorgan Chase Vision Plan)

Services, supplies, or treatment for weight loss, nutritional supplements, or dietary therapy;

Sickness or loss covered by state workers' compensation law or automobile insurance;

Sickness or loss that is later determined to be the legal responsibility of another person or company;

Treatments, services, or supplies that are not medically necessary or not approved by a licensed provider or services provided outside the scope of a provider's license;

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

• A procedure or surgery to remove fatty tissue such as abdominoplasty, brachioplasty, mastopexy, thighplasty, or panniculectomy.

The above list is subject to change at any time.
If You Are Covered by More Than One Medical Plan

The JPMorgan Chase Medical Plan has a provision to ensure that payments from all of your group medical plans don’t exceed the amount the JPMorgan Chase Medical Plan would pay if it were your only coverage.

The rules described here apply to Option 1 and Option 2 and the Medicare Indemnity Options. The following rules do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

The JPMorgan Chase Medical Plan does not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. The non-duplication provisions of the Medical Plan will ensure that, in total, you receive benefits up to what you would have received with the Medical Plan 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 (i.e., how JPMorgan Chase coordinates coverage with another group plan to ensure non-duplication of benefits) is provided below. If you have questions, please contact your health care company for help. (Please see contact information” on page 2.)

Here’s an example of how the JPMorgan Chase Medical Plan coordinates benefits with other medical plans:

Assume your spouse/domestic partner has a medically 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 Medical Plan option — Option 1 or Option 2 (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 medically necessary procedure. In this case, your spouse/domestic partner normally would receive an $80 benefit (80% of $100) from the JPMorgan Chase Medical Plan option. Since your spouse/domestic partner already received $70 from her or his primary plan, he or she would receive the balance ($10) from the JPMorgan Chase Medical Plan. If, however, your Medical Plan (Option 1 or Option 2) considered the R&C charge to be $80, no additional benefit would be payable, as the JPMorgan Chase Medical 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 Medical Plan.

Determining Primary Coverage

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

- While you remain an active JPMorgan Chase employee, the Medical Plan will be primary for you and consider claims for your medical expenses first. Even if you work past age 65 and you and/or a covered spouse/domestic partner enroll in Medicare, the Medical Plan will remain the primary plan while you are an active employee. Please see “If You Work Past Age 65” in the “If Your Situation Changes” chart on page 103.
• If you or a covered dependent become entitled to Medicare benefits because of a qualifying disability or end-stage renal disease, Medicare becomes the primary plan 29 months after the disability determination date. Please see “Coordination with Medicare” below.

• 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 has coverage under both parent’s 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 Order” on page 102 for more information.)

• If your other medical plan doesn’t have a coordination of benefits provision, that plan will be considered primary and will pay first for you and your covered dependents.

• If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

After it’s 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 (EOB) from your primary plan.

Coordination with Medicare

This section describes how benefits coordinate with Medicare if you or a covered dependent are Medicare-eligible due to a disability or end-stage renal disease (ESRD).

Coordination with Medicare Parts A and B in the Event of Disability

Entitlement to Medicare coverage is automatic for anyone who receives Social Security Disability Income for 24 months. (An individual must be disabled for five months prior to receiving Social Security Disability Income.) Therefore, if you or a covered dependent become entitled to Medicare because of a qualifying disability, Medicare becomes the primary source of medical coverage for the disabled individual 29 months after the disability determination date. This means that Medicare pays benefits first. Then, the JPMorgan Chase Medical Plan pays the difference between what Medicare paid and what the JPMorgan Chase Medical Plan would have paid if it were the only coverage available (in other words, if Medicare did not exist). JPMorgan Chase will pay second even if a provider does not participate in Medicare. This means that JPMorgan Chase will determine how much it will pay based on what Medicare would have paid, even if Medicare did not pay any of the cost.

Here’s an example of how coordination of benefits works between Medicare and the JPMorgan Chase Medical Plan even if you do not elect Medicare Parts A & B. The example uses the following assumptions:
You are a JPMorgan Chase employee who has qualified for Medicare as a result of disability;

You participate in the Medicare Indemnity High Option, which generally covers 90% of eligible expenses;

You have $1,000 in eligible medical expenses, not including outpatient prescription drugs;

These expenses are covered under Medicare Part B at 80%; and

You’ve met your Medicare and JPMorgan Chase Medical Plan annual deductibles.

First, let’s take a look at what Medicare pays: 80% of $1,000, which equals $800.

Next, we must consider what the JPMorgan Chase Medical Plan would have paid if Medicare coverage did not exist: 90% of $1,000, which equals $900.

Since the JPMorgan Chase Medical Plan would pay more than what Medicare pays, the JPMorgan Chase Medical Plan will pay the difference, which is $100 ($900 - $800 = $100). (If the benefits payable under the JPMorgan Chase Medical Plan were equal to or less than those payable under Medicare, no additional benefits would be payable.)

This means that you are responsible for the remaining $100 of total expenses.

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>A. Total amount of eligible expenses</td>
<td>$1,000</td>
</tr>
<tr>
<td>B. Amount for reimbursement under Medicare (generally 80%)</td>
<td>$800</td>
</tr>
<tr>
<td>C. Amount eligible for reimbursement under the JPMorgan Chase Medicare Indemnity High Option (generally 90%), if only coverage available</td>
<td>$900</td>
</tr>
<tr>
<td>D. Amount paid under the JPMorgan Medicare Indemnity High Option after Medicare (C minus B)</td>
<td>$100</td>
</tr>
<tr>
<td>* Amount paid by you (A minus B minus D)</td>
<td>$100</td>
</tr>
</tbody>
</table>

* Assumes you have met your Medicare and JPMorgan Chase annual deductibles.

Please Note: If you and/or a covered dependent are eligible for Medicare and do not apply for Medicare coverage, or if your provider does not accept Medicare, the Medicare benefits that would have been paid will still be considered before JPMorgan Chase benefits are determined (if Medicare is the primary payer). Therefore, even if you and/or a covered dependent do not elect Medicare Part A and B, or if a provider does not accept Medicare, benefits will be paid on a Medicare-primary basis. This will increase your payment responsibility.

**Coordination of Benefits with Medicare Parts A and B Based on ESRD Entitlement**

Medicare pays secondary to the JPMorgan Chase Medical Plan during the first 30 months that you or your covered dependents are entitled to Medicare based on end-stage renal disease (ESRD). After 30 months, Medicare is considered primary and will pay first for all Medicare-covered services. JPMorgan Chase Medical Plan coverage pays second. Refer to the section above for details about coordination of benefits after the 30-month period.
Coordination of Benefits with Medicare Part D

Enrolling in a Medicare prescription drug plan is your choice — it’s completely voluntary. To enroll, you must have Medicare Part A and Part B. It’s important to note that the JPMorgan Chase Medical Plan does not coordinate benefits with Medicare Part D. You and/or your dependents cannot have prescription drug coverage under both the JPMorgan Chase Medical Plan and a Medicare Prescription Drug Plan. If you enroll in a Medicare prescription drug plan, your and your dependents’ medical and prescription drug coverage under the JPMorgan Chase Medical Plan will be discontinued (even if all of your covered dependents are not eligible for Medicare).

Right of Recovery

If the Medical Plan provides benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the Medical Plan has 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 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 plan making payments on your behalf.

Subrogation of Benefits

The purpose of the Medical Plan is to provide benefits for eligible medical expenses that are not the responsibility of any third party. The Medical Plan has the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the plan 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 plan has first priority from any amounts recovered from a third party for the full amount of benefits it has paid on your behalf regardless of whether you are fully compensated by the third party for your losses.

- You agree to help the plan use this right when requested.

- In the event that you fail to help the plan use this right when requested, the plan may deduct the amount the plan paid from any future benefits payable under the plan.

- The plan has the right to take whatever legal action it deems appropriate against any third party to recover the benefits paid under the plan.

- If the amount you receive as a recovery from a third party is insufficient to satisfy the plan’s subrogation claim in full, the plan’s subrogation claim shall be first satisfied before any part of a recovery is applied to your claim against the third party.

- The plan is not responsible for any attorney fees, attorney liens, or other expenses you may incur without the plan’s 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 plan.

If you receive a subrogation request and have questions, please contact your health care company (see contact information on page 2).
Right of Reimbursement

In addition to its subrogation rights, the Medical Plan is entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for medical expenses that have been paid by the Medical Plan. The following rules apply to the plan's right of reimbursement:

- You must reimburse the plan 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 plan shall have a right of full reimbursement, in first priority, from the recovery.

- You must hold in trust for the benefit of the plan the gross proceeds of a recovery, to be paid to the plan immediately upon your receipt of the recovery. You must reimburse the plan, 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 plan.

- If you fail to reimburse the plan, the plan may deduct any unsatisfied portion of the amount of benefits the plan has paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plan.

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

Your primary contact for matters relating to Medical Plan benefits is your health care company. Contact the Benefits Call Center for information about general administration issues such as enrollment and eligibility for the Plan.

Your benefits as a participant in the Medical Plan (and Prescription Drug Plan) 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 Medical Plan (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 sole and absolute discretion to construe and interpret the terms of the Medical Plan and any underlying insurance policies and/or contracts, including the eligibility to participate in the Medical Plan. All decisions of the Plan Administrator for the JPMorgan Chase Benefits Program are final and binding upon all affected parties.

**HIPAA Privacy Rights and Protected Health Information**

JPMorgan Chase is committed to maintaining the highest level of privacy and discretion regarding 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.

A copy of the privacy notice is also available at My Health > Privacy protection or by contacting the Benefits Call Center 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 in the event that 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
o 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 the address shown below:

HIPAA Privacy Officer for the JPMorgan Chase Health Care Plans
Corporate Benefits
JPMorgan Chase
611 Woodward Avenue
Mail Code: MI1-8010
Detroit, MI 48226
Fax : 1-313-256-0683

HIPAA Special Enrollment Rights

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

If you or your eligible dependent declined coverage under the Medical Plan, you may enroll for medical coverage within 31 days of one of the following events for coverage to be effective the date of the event. If you miss the 31-day deadline, coverage for certain benefits (i.e., medical, dental, vision, and the Health Care Spending Account) will be effective as of the date you contact the Benefits Call Center, and, in order to have retroactive coverage, you may be required to pay for your coverage on an after-tax basis for the period prior to the date you first contact the Benefits Call Center. Otherwise, you will not be able to make the change until the following benefits enrollment period:

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

If you qualify for this HIPAA special enrollment, your coverage under the Medical Plan will begin on the date of the event provided you enroll within the appropriate timeframe and pay the required contributions.

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

If the Medical Plan receives a judgment, decree, or order known as a Qualified Medical Child Support Order (QMCSO) requiring the plan to provide health coverage to your child who is your dependent, the Medical Plan will automatically change your benefits elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin on the date the QMCSO is processed by JPMorgan Chase. You may decrease your coverage for that child, if the court order requires the child’s other parent to provide coverage and your spouse’s or former spouse’s plan actually provides that coverage. You also may make other corresponding changes to your benefits elections under the Medical Plan, to the extent permitted by the Internal Revenue Code (IRC) and the Medical Plan.
If Your Situation Changes

The following chart summarizes how your JPMorgan Chase Medical Plan coverage may be affected in certain situations, for example, if you have a qualified change in status.

| If Your Work Status Changes | Your Medical 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, however, you may be able to continue medical coverage for a certain period of time under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see the Plan Administration section of this Guide for more information on COBRA.) |
| If You Go on Disability Leave | Under the Short-Term Disability Plan, you may have the financial protection of full or partial pay for up to 25 weeks. For the approved period of your disability leave, you’ll remain eligible to be covered under the Medical Plan. JPMorgan Chase will deduct any required contributions for medical coverage from the pay you receive during this period on a before-tax basis. |
| If You Go on Long-Term Disability | If you receive long-term disability (LTD) benefits from the LTD Plan, your premium will be converted to a monthly rate. (The actual cost of your coverage will not change; however, 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.  

**If you become disabled on or after January 1, 2011,** you’ll be eligible to continue your medical coverage at active employee rates for the first 24 months after going on approved LTD (i.e., 30 months from the date of disability).  

Your employment with JPMorgan Chase will end immediately after you have received 24 months of payments under the LTD Plan. You will continue to be eligible for LTD benefits provided you meet all contractual provisions of the plan. (Please see the Long-Term Disability section of this Guide for more information.)  

Even if your coverage ends, however, you may be able to continue medical coverage for a certain period of time under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). (Please see the Plan Administration section of this Guide for more information on COBRA.)  

**If you became disabled before January 1, 2011,** your medical 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 Medical Plan coverage, your coverage will be canceled.

(Table continued next page)
### If You Go on an Unpaid Leave

For an approved leave of absence, you'll still be covered by the Medical Plan as long as you make any required contributions. JPMorgan Chase will directly bill you for any required contributions on an after-tax basis.

If you do not make the required contributions to continue your Medical Plan coverage, your coverage will be canceled. However, your coverage may be reinstated when you return to work.

Please see the *Plan Administration* section of this Guide for more information about what happens to your benefits during an unpaid leave of absence (i.e., FMLA, Military Leave).

### If You Leave JPMorgan Chase

If your employment with JPMorgan Chase terminates, participation for you and your covered dependents usually 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 of time under COBRA. (Please see the *Plan Administration* section of this Guide for more information on COBRA.) Medical expenses incurred after the end of the month in which you leave JPMorgan Chase cannot be reimbursed by the Medical Plan unless you choose to continue your participation under COBRA. For more information, please see the As You Leave Guide on me@jpmc > Health & Life > Life Events > Leaving the Company.

### If You Retire from JPMorgan Chase

You need to meet minimum age and service requirements at the time of retirement to be eligible for retiree medical coverage. For more information, please refer to the As You Retire Guide on me@jpmc > Health & Life > Life Events > Retiring.

### If You Work Past Age 65

If you continue to work for JPMorgan Chase after you reach age 65 (and/or if your spouse/domestic partner reaches age 65 while you’re still working at JPMorgan Chase), you and your spouse/domestic partner can continue to be covered under the Medical Plan. If you or your spouse/domestic partner enroll in Medicare at that time, Medicare coverage will provide secondary benefits to the JPMorgan Chase Medical Plan while you remain actively employed.

If you’re covered under both the Medical Plan and Medicare, your claims need to be submitted to the Medical Plan first. If any bills remain unpaid after the Medical Plan has paid up to the limits of its coverage, you should file a claim with Medicare.

Please note that medical coverage under Medicare is not automatic. You must file for coverage when you first become eligible. If you continue to work past age 65 and you have coverage under the Medical Plan, you may wait and apply for Medicare immediately after you leave JPMorgan Chase. For more information about Medicare, contact your local Social Security office.

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**If You Work Past Age 65...**

Medicare will pay benefits for outpatient hospital care and certain other outpatient therapies only if you receive them from Medicare-certified organizations. Other services can be received from any physician, provider, or supplier taking part in the Medicare program.
| If You Divorce or Become Legally Separated | If your spouse and/or children lose coverage as a result of divorce/separation, they may have a right to elect COBRA for up to 36 months. (Please see the Plan Administration section of this Guide for more information on COBRA.)  
If you divorce or become legally separated, certain court orders could require you to provide medical benefits to covered children. JPMorgan Chase is legally required to recognize qualified medical child support orders within the limits of the Medical Plan. If you’re a party in a divorce settlement that involves the Medical Plan, you should have your attorney contact the Benefits Call Center 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 Order” on page 102 for more information. |
| If You Die | If you die while actively employed at JPMorgan Chase, any dependents who were covered under your Medical Plan before your death will continue to be covered until the last day of the month in which you die. 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 the Plan Administration section of this Guide for more information on COBRA.)  
In addition, your dependents may be eligible to continue coverage under the Retiree Medical Plan if, at the time of death:  
• You have already met the general eligibility requirements for retirement. (For more information, please refer to the As You Retire Guide, available on me@jpmc > Health & Life > Life Events > Retiring); or  
• You have already met the alternative eligibility requirements for retirement in the event of position elimination. (For more information, please refer to the As You Retire Guide as noted above); or  
• You have 25 years of total service with JPMorgan Chase.  
Dependents may continue coverage under the Retiree Medical Plan as long as they meet the Medical Plan’s requirements.  
Please Note: The requirements detailed above denote the requirements to qualify for unsubsidized or “access only” retiree medical coverage. To qualify for subsidized retiree medical coverage, the deceased employee must have met certain requirements with respect to hire dates, age, and service requirements as of December 31, 2005, and must meet the requirements above in relation to “cumulative” service (rather than total service). Please refer to the As You Retire Guide as noted above. |
When Coverage Ends

Coverage under any JPMorgan Chase Medical Plan option will end on the last day of the month in which:

- You cancel coverage due to a qualified change in status;
- You stop making required contributions;
- Your employment with JPMorgan Chase is terminated for any reason;
- You no longer meet the eligibility requirements of the Medical Plan;
- The Medical Plan is discontinued;
- You have been on long-term disability benefits under the Long-Term Disability Plan for 24 months, unless you were disabled prior to January 1, 2011, in which case your coverage will continue at active employee rates while you receive benefits under the Long-Term Disability Plan; or
- You die.

Coverage for your dependents also ends when they no longer meet the eligibility requirements described in “Your Eligible Dependents” on page 16. For your spouse, this means the last day of the month in which you die (unless you are eligible for retiree medical coverage) or divorce. For a child, this means the last day of the month in which he or she:

- Turns age 26. Please see “Your Eligible Dependents” on page 16 for more information.; or
- Is no longer eligible for coverage under a Qualified Medical Child Support Order (QMCSO).

Coverage for a domestic partner ends on the last day of the month in which the domestic partner ceases to meet the eligibility requirements described in “Your Eligible Dependents” on page 16.

Please see “If Your Situation Changes” on page 103 for details on how coverage is affected in certain situations.

Continuing Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents have the right to continue medical coverage at your own expense for a certain period of time if your JPMorgan Chase-provided coverage ends due to certain circumstances. (For domestic partners, JPMorgan Chase may provide COBRA-like coverage if the domestic partner was covered under the JPMorgan Chase Medical Plan at the time that coverage ended.) If continuation coverage is elected, the cost is typically 102% of the plan’s total cost of providing coverage for up to 18 months. You must make timely monthly payments for your COBRA coverage. However, if you are eligible for benefits under the Severance Pay Plan, you will receive a COBRA subsidy and will pay the active employee rate for medical coverage under COBRA for the lesser of 1) six months; or 2) the number of months of severance benefits you receive. Please see the Plan Administration section of this Guide for more information on COBRA.
Certificate of Creditable Coverage

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), JPMorgan Chase is required to provide you with a Certificate of Creditable Coverage if your JPMorgan Chase-provided coverage ends. For more information, please see “Certificate of Creditable Coverage” in the Plan Administration section of this Guide.

Prescription Drug Notice of Creditable Coverage

JPMorgan Chase will send a Notice of Creditable Coverage to participants who become eligible for Medicare. This notice states that the JPMorgan Chase Medical Plan options provide prescription drug benefits that are, on average, at least as good as the standard Medicare prescription drug plan benefits. The notice is important because it can help you avoid late enrollment penalties associated with Medicare prescription drug plans that may apply given that JPMorgan Chase benefits-eligible employees would generally wait until retirement to enroll in Medicare Part B and Part D.

If you have a dependent who is eligible for Medicare benefits and you do not receive a Notice of Creditable Coverage, you can contact the Benefits Call Center to request one.
Other Benefits

In addition to medical coverage, JPMorgan Chase provides other benefits to give you and your family more ways to stay healthy.

Who is Eligible

The programs described in this section are generally available to active U.S. benefits-eligible employees (i.e., U.S. employees who are regularly scheduled to work 20 hours or more a week). That means you can participate in these programs even if you’re not enrolled in a JPMorgan Chase Medical Plan. Many of the resources are available to family members; however, family members cannot visit the Onsite Health & Wellness Centers.

The Wellness Program for Employees Who Waive Coverage in the Medical Plan

Employees who waive coverage in the Medical Plan have access to a Wellness Program designed to provide ways to get and stay healthy. The program, which is administered by Cigna, provides tailored, personalized support.

The Wellness Rewards component of the program allows you to earn rewards that can be redeemed onto a debit card when you participate in certain wellness activities. Once you redeem your Wellness Rewards onto the debit card, you can use the debit card for any expense. Redeemed Wellness Rewards are considered taxable income and will be reflected in your pay. (See the “Wellness Rewards” chart on the following page to learn more.)

<table>
<thead>
<tr>
<th>Questions/Ready to Redeem Your Rewards Onto a Debit Card?</th>
<th>To Access the Wellness Web Center through My Health:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you waived coverage in the Medical Plan, your Wellness Program is administered by Cigna.</td>
<td>• From work: My Health from the intranet &gt; Wellness Web Center</td>
</tr>
<tr>
<td>To redeem your Wellness Rewards onto a debit card that you can use for any reason, go to My Health &gt; Wellness Web Center. You can also contact Cigna at 1-800-854-7304 to learn more about the wellness resources that they offer.</td>
<td>• From home: myhealth.jpmorganchase.com</td>
</tr>
</tbody>
</table>
Wellness Rewards for Employees Who Waive Coverage in the Medical Plan

For 2014, you can earn up to $600 in Wellness Rewards that can be redeemed onto a debit card by completing certain wellness activities, as described below.

<table>
<thead>
<tr>
<th>Wellness Activity</th>
<th>What You Need to Do</th>
<th>What You’ll Earn in Wellness Rewards that can be loaded onto a debit card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Screening</td>
<td>Get your Wellness Screening by February 28, 2014.*</td>
<td>$300 that can be loaded onto a debit card</td>
</tr>
<tr>
<td></td>
<td>Three ways to get a Wellness Screening:</td>
<td></td>
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<tr>
<td></td>
<td>- Through February 28, 2014, sign up for an onsite Wellness Screening at larger company locations. Go to My Health &gt; Take Action &gt; Wellness Screenings.</td>
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<tr>
<td></td>
<td>- Go to a local lab to get your Wellness Screening. Schedule your Wellness Screening and print necessary forms at My Health &gt; Take Action &gt; Wellness Screenings.</td>
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<tr>
<td></td>
<td>- See your doctor for a Screening. Print a Wellness Screening Results Form to bring to your doctor at My Health &gt; Take Action &gt; Wellness Screenings.</td>
<td></td>
</tr>
<tr>
<td>Wellness Assessment</td>
<td>Complete the Wellness Assessment by February 28, 2014.*</td>
<td>$300 that can be loaded onto a debit card</td>
</tr>
<tr>
<td></td>
<td>Go to My Health &gt; Wellness Web Center.</td>
<td></td>
</tr>
</tbody>
</table>

* If you completed a Wellness Screening and Wellness Assessment in 2013, those activities will count for earning 2014 funds for a debit card. If your benefits eligibility date is after January 1, 2014, you have until December 31, 2014 to complete the Wellness Screening and Wellness Assessment in order to earn funds for a debit card.
Employee Assistance Program (EAP) & Work-Life Program

The Employee Assistance and the Work-Life Program (EAP) is available to provide professional, confidential counseling, consultation, and referral services to help you and your eligible dependents find solutions to the many challenges faced in managing work and personal lives. Some of the services provided by the program include:

- Referrals for free counseling for emotional or behavioral issues;
- Assistance with adoption services;
- Adult and elder professional care management;
- Child care and parenting help;
- Financial and legal counseling;
- Relocation resources; and
- Pet care.

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

Employees can receive up to five counseling sessions a year. All services provided by the EAP are free, confidential, and available 24 hours a day, seven days a week. If referral to some other professional is made and fees are involved, the counselor will help you determine whether your Medical Plan benefits will offset some of the costs.

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

When Employee Assistance and Work-Life Program coverage ends for you and/or your eligible dependents, you may be able to continue coverage for a certain period of time under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please see the Plan Administration section of this Guide for more information on COBRA.

Provided by: MHN (EAP) and LifeCare (Work-Life).

Call 1-877-576-2007 for more information. You can also access the Employee Assistance Program on My Health.

Tobacco Cessation Program

By enrolling in the Tobacco Cessation Program, offered in partnership with Alere, you and/or your covered spouse/domestic partner can obtain experienced help in committing to a tobacco-free lifestyle.

The program provides:

- Telephone coaching and online support;
- A Quit Guide; and
- Quitting aids at no cost (e.g., patches, gum).

Upon completion of the program you may be eligible for lower “non-tobacco user” rates for certain benefits, including the Medical Plan (see “Tobacco User Status” on page 19 for more information).

Call 1-866-QUIT-4-LIFE (1-866-784-8454); or access the program at My Health > Tobacco cessation.
Onsite Health & Wellness Centers

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

- basic medical services;
- Wellness Screenings (see "The Wellness Screening and Wellness Assessment" on page 55 for more information) and other health evaluations; and
- help understanding health information and guidance on resources available to you.

You pay nothing for these services. These Centers are for benefits-eligible employees (not just those enrolled in the JPMorgan Chase Medical Plan) and are not available for use by spouses/domestic partners, or children. If you leave JPMorgan Chase, you can elect continued access to the Health & Wellness Centers and Wellness Screenings through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

For a list of the locations of the JPMorgan Chase Health & Wellness Centers, visit My Health.

Please see the Health & Wellness Centers section of this Guide for more information and the Plan Administration section for more information on COBRA.
Privacy Information

The privacy of your health information is important to you and to JPMorgan Chase. We are committed to ensuring your personal health information is protected and secure, and that our practices comply with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). (For detailed information regarding HIPAA Privacy Rights, please see page 99.) 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.

If you are enrolled in Option 1 or Option 2, 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 > Privacy protection.
Right to Amend

JPMorgan Chase reserves the right to amend, modify (including cost of coverage), reduce or curtail benefits under, or terminate the Medical Plan at any time for any reason by act of the Benefits Executive, other authorized officers, or the Board of Directors. In addition, the Medical Plan does not represent a vested benefit.

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. Neither this Guide nor the benefits described in this Guide create a contract or a guarantee of employment between JPMorgan Chase and any employee.

If you have any questions about this plan, please contact the Benefits Call Center.