

The Medical Plan

When you or a family member needs medical care, what are the things you look for? A physician who knows you and your family history and whom you can trust? The convenience of medical facilities that are close to where you live or work? Access to specialists who can treat very specific conditions? Reasonable cost? Physicians that your friends and colleagues recommend?

You may have any number of concerns that you consider when it comes to medical care. JPMorgan Chase is committed to providing you and your family with access to high-quality, cost effective health care coverage. That's why the JPMorgan Chase Medical Plan offers you a range of options, so you can choose the most appropriate type of coverage for you and your family.

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

Questions?	To Access the Benefits Web Center:
<p>Contact the Benefits Call Center through accessHR:</p> <ul style="list-style-type: none"> • 1-877-JPMChase (1-877-576-2427) • <i>Quick Path:</i> Enter your Standard ID or Social Security number; press 1, enter your PIN; press 1 • TDD: 1-800-719-9980 <p>If calling from outside the United States:</p> <ul style="list-style-type: none"> • 1-212-552-5100 (GDP#352-5100) <p>Service Representatives are available from 8 a.m. to 7 p.m., Eastern Time, Monday through Friday except certain U.S. holidays.</p>	<p><i>From Work:</i> Go to Company Home > My Rewards @ Work</p> <p><i>From Home:</i> Go to www.MyRewardsAtWork.com via the Internet.</p>

Update: Your Guide to Benefits at JPMorgan Chase

This document modifies and changes any summary plan descriptions previously distributed to you. 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 does not include all of the details contained in the applicable insurance contracts, plan documents, and trust agreements. If there is a discrepancy between the official plan documents and this summary, the official plan documents will govern.

Be sure to read the "About This Guide" section and the "Plan Administration" section for more important details about the plan and this description, and for references to the official plan documents that contain the full specifics about the plan.

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The JPMorgan Chase Benefits Program is available to most full-time and part-time U.S. dollar-paid salaried employees 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 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 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 without notice at any time.

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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.

Term	Definition
Annual Total Cash Compensation	<p>Annual total cash compensation is your 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, commission, 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 annual total 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, annual total cash compensation will be equal to base salary plus job differentials.</p> <p>Separate definitions may apply to employees in certain sales positions who are paid on a draw-and-commission basis. If this situation applies to you, you will be notified.</p>
Before-Tax Contributions	<p>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.</p> <p>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 (\$94,200 in 2006). 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.</p>
Claims Administrator	<p>The company, or its affiliate, that provides certain claims administration services for the Medical Plan.</p>
Coinsurance	<p>The way you share costs for certain Medical Plan coverage options — and Prescription Drug Plan preferred and non-preferred brand drugs — after you meet the annual deductible. Certain Medical Plan options pay a percentage of reasonable and customary (R&C) charges for medically necessary services, and you pay the remainder. Other Medical Plan options with in-network providers pay a percentage of the claims administrator's negotiated fee with the provider. The actual percentage depends on the option you've chosen and the type of covered service.</p>

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Term	Definition
Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA)	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 have ended. The “Plan Administration” section of this Guide provides details on COBRA coverage.
Coordination of Benefits	<p>The rules that determine how benefits are paid when a patient is covered by more than one group plan. Rules include:</p> <ul style="list-style-type: none"> • 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. <p>In general, the following coordination of benefits rules apply:</p> <ul style="list-style-type: none"> • As a JPMorgan Chase employee, your JPMorgan Chase coverage is considered primary for you. • For your spouse/domestic partner, extended family member, or dependent child covered as an active employee 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). <p>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.</p>
Copay or Copayment	The amount you pay toward certain health care services under the Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options (for in-network care), the Health Maintenance Organization (HMO) Option, and the Exclusive Provider Organization (EPO) Option. For example, the PPO/POS Low Option might require a \$40 copayment for an office visit. The PPO/POS High Option, HMO Option, and EPO Option may require a \$20 copayment for an office visit. Copayments may also apply to certain drugs under the Prescription Drug Plan.
Covered Expenses	The reasonable and customary (R&C) charges for medically necessary covered services or supplies that qualify for full or partial reimbursement under the Medical Plan’s PPO/POS High and Low Options, the HMO Option, the EPO Option, and the Traditional Indemnity Option.
Covered Services	Medical procedures that are generally reimbursable by the JPMorgan Chase Medical Plan when they are “medically necessary.” (See the definition for “medically necessary” in this section.) 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 and outpatient private duty nursing are not covered under the Medical Plan. So, while a service or supply may be medically necessary, it may not be covered under the Medical Plan.
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.

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Term	Definition
Deductible	The amount you pay in a calendar year for covered expenses before the PPO/POS High and Low Options (for out-of-network care) or the Traditional Indemnity Option begins to pay benefits. Amounts in excess of reasonable and customary (R&C) charges or ineligible charges do not count toward the deductible. A deductible may also apply to the Prescription Drug Plan.
Eligible Dependents	Under the Medical Plan, your eligible dependents can include your spouse, a qualified adult dependent (including a domestic partner or an extended family member; please see the definition for “Qualified Adult Dependent” in this section for more information), and your dependent children. Please see “Your Eligible Dependents” on page 13 for more information.
Experimental, Investigational, or Unproven Services	<p>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:</p> <ul style="list-style-type: none"> • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and 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. <p>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:</p> <ul style="list-style-type: none"> • Is safe with promising effectiveness; and • 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. <p>Please Note: For the purpose of this definition, the term “life-threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.</p> <p>If services are denied because they are deemed to be experimental, investigational, or unproven, and the service is approved within six months of the date of service, you may resubmit your claim for payment.</p>
Explanation of Benefits (EOB)	A statement that the claims administrator prepares, which documents your claim and provides a description of benefits paid and not paid under the Medical Plan.
Fully-Insured	Medical Plan options for which the benefits payments are the responsibility of the insurance carrier or HMO. (HMOs offered under the Medical Plan are fully insured.)

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Term	Definition
Home Health Care	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.
Hospice Care Program	A program that tends to the needs of a terminally ill patient as an alternative to traditional health care, while meeting medically necessary and acceptable standards of quality and sound principles of health care administration. The program must be a written plan of hospice care for a covered person, and it must be approved by the appropriate claims administrator.
Hospital	An institution legally licensed as a hospital — other than a facility owned or operated by the United States Government — that's engaged primarily in providing bed patients with diagnosis and treatment under the supervision of licensed physicians. The hospital must have 24-hour-a-day registered graduate nursing services and facilities for major surgery. Institutions that don't meet this definition don't qualify as hospitals.
Hospital Notification	A requirement under certain Medical Plan options that you notify the claims administrator of a non-emergency hospital admission before the admission takes place or if a maternity stay exceeds the guidelines. If you're a participant in the Traditional Indemnity Option or if you are admitted to a hospital under the PPO/POS High or Low Option or the EPO Option, you need to provide notification to the claims administrator.
In-Network/ Out-of-Network	Terms referring to whether a covered service is performed by a physician who is part of the network associated with the Medical Plan PPO/POS High or Low Option ("in-network") or by a physician who is not part of the network ("out-of-network"). 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.
Maximum Lifetime Benefit	The most a Medical Plan option will pay for covered services in each participant's lifetime.
Medically Necessary or Medical Necessity	<p>Health care services and supplies that are determined by the claims administrator to be medically appropriate and:</p> <ul style="list-style-type: none"> • 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;

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Term	Definition
Medically Necessary or Medical Necessity (continued)	<ul style="list-style-type: none"> • Required for reasons other than the convenience of the covered person or her or his physician; and • Demonstrated through prevailing peer-reviewed medical literature to be either: <ul style="list-style-type: none"> — Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or — Safe with promising effectiveness: <ul style="list-style-type: none"> - 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. <p>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.</p> <p>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.”</p> <p>Finally, to be considered necessary, a service or supply cannot be educational or experimental in nature in terms of generally accepted medical standards.</p>
Medicare	<p>Medicare is the 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 those individuals who are age 65 and older, unless these individuals are actively working.</p>
Multiple Surgical Procedure Reduction Policy	<p>Under the PPO/POS High and Low Options (both in-network and out-of-network), the EPO Option, and the Traditional Indemnity Option, surgical procedures that are performed on the same date of service are subject to the multiple surgical procedure reduction policy. Of the reasonable and customary (R&C) charges, 100% are reimbursable for the primary/major procedure, 50% of R&C charges are reimbursable for the secondary procedure, and 50% of R&C charges are reimbursable for all subsequent procedures. Participants undergoing surgery are urged to discuss this policy with their health care provider.</p>
Non-Duplication of Benefits	<p>The Medical Plan does not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. You are entitled to receive benefits up to what you would have received under the Medical Plan if it were your only source of coverage, but not in excess of that amount. If you have other coverage that is primary to the Medical Plan, the claims administrator will reduce the amount of coverage that you would otherwise receive under this plan by any amount you receive from your primary coverage. Please see the definition of “Coordination of Benefits” in this section.</p>

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Term	Definition
Out-of-Pocket Maximum	The most you would need to pay in a calendar year for medically necessary covered services under the PPO/POS High and Low Options or the Traditional Indemnity Option. Once the out-of-pocket maximum is reached, the Medical Plan option will pay 100% of reasonable and customary (R&C) charges for medically necessary covered services for the rest of the year. However, amounts that you pay toward your deductible, copay, and amounts above R&C charges, do not count toward your out-of-pocket maximum. An out-of-pocket maximum also applies to the Prescription Drug Plan.
Primary Care Physician (PCP)	Under many HMO Options and EPO Options, the network physician who provides or coordinates all the care you receive. Services not authorized by your PCP (or network obstetrician/gynecologist, where applicable) may not be covered unless it qualifies as emergency care.
Primary Plan	<p>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.</p> <p>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.</p>
Qualified Adult Dependent	<p>You may cover a “qualified adult” as an eligible dependent under the Medical Plan if you’re not currently covering a spouse. At JPMorgan Chase, a qualified adult can be either a “domestic partner” or an “extended family member.” The definitions are as follows:</p> <ul style="list-style-type: none"> • Domestic Partner. You and your domestic partner must: <ul style="list-style-type: none"> — Be age 18 or older; — Have lived together for at least six months and have a serious, committed relationship; — Be financially interdependent; — Not be related to each other in a way that would prohibit legal marriage; and — Not be legally married to or the domestic partner of anyone else. <p>OR</p> <ul style="list-style-type: none"> — 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. <ul style="list-style-type: none"> • Extended Family Member. This person must: <ul style="list-style-type: none"> — Be age 18 or older; — Meet the definition of “dependent” as defined by the Internal Revenue Code (IRC) during the period of coverage; — Have lived with you for at least six months and remain a member of your household during the entire period of coverage; and — Not otherwise be eligible for coverage under the JPMorgan Chase Medical Plan.

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Term	Definition
Qualified Adult Dependent (continued)	<p>You must certify that your qualified adult 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.</p> <p>Please Note: Some HMOs may not cover domestic partners, and/or extended family members. Please check with your carrier for details, or refer to the Qualified Adult Coverage Kit available on Company Home > HR & Personal > Pay & Benefits > Library, or contact the Benefits Call Center for more information on qualified adult coverage.</p>
Qualified Change in Status	<p>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 marriage, divorce, the birth or adoption of a child, etc.) within 31 days of the event.</p> <p>Please Note: Any changes you make during the year must be consistent with your qualified change in status. Please see "Qualified Change in Status" on page 19 for more information.</p>
Reasonable and Customary (R&C) Charges	<p>The actual charges that are considered for payment when you receive medically necessary care for covered services from an out-of-network provider under the PPO/POS High and Low Options and the Traditional Indemnity Option. 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.</p> <p>If your provider charges more than the R&C charges considered under the plans, you'll have to pay the difference. Amounts that you pay in excess of the R&C charge are not considered eligible expenses. Therefore, they don't count toward your deductible, benefit limits, or maximums.</p>
Self insured	<p>How JPMorgan Chase pays for medical claims under the PPO/POS High and Low Options, the EPO Option, the Traditional Indemnity Option, and the Prescription Drug Plan.</p>
Skilled Nursing Facility	<p>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.</p>
Visit	<p>A visit is an encounter with a provider which involves 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.</p>

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Some Quick Facts

<p>Your Choices</p>	<p>Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Option. Both the PPO/POS High and Low Options let you choose between in-network or out-of-network providers each time you need medical care. When you obtain care from in-network providers, lower, negotiated rates will be reimbursed at a higher coinsurance percentage or will only require a copayment. Care obtained from out-of-network providers is subject to an annual deductible and is then reimbursed at a lower coinsurance percentage of reasonable and customary fees.</p> <p>Health Maintenance Organization (HMO) Option and Exclusive Provider Organization (EPO) Option. HMO Options and EPO Options generally pay the full cost of most medical services when you use a network provider, after you pay a copayment. HMO Options offered under the Medical Plan are fully insured, which means the individual HMO carriers have full financial responsibility and liability. In the case of an EPO Option that is self insured by the JPMorgan Chase Medical Plan, the Medical Plan has the responsibility to fund the benefits. Please see the “Plan Administration” section of this Guide for more information relating to whether a particular option is fully insured or self insured.</p> <p>If you enroll in a fully insured HMO Option, you will receive separate materials directly from the HMO Option in which you enroll. These materials will provide specific details on your HMO Option’s benefits, including your rights as a participant in the HMO. These materials, combined with this Guide, will form the full summary plan description for the HMO Option in which you participate.</p> <p>Traditional Indemnity Option. The Traditional Indemnity Option lets you choose to receive care from any doctor you like. After you pay the annual deductible, the option pays a percentage of the covered services up to the reasonable and customary (R&C) amount — subject to certain annual and lifetime maximums. This option also contains a preferred provider feature. Although the benefit percentage paid under this option is the same whether or not you use a preferred provider, your overall costs will probably be reduced by using a preferred provider because you will be charged lower, negotiated fees.</p>
<p>Coverage Categories</p>	<p>Your coverage level is based on the dependents you enroll, as shown below:</p> <ul style="list-style-type: none"> • Employee Only; • Employee Plus Adult; • Employee Plus Child(ren); or • Employee Plus Adult Plus Child(ren).
<p>Covered Services</p>	<p>Depending on the option you choose, covered services can include some or all of the following:</p> <ul style="list-style-type: none"> • Hospitalization; • Surgical procedures; • Physician’s office visits; • Emergency room services; • Maternity care; • Mental health and substance abuse care; and • Prescription drugs. <p>Many of the options also cover various forms of preventive care.</p>

Participating in the Medical Plan

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

Eligibility

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

- A U.S. dollar-paid employee who receives salary or earns draw, commissions, or production overrides (“salaried employee”);
- 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:

- Preferred Provider Organization (PPO)/Point-of-Service (POS) High Option;
- Preferred Provider Organization (PPO)/Point-of-Service (POS) Low Option;
- Health Maintenance Organization (HMO) Option;
- Exclusive Provider Organization (EPO) Option;
- Traditional Indemnity Option; and
- No Coverage.

Coverage Categories

When you enroll in the Medical Plan, your coverage level is based on the dependents you enroll and includes the following coverage categories:

- Employee Only;
- Employee Plus Adult;
- Employee Plus Child(ren); and
- Employee Plus Adult Plus Child(ren).

Provider Directories

You can easily check which health care providers participate in the various JPMorgan Chase Medical Plan options by using the Enrollment Decision Toolkit on the Benefits Web Center via My Rewards @ Work, or by accessing the individual Medical Plan option's web site. You also can request a print copy at any time by contacting the appropriate Medical Plan option and requesting information from a Service Representative.

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

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 for further 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 to whom you’re legally married or a qualified adult dependent (see “Qualified Adult Dependents” on page 14 for more information);
- Your unmarried dependent children up to the end of the month in which they reach age 23; and
- Your unmarried dependent children age 23 or older who meet both of the following conditions. They’re:
 - Not capable of supporting themselves due to a mental or physical disability that began before age 23; and
 - Fully dependent on you for financial support.

If JPMorgan Chase also employs your spouse, other adult dependent, or dependent 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 dependent child(ren), you or your spouse/domestic partner (but not both of you) may elect to provide this coverage.

Dependent Age Exceptions Under the HMO Option

The dependent eligibility guidelines described here may be superseded by state mandates that govern minimum dependent eligibility requirements within a particular state. If you are enrolled in an HMO Option (as defined by JPMorgan Chase) in one of these states, the state mandates will govern the eligibility rules for dependents. Known exceptions to the JPMorgan Chase eligibility rules are noted below. Please check with your HMO Option administrator for more details.

- If you are a child living in **Colorado**, then the maximum age is 24 where coverage ends at the end of the month. This currently applies to fully insured plans and HMOs. It does not include EPOs.
- If you are a child living in **Florida**, then the maximum age is 25 where coverage ends at the end of the year. This currently applies to fully insured plans and HMOs. It does not include EPOs.
- If you are a child living in **Louisiana**, then the maximum age is 24 where coverage ends at the end of the month. This currently applies to fully insured plans and HMOs. It does not include EPOs.
- If you are a child living in **New Mexico**, then the maximum age is 26 where coverage ends at the end of the month. This currently applies to fully insured plans and HMOs. It does not include EPOs.
- If you are a child living in **Texas**, then the maximum age is 25 where coverage ends at the end of the month. This currently applies to fully insured plans and HMOs. It does not include EPOs.
- If you are a child living in **Utah**, then the maximum age is 26 where coverage ends at the end of the month. This currently applies to fully insured plans and HMOs. It does not include EPOs.
- For all other states, the maximum age is 23.
- The same rules apply for a Domestic Child.

Please Note: The dependent age exceptions do not apply if you are enrolled in an EPO Option.

Dependent Children

“Children” include your natural children, stepchildren, children under your legal guardianship, children of your domestic partner, and legally adopted children whom you claim as dependents on your income tax return or provide at least 50% of support. “Children” also include a child under age 18 who lives with you and for whom (1) adoption proceedings have already begun and (2) you have the legal obligation to support (in whole or in part).

Federal law requires that any child of a plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) will be considered as having a right to dependent coverage under the JPMorgan Chase Medical Plan (and Dental Plan). In general, QMCSOs are state court orders requiring a parent to provide medical support to an eligible child, for example, in the case of a divorce or separation. For a detailed description of the procedures for a QMCSO, free of charge, contact:

JPMorgan Chase Health and Income Protection Plans
800 Brookside Blvd
Floor 274A
OH1-0141
Westerville, OH 43081-2822

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.

Qualified Adult Dependents

In addition to the dependents previously listed, you may also cover a “qualified adult” as an eligible dependent under the Medical Plan — and under certain other plans as referenced in those plan sections of this Guide — if you’re not currently covering a spouse. You generally must cover your qualified adult dependent under the same option you choose.

For the purposes of the Medical Plan, a qualified adult can be either a “domestic partner” or an “extended family member.” The definitions are as follows:

- **Domestic Partner.** You and your domestic partner must:
 - Be age 18 or older;
 - Have lived together for at least six months and have a serious, committed relationship;
 - Be financially interdependent;
 - Not be related to each other in a way that would prohibit legal marriage; and
 - Not be legally married to anyone else;
- 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.

- **Extended Family Member.** The person must:
 - Be age 18 or older;
 - Meet the definition of “dependent” as defined by the Internal Revenue Code (IRC) during the period of coverage;
 - Have lived with you for at least six months and remain a member of your household during the entire period of coverage; and
 - Not otherwise be eligible for coverage under the JPMorgan Chase Medical Plan.

You can elect coverage under the Medical Plan for a maximum of two adults (including yourself), in addition to any eligible dependent children. If you’re married, you can elect adult coverage for either you plus your spouse, or you plus a qualified adult dependent.

In addition, you can enroll children of a domestic partner, as long as they meet the eligibility requirements of being your dependent children under the Medical Plan as described under “Your Eligible Dependents” on page 13, and the domestic partner is also enrolled. You may not cover the child(ren) of an extended family member. If your domestic partner is not enrolled, you generally may only cover their child(ren) if you have adopted them.

Please Note: Not all the HMOs allow qualified adult coverage. If you currently cover a qualified adult, it’s your responsibility to ensure that your option allows for qualified adult coverage. You must certify your request to cover a qualified adult before coverage can begin.

For more information on covering a qualified adult, please refer to the **Qualified Adult Coverage Kit** available on Company Home > HR & Personal > Pay & Benefits > Library, or by contacting the Benefits Call Center.

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.

The amount you pay depends on the level of your annual total cash compensation, the medical option you choose, the number and type of eligible dependents you cover, your and/or your covered dependents’ smoker status, and whether you work on a full-time or part-time basis.

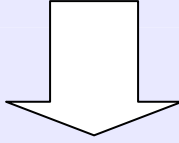
Annual Total Cash Compensation

“Annual total cash compensation” is your 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, commission, 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 annual total 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, annual total cash compensation will be equal to base salary plus job differentials.

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

The chart below shows the levels of annual total cash compensation used to determine Medical Plan contributions.

Annual Total Cash Compensation Levels Used to Determine Medical Plan Contributions

Level	Total Cash Compensation (excluding overtime)	Employee Pays
1	Up to \$39,999.99	
2	\$40,000–\$79,999.99	
3	\$80,000–\$149,999.99	
4	\$150,000–\$249,999.99	
5	\$250,000–\$349,999.99	
6	\$350,000 and above	

In most cases, the annual total cash compensation level for part-time employees regularly scheduled to work at least 20 but less than 40 hours per week is set to equal those of Level 2. However, if your annual total cash compensation is greater than the amounts included in Level 2, your Medical Plan contributions will be based on the applicable higher level. **Please Note:** Your employment status is measured as of August 1 and remains unchanged for purposes of determining Medical Plan contributions for the next calendar year.

Medical Option

Employee contributions will also vary due to the type of Medical Plan option and the level of coverage the option provides.

Covered Dependents

Your costs will vary based on which of the following coverage levels you choose:

- Employee Only;
- Employee Plus Adult;
- Employee Plus Child(ren); and
- Employee Plus Adult Plus Child(ren).

Smoker Status

Employees and their covered dependents who do not smoke pay less for medical coverage. Each year, employees must verify their status as a non-smoker or smoker, as well as the status of all covered dependents under the applicable plans. To be considered a non-smoker and pay lower, non-smoker rates under the applicable plans for a plan year, you and/or any covered dependents must be smoke-free for at least 12 months as of January 1 of that plan year, or complete an approved smoking cessation program. If you continue to smoke, you will need to complete an approved smoking cessation course annually to continue to qualify for the lower, non-smoker rates. You and all your covered dependents (adult and children) must be non-smokers to qualify for lower, non-smoker rates.

An Important Note on Dependent Coverage

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

Please Note: In your first calendar year of employment, you will be assigned non-smoker rates for your and your dependents' coverage even if you declare yourself, and/or your dependent(s) a smoker, because you may not have had an opportunity to complete a smoking cessation course in order to qualify for the lower non-smoker rates. In subsequent years, however, you will be eligible for non-smoker rates only if you have been smoke-free for 12 months (as of January 1) or if you complete a smoking cessation course, as described in the preceding paragraph.

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

For more information on the Smoking Cessation Program, please go to Company Home > HR & Personal > Life & Well-Being > Personal Health > Smoking Cessation Program.

How Smoker Is Defined

Under the JPMorgan Chase Benefits Program, a person who has smoked any type of tobacco product (e.g., cigarettes, cigars, or a pipe) regardless of the frequency or location (this includes daily, occasionally, socially, at home only, etc.) in the 12 months preceding any January 1 is considered a "smoker." This definition does not pertain to users of tobacco products that are not smoked, such as chewing tobacco or snuff.

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.

If you become totally and permanently disabled and are eligible for benefits from the JPMorgan Chase Long-Term Disability (LTD) Plan, you're treated as having "benefits eligible" status for certain benefits. In the case of the Medical Plan, you'll be eligible to continue coverage while receiving benefits from the LTD Plan. You'll pay for coverage on a direct-bill basis.

Cost for Qualified Adult Coverage

If you're covering a qualified adult as described in "Your Eligible Dependents" on page 13, there are some cost implications of which you should be aware. Specifically, in many cases a "domestic partner" will not satisfy the definition of "dependent" under the Internal Revenue Code (IRC). As a result, federal law requires JPMorgan Chase to report the entire value of the medical coverage for a "domestic partner" as taxable income to you. The entire value of this coverage includes the amount that both you and JPMorgan Chase contribute towards the cost of coverage.

Alternatively, an "extended family member" is treated as any other eligible dependent for cost and tax purposes. Accordingly, there is no additional taxable income.

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.

Enrolling a Qualified Adult Dependent

*For more information on enrolling and the tax consequences of covering a qualified adult dependent (domestic partner or extended family member), please refer to the **Qualified Adult Coverage Kit** available on Company Home > HR & Personal > Pay & Benefits > Library.*

How to Enroll

Participation in the Medical Plan is optional.

If You:	What You Need to Do to Enroll:
Are an Employee	<p>During an annual benefits enrollment period, you can make your elections through the Benefits Web Center via My Rewards @ Work or via the Benefits Call Center. At the beginning of each enrollment period, you'll receive instructions on how to enroll.</p> <p>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 19 for more information.</p>
Are a Newly Hired Employee	<p>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 via My Rewards @ Work or via 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. Part-time employees will receive their enrollment materials within 31 days prior to becoming eligible and can enroll at that time. You can access your benefits enrollment materials online via Company Home > HR & Personal > Pay & Benefits > Enrollment Materials. (In most cases, a copy of these materials will also be sent to you via interoffice mail. However, you do not need to wait for these materials to arrive to make your enrollment elections online.)</p>
Have a Change in Work Status or Qualified Change in Status	<p>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 to make your new choices through the Benefits Web Center via My Rewards @ Work or via the Benefits Call Center and speaking with a Service Representative. Please see "Qualified Change in Status" on page 19 for more information.</p>

If You Do Not Enroll

If You:	What Happens If You Do Not Enroll:
Are an Employee	<p>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 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.</p>
Are a Newly Hired or Newly Eligible Employee	<p>If you're a new hire or newly eligible employee and do not enroll within the designated 31-day eligibility period, you won't be able to choose medical coverage until the next annual benefits enrollment period unless you have a qualified change in status. Please see "Qualified Change in Status" on page 19 for more information.</p>
Have a Qualified Change in Status	<p>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, you won't be able to choose medical coverage until the next annual benefits enrollment period. Please see "Qualified Change in Status" on page 19 for more information.</p>

When Coverage Begins

If You:	When the Coverage You Elect Begins:
Are an Employee	The coverage you elect during the annual benefits enrollment period takes effect the beginning of the following plan year (January 1).
Are a Newly Hired or Newly Eligible Employee	The coverage you elect as a new hire takes effect as follows: <ul style="list-style-type: none"> • If you are a full-time employee, coverage begins on the first of the month following your date of hire. • If you are a part-time employee regularly scheduled to work at least 20 but less than 40 hours per week, coverage begins the first of the month following 90 days from your date of hire.
Have a Change in Work Status or Qualified Change in Status	The coverage you elect as a result of a qualified change in status (such as marriage, divorce, or the birth or adoption of a child) or work status change (such as 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 have already met the plan's eligibility requirements.

Please Note: The Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options, most Health Maintenance Organization (HMO) Options and Exclusive Provider Organization (EPO) Options, and the Traditional Indemnity Option cover pre-existing conditions. So, your coverage under these options begins as soon as you're eligible and enroll.

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** available on Company Home > HR & Personal > Pay & Benefits > Library, which includes details on how to make changes. This Guide is also available on request through the Benefits Call Center. You need to enroll through the Benefits Web Center via My Rewards @ Work or via the Benefits Call Center within 31 days of the qualifying event. Otherwise, you will not be able to make the change in coverage until the following annual benefits enrollment period. **Please Note:** Documentation of eligibility isn't always required when you enroll but may be requested at any time by JPMorgan Chase or the claims administrator. Your changes will take effect as of the day of the qualifying event.

If you have questions during the year about qualifying events and what the allowed benefit changes are, please visit the Benefits Web Center via My Rewards @ Work, 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.

Medical Plan Changes for Qualified Change in Status

Event	Medical Plan Changes
Spouse and Children	
You get married	<ul style="list-style-type: none"> Add coverage for you and/or your eligible dependents Change Medical Plan option
You have, adopt, or obtain legal guardianship of a child*	<ul style="list-style-type: none"> Add coverage for you and/or your eligible dependents Change Medical Plan option
You and/or your covered dependents gain other benefits coverage*	Cancel coverage for you and/or your covered dependents who have gained other coverage
You and/or your eligible dependents lose other benefits coverage*	<ul style="list-style-type: none"> Add coverage for you and/or your eligible dependents Change Medical Plan option
You get legally separated or divorced	Cancel coverage for your former spouse and/or dependent children who are no longer eligible
A covered family member dies*	Cancel coverage for your deceased dependent and any dependent children who are no longer eligible
A dependent child is no longer eligible*	Cancel coverage for your dependent child
You move out of a Medical Plan option service area and your current option is no longer available	Change Medical Plan option for you and your covered dependents. (Please Note: In this situation, you will be assigned new coverage by JPMorgan Chase based on your new service area. However, you will have the ability to change this assigned coverage within 31 days of the qualifying event.)
Qualified Adult Dependents — Domestic Partner	
You add a newly eligible domestic partner	<ul style="list-style-type: none"> Add coverage for you, your domestic partner, and any eligible dependent children. Change Medical Plan option. Change Medical Plan option for you and your covered dependents if your current plan does not allow for domestic partner enrollment.
You end a domestic partner relationship	Cancel coverage for your domestic partner, and your domestic partner's eligible dependent children who are no longer eligible.
Qualified Adult Dependents — Extended Family Members	
You add an extended family member (for example: an individual meets the definition of an extended family member)	<ul style="list-style-type: none"> Add coverage for you, your extended family member, and any eligible dependent children not previously covered. Change Medical Plan option. Change Medical Plan option for you and your covered dependents if your current plan does not allow for qualified adult dependent enrollment.
You drop an extended family member (for example: an extended family member gains other benefits coverage)	Cancel coverage for your extended family member.
An extended family member dies	Cancel coverage for your extended family member.

* Applies to domestic partner relationship

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) now 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.

The information included in this section is a summary of HIPAA privacy regulations. To comply with the law, JPMorgan Chase will distribute to you periodically, 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 on Company Home > HR & Personal > Pay & Benefits > Library, or you can contact 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;
- 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;
- 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;
- 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; and
- 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.

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 complete a HIPAA complaint form and send it to the HIPAA Privacy Officer:

HIPAA Privacy Officer for the JPMorgan Chase Health Care Plans
 Corporate Benefits
 JPMorgan Chase
 611 Woodward Avenue
 Mail Suite MI1-8010
 Detroit, MI 48226
 Fax : 1-312-226-0946

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:

- 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 the other coverage end; 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 and pay the required contributions.

Qualified Medical Child Support Order

If the Medical Plan receives a judgment, decree, or order — including a Qualified Medical Child Support Order (QMCSO) — requiring the plan to provide health coverage to your child or foster 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 specified in the order, or if none is specified, the date of the order. 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.

The Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options

The Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options are two of the options available under the JPMorgan Chase Medical Plan. Depending upon your home address, the PPO/POS Option is administered by:

- UnitedHealthcare (UnitedHealthcare: Choice Plus POS);
- Aetna (Aetna: Choice II POS);
- Empire BlueCross BlueShield (Empire BlueCross BlueShield: PPO); or
- Anthem BlueCross BlueShield (Anthem BlueCross BlueShield: POS).

Both the PPO/POS High and Low Options combine the advantages of traditional medical coverage with a cost effective “managed care” arrangement that includes participating providers who have agreed to negotiated fees with the claims administrators. The PPO/POS High and Low Options help you manage your medical costs by giving you the flexibility to choose between in-network and out-of-network care for covered services.

Each of the network health care providers has agreed to accept negotiated rates, which are lower fees, when treating JPMorgan Chase Medical Plan participants. This means your out-of-pocket costs generally will be:

- Lower when you receive your care from in-network providers; and
- Higher when you receive your care from out-of-network providers.

High Option — If you are enrolled in this PPO/POS Option, you pay higher premiums, but have lower deductibles and copayments for doctor’s office visits and other services.

Low Option — If you are enrolled in this PPO/POS Option, you pay lower premiums but your deductibles and copayments for doctor’s office visits and other services are higher.

At the time of hire (or plan eligibility) and during each annual benefits enrollment period, you’ll have access to information about the PPO/POS High and Low Options’ coverage provisions, including benefits and costs. Before enrolling for coverage, please review that information so that you can compare the key features of the PPO/POS High and Low Options and your other JPMorgan Chase Medical Plan Options.

With the PPO/POS High and Low Options...

- Each time you need medical care, you can choose to use an in-network or out-of-network provider.
- You do not need to designate a primary care physician (PCP). However, specialist copayments are higher than PCP copayments. Generally, PCPs include internists, general practitioners, family practice doctors, and pediatricians. Check with your administrator for details.
- In-network physician and specialist office visits are covered after a copayment, while most other services are subject to coinsurance.
- Out-of-network care is subject to an annual deductible, and expenses are generally covered at a lower percentage than in-network services.
- If you use out-of-network providers, you generally need to notify your claims administrator before a hospital admission.
- Claim forms are usually required for out-of-network care.
- If you need specialist care, you may self-refer to an in-network provider and still receive a higher level of benefits.

How the PPO/POS High and Low Options Work

The PPO/POS Options have networks of participating physicians, hospitals, and other health care professionals who have agreed to a negotiated fee arrangement for covered health services.

The PPO/POS Options have different claims administrators based on geographic location:

- United Healthcare for National (all states *not* listed below);
- Empire BlueCross BlueShield in Louisiana, Michigan, and Western New York;
- Anthem BlueCross BlueShield in Indiana, Kentucky, and Ohio; and
- Aetna in Delaware, Maryland, Texas, and West Virginia.

Where you live determines the PPO/POS network that you are able to access. If you're interested in enrolling in a PPO/POS Option, you may view an online provider directory by visiting the Benefits Web Center on My Rewards @ Work and going to Manage Your Health Care > Find a Doctor, or by directly visiting the option's web site. You may also request a print copy at any time by contacting the appropriate PPO/POS claims administrator and requesting information from a Service Representative.

Please Note: Even though a network's service providers may change during the year, the fact that your physician drops out of your network is not an allowable reason to change your Medical Plan option. You won't be able to change to another option until the next annual benefits enrollment period (unless you experience a qualifying event).

How the PPO/POS High Option Pays Benefits

The way benefits are paid depends on whether you receive your care in-network or out-of-network. For additional information, please see “What Is Covered Under All Medical Plan Options (Except the HMO Option)” on page 50.

Benefit Provision	In-Network	Out-of-Network
Annual Deductible (No individual family member may satisfy more than the single deductible amount. Any amount paid towards in-network services is not applied to the out-of-network deductible.)	None	\$600 individual \$1,200 individual + one \$1,200 individual + children \$1,800 family
Coinsurance Percentage	90%	70%
Annual Out-of-Pocket Maximum* (No individual family member's covered expenses will exceed the individual out-of-pocket maximum.)	\$1,200 individual \$2,400 individual + one \$2,400 individual + children \$3,600 family	\$2,400 individual \$4,800 individual + one \$4,800 individual + children \$7,200 family
Lifetime Maximum (Separate lifetime maximums apply to fertility services, substance abuse care, and skilled nursing facility.)	Unlimited	\$2,000,000 per individual
Outpatient Services		
Well-Child Care Office Visits	100% coverage after \$20 primary care office visit copayment ** \$30 specialist office visit copayment;	70% coverage after deductible
Doctor's Office Visits (Includes tests, supplies, and other services authorized by the plan and provided during the visit, consultations, specialist referrals, and second surgical opinions.)	100% coverage after \$20 primary care office visit copayment ** \$30 specialist office visit copayment;	70% coverage after deductible
X-rays and Labs (When performed to diagnose a medical problem or treat an illness or injury.)	90% coverage	70% coverage after deductible

* Excludes annual deductible and copayments.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with your Medical Plan option's Member Services for details.

*** Combined in network and out of network. All out of network expenses are subject to reasonable and customary (R&C) charges. You should note that since in network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

(continued on next page)

Benefit Provision	In-Network	Out-of-Network
Outpatient Services (continued)		
Routine Mammograms (Check with claims administrator for age and frequency limitations.)	100% coverage; office visit copay may apply	70% coverage after deductible
Fertility Services (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 individual.***)	100% coverage after a \$30 specialist office visit copayment; 90% coverage elsewhere (no copayment if in a facility)	70% coverage after deductible
Routine Eye Exams	Not covered	Not covered
Speech, Physical, or Occupational Therapy (Combined in-network and out-of-network limit of 40 visits/calendar year per therapy type.***)	90% coverage (no copayment if in a facility); 100% coverage after \$30 office visit copayment (if in a doctor's office)	70% coverage after deductible
Chiropractic Care (Must be medically necessary; coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year***)	100% coverage after \$30 per visit copayment	70% coverage after deductible
Mental Health Care (Limited to combined in-network and out-of-network maximum of 40 visits/calendar year.***)	100% coverage after \$30 per visit copayment	70% coverage after deductible
Substance Abuse Care (Limited to combined in-network and out-of-network \$20,000/lifetime maximum for inpatient and outpatient care for each covered individual.***)	100% coverage after \$30 per visit copayment	70% coverage after deductible

* Excludes annual deductible and copayments.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with your Medical Plan option's Member Services for details.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to reasonable and customary (R&C) charges. You should note that since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

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Benefit Provision	In-Network	Out-of-Network
Inpatient Services		
Acute hospital care (Based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases. Pre-certification requirements may apply.)	90% coverage after \$250 copayment per admission; waived if re-admitted for same or related condition within 14 days	70% coverage after deductible
Skilled Nursing Facility (Must be ordered by physician as medically necessary; includes charges for services and supplies provided while patient is under continuous care and requires 24-hour nursing care and room and board; limited to combined in-network and out-of-network maximum of 365 days/lifetime for each covered individual.***)	90% coverage after \$250 copayment per admission; waived if admitted from hospital	70% coverage after deductible
Hospice Care	90% coverage	70% coverage after deductible
Mental Health Care (Limited to combined in-network and out-of-network maximum of 30 days/calendar year.***)	90% coverage after \$250 copayment per admission	70% coverage after deductible
Substance Abuse Care (Limited to combined in-network and out-of-network maximum of \$20,000/lifetime for inpatient and outpatient care for each covered individual.***)	90% coverage after \$250 copayment per admission	70% coverage after deductible

* Excludes annual deductible and copayments.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with your Medical Plan option's Member Services for details.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to reasonable and customary (R&C) charges. You should note that since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

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Benefit Provision	In-Network	Out-of-Network
Other Services		
Emergency Room (For sudden and serious medical conditions approved by claims administrator as required for emergency care.)	100% after a \$100 copayment per visit; must be sudden and serious; waived if admitted 70% coverage if <i>not</i> considered an emergency	100% after a \$100 copayment per visit; must be sudden and serious; waived if admitted 70% coverage if <i>not</i> considered an emergency
Home Health Care (Medically necessary only; may require pre-certification; limited to combined in-network and out-of-network maximum of 200 visits/calendar year; one visit = four hours. ***)	90% coverage	70% coverage after deductible
Durable Medical Equipment and Prosthetics	90% coverage	70% coverage after deductible
Prescription Drugs	Please see "The Prescription Drug Plan" on page 60.	Please see "The Prescription Drug Plan" on page 60.

* Excludes annual deductible and copayments.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with your Medical Plan option's Member Services for details.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to reasonable and customary (R&C) charges. You should note that since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

How the PPO/POS Low Option Pays Benefits

Benefit Provision	In-Network	Out-of-Network
Annual Deductible (No individual family member may satisfy more than the single deductible amount. Any amount paid towards in-network services is not applied to the out-of-network deductible.)	None	\$700 individual \$1,400 individual + one \$1,400 individual + children \$2,100 family
Coinsurance Percentage	80%	60%
Annual Out-of-Pocket Maximum* (No individual family member's covered expenses will exceed the individual out-of-pocket maximum.)	\$3,000 individual \$6,000 individual + one \$6,000 individual + children \$9,000 family	\$6,000 individual \$12,000 individual + one \$12,000 individual + children \$18,000 family

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Benefit Provision	In-Network	Out-of-Network
Lifetime Maximum (Separate lifetime maximums apply to fertility services, substance abuse care, and skilled nursing facility.)	Unlimited	\$2,000,000 per individual
Outpatient Services		
Well-Child Care Office Visits	100% coverage after \$40 primary care office visit copayment; ** \$50 specialist office visit copayment	60% coverage after deductible
Doctor's Office Visits (Includes tests, injection drugs, supplies, and other services authorized by the plan and provided during the visit, consultations, specialist referrals, and second surgical opinions.)	100% coverage after \$40 primary care office visit copayment; ** \$50 specialist office visit copayment	60% coverage after deductible
X-rays and Labs (When performed to diagnose a medical problem or treat an illness or injury.)	80% coverage	60% coverage after deductible
Routine Mammograms (Check with claims administrator for age and frequency limitations.)	100% coverage after \$40 primary care office visit copayment; ** \$50 specialist office visit copayment	60% coverage after deductible
Fertility Services (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 individual. ***)	100% coverage after \$50 specialist office visit copayment; 80% coverage (no copayment if in a facility)	60% coverage after deductible
Routine Eye Exams	Not covered	Not covered
Speech, Physical, or Occupational Therapy (Combined in-network and out-of-network limit of 40 visits/ calendar year per therapy type. ***)	80% coverage (no copayment if in a facility); 100% coverage after \$50 office visit copayment (if in a doctor's office)	60% coverage after deductible

* Excludes annual deductible and copayments.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with your Medical Plan option's Member Services for details.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to reasonable and customary (R&C) charges. You should note that since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

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Benefit Provision	In-Network	Out-of-Network
Outpatient Services (continued)		
Chiropractic Care (Must be medically necessary; coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to 20 visits/calendar year.***)	100% coverage after \$50 per visit copayment	60% coverage after deductible
Mental Health Care (Limited to combined in-network and out-of-network maximum of 40 visits/calendar year.***)	100% coverage after \$50 per visit copayment	60% coverage after deductible
Substance Abuse Care (Limited to combined in-network and out-of-network \$20,000/lifetime maximum for inpatient and outpatient care for each covered individual.***)	100% coverage after \$50 per visit copayment	60% coverage after deductible
Inpatient Services		
Acute Hospital Care (Based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases. Pre-certification requirements may apply.)	80% coverage after \$500 copayment per admission; waived if readmitted for same or related condition within 14 days	60% coverage after deductible
Skilled Nursing Facility (Must be ordered by physician as medically necessary; includes charges for services and supplies provided while patient is under continuous care and requires 24-hour nursing care and room and board; limited to combined in-network and out-of-network maximum of 365 days/lifetime for each covered individual.***)	80% coverage after \$500 copayment per admission; waived if admitted from hospital	60% coverage after deductible
Hospice Care	80% coverage	60% coverage after deductible

* Excludes annual deductible and copayments.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with your Medical Plan option's Member Services for details.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to reasonable and customary (R&C) charges. You should note that since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

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Benefit Provision	In-Network	Out-of-Network
Inpatient Services (continued)		
Mental Health Care (Limited to combined in-network and out-of-network maximum of 30 days/calendar year.***)	80% coverage after \$500 copayment per admission	60% coverage after deductible
Substance Abuse Care (Limited to combined in-network and out-of-network maximum of \$20,000/lifetime for inpatient and outpatient care for each covered individual.***)	80% coverage after \$500 copayment per admission	60% coverage after deductible
Other Services		
Emergency Room (For sudden and serious medical conditions approved by claims administrator as required for emergency care.)	100% after a \$100 copayment per admission; must be sudden and serious; waived if admitted 60% coverage if <i>not</i> considered an emergency	100% after a \$100 copayment per admission; must be sudden and serious; waived if admitted 60% coverage if <i>not</i> considered an emergency
Home Health Care (Medically necessary only; may require pre-certification; limited to combined in-network and out-of-network maximum of 200 visits/calendar year; one visit = four hours.***)	80% coverage	60% coverage after deductible
Durable Medical Equipment and Prosthetics	80% coverage	60% coverage after deductible
Prescription Drugs	Please see “The Prescription Drug Plan” on page 60.	Please see “The Prescription Drug Plan” on page 60.

* Excludes annual deductible and copayments.

** Generally includes doctors certified in family, general, internal medicine, or pediatrics. Check with your Medical Plan option’s Member Services for details.

*** Combined in-network and out-of-network. All out-of-network expenses are subject to reasonable and customary (R&C) charges. You should note that since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

In-Network Benefit

The PPO/POS High and Low Options' greatest financial advantages generally occur when you receive your care from a network provider.

When you receive in-network care through the PPO/POS High or Low Option:

- You pay a fixed copayment for office visits.
- 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.
- You don't have to pay any deductibles, except the inpatient hospital or skilled nursing facility copayment.
- There's no lifetime dollar maximum covered benefit limit, except a \$20,000 combined lifetime limit for covered fertility services and a \$20,000 combined lifetime limit for substance abuse care.

Out-of-Network Benefits

Under both the PPO/POS High and Low Options, you have the option of visiting an out-of-network physician, hospital, or other provider at any time. For both options, if you choose to receive medically necessary covered services on an out-of-network basis:

- Services performed by providers not participating in the network will be reimbursed at the out-of-network level of benefits, based on reasonable and customary (R&C) charges, with respect to medically necessary covered services, before out-of-network benefits are paid.
- You'll need to file a claim form to receive out-of-network benefits. See "How to File Claims" on page 79 for more information.
- Your own costs for medically necessary covered services generally will be higher than if you received in-network care.
- There is a \$2,000,000 per person lifetime benefit limit for out-of-network services.

Annual Deductible

Before you receive coverage for out-of-network benefits from either the PPO/POS High or Low Option, you need to satisfy an annual deductible. Only Reasonable and Customary (R&C) charges for medically necessary services will count towards the out-of-network deductible. Amounts above R&C charges do not count toward your deductible.

Under the PPO/POS High and Low Options, if you elect coverage for yourself or yourself plus one dependent:

- Each covered person must pay all eligible expenses until the individual deductible is met. Then, eligible expenses are covered at the coinsurance indicated for that expense. Expenses for two covered individuals are not combined.
- After a covered person meets the individual deductible amount, that person will pay no further deductible.

Please Note

When you visit an in-network facility for a scheduled surgery, the PPO/POS High or Low Option will cover care provided by radiologists, anesthesiologists, and/or pathologists at the in-network percent of the reasonable and customary (R&C) charge, even if the provider is considered an out-of-network provider. For example, assume you are enrolled in the POS High Option and visit an in-network facility for surgery and are treated by an out-of-network anesthesiologist whose charge is \$500. If the R&C charge for the anesthesiologist's services is \$400, the plan will reimburse you 90% of \$400 (\$360); you will be responsible for payment of the remaining \$140. 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, as explained in "Out-of-Network Benefits" on this page.

If you elect coverage for yourself plus two or more dependents:

- All expenses incurred by you and/or your covered dependents combine to meet the appropriate total deductible (individual plus children or family deductible).
- If no one person meets the individual deductible, but combined participant expenses meet the total deductible amount, no further deductible is required.
- After a covered person meets the individual deductible amount, that person will pay no further deductible.

The maximum deductible any one covered person must pay is equal to the individual amount. After one person meets the individual deductible, that person will pay no further deductible, but other covered persons must continue to pay deductibles until the total is satisfied.

An Example: Amounts Applied Toward Out of Network Deductibles

On behalf of you	\$600
On behalf of your spouse/qualified adult	\$500
On behalf of one child	\$400
On behalf of a second child	\$300
TOTAL	\$1,800

In this example, one person has met the PPO/POS High Option of the \$600 individual deductible (you), and the combined costs have reached \$1,800. So, any reasonable and customary (R&C) charges for medically necessary covered services would be reimbursable at 70% or until your out of pocket limit is met by the PPO/POS Option, even if they were on behalf of a person who has not yet met the \$600 individual deductible. No other covered family members need to meet their individual deductible for the rest of the year.

Annual Out-of-Pocket Maximum

Under the PPO/POS High and Low Options, this is the maximum amount (excluding items such as annual deductible and copayments) you must pay in a calendar year toward each covered person's eligible expenses. Only reasonable and customary (R&C) charges for medically necessary services will count towards the annual out-of-pocket maximum. Amounts above R&C charges do not count toward your annual out-of-pocket maximum.

If you elect coverage for yourself or yourself plus one dependent:

- Each covered person must pay all eligible out-of-pocket expenses until the individual maximum is met. Eligible out-of-pocket expenses are then covered at 100% for that person.
- After a covered person meets the individual out-of-pocket maximum, that person will pay no further out-of-pocket expenses.

If you elect for yourself plus two or more dependents:

- All eligible out-of-pocket expenses paid by you and/or your covered dependents combine to meet the appropriate total maximum amount (employee plus children or family).
- If no one person meets the individual maximum, but combined participant out-of-pocket payments meet the total amount, eligible out-of-pocket expenses are then covered at 100%.
- After a covered person meets the individual out-of-pocket maximum, that person will pay no further out-of-pocket expenses.

The maximum out-of-pocket expense any one covered person must pay is equal to the individual amount. After one person's expenses reach the individual out-of-pocket maximum, eligible out-of-pocket expenses are then covered at 100% for that person, but other covered persons must continue to pay out-of-pocket expenses until the total family out-of-pocket maximum is satisfied.

An Example: Amounts Applied Toward Out-of-Network Family Out-of-Pocket Maximum

On behalf of you	\$2,400
On behalf of your spouse/qualified adult	\$2,000
On behalf of one child	\$2,000
On behalf of a second child	\$800

In this example, one person has met the \$2,400 individual out-of-pocket maximum (you), and the combined out-of-pocket costs have reached \$7,200. So, any reasonable and customary (R&C) charges for medically necessary covered services would be reimbursable at 70% by the PPO/POS High Option, even if they were on behalf of a person who has not yet met the individual out-of-pocket maximum. No other covered family members need to meet their individual out-of-pocket maximum for the rest of the year.

Maximum Lifetime Benefit

The maximum lifetime benefit for out-of-network care for each individual covered under the PPO/POS High and Low Option is **\$2,000,000**. This includes the **\$20,000** lifetime fertility services maximum and the **\$20,000** lifetime substance abuse care maximum. The fertility services and substance abuse care lifetime maximum benefits apply to both in-network and out-of-network care. In addition, all benefits you receive under the PPO/POS High or Low Option, the Traditional Indemnity Option, and the Medicare Indemnity Options are added together for purposes of the lifetime maximums.

An Important Note on the Plan's Lifetime Maximum

The Medical Plan's lifetime maximum (overall, fertility services and substance abuse care) reflects services received across the following plans:

- PPO/POS High or Low Option
- Traditional Indemnity Option
- Medicare Indemnity Options combined

You do not gain a new maximum if you switch your coverage between options.

Important Note

Any benefits that have been applied to a lifetime maximum provision under a medical plan of your heritage organization will also be applied to the lifetime maximums of the JPMorgan Chase Medical Plan.

Hospital Notification

You must contact the claims administrator within 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 must also contact the claims administrator if a maternity stay will exceed 48 hours for the mother and newborn child following a vaginal delivery, or 96 hours for the mother and newborn child following a Cesarean section delivery.

To provide notification, please contact your PPO/POS High or Low Option's claims administrator at the number listed in the "Claims Administrators' Contact Information" on page 80.

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 100% as if you received the care in-network as long as:

- You, the physician, or a member of your family calls the PPO/POS High or Low Option claims administrator within 48 hours after the emergency; and
- The PPO/POS High or Low Option claims administrator approves the care.

If you don't follow these guidelines to receive approval, your benefits will be paid as if you received the care out-of-network.

The Health Maintenance Organization (HMO) Option and the Exclusive Provider Organization (EPO) Option

The Health Maintenance Organization (HMO) Option and the Exclusive Provider Organization (EPO) Option are two of the options available under the JPMorgan Chase Medical Plan that may be available to you based on your home address. These options are designed to provide you and your family with a full range of health care services.

At the time of hire (or plan eligibility) and during each annual benefits enrollment period, you'll have access to information about available HMO Option and EPO Option coverage, including benefits and costs. Before enrolling for coverage, please review that information so that you can compare the key features of the available HMO Option, EPO Option, and your other JPMorgan Chase Medical Plan options.

This section provides a general description of how the HMO Option and EPO Option work and the medical benefits typically available to participants.

The HMO Option

If you enroll in an HMO Option, you will receive separate materials directly from the HMO in which you enroll, including a summary plan description specific to that HMO. These materials will provide specific details on your HMO Option's benefits, including your rights as a plan participant. These materials, combined with this Guide, will form the full summary plan description for the HMO in which you participate.

The contact information, as well as the costs and coverage offered by each HMO Option, based on information submitted by the HMO, are available on the Benefits Web Center via My Rewards @ Work. But remember, this information changes as of January 1 each year, so please refer to the appropriate benefits enrollment material before making your enrollment decisions.

Detailed summaries of coverage under each HMO Option also can be obtained from each HMO without charge by writing to the HMO. These detailed summaries include:

- Copayments;
- Annual and lifetime limits;
- Whether, and under what circumstances, existing and new drugs are covered;
- Whether, and under what circumstances, coverage is provided for medical tests, devices, and procedures;
- Procedures governing the "composition" of provider networks;
- Conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Provider lists; and
- Claims procedures.

With Most HMO Options...

- Out-of-network services are generally not covered.
- Most in-network services are fully paid after a copayment.
- There are generally no claim forms to file.
- Many HMOs cover preventive services, such as well-child care, vision, and hearing screenings, etc.
- If you are enrolled in an HMO Option and need specialist care, your primary care physician (PCP) will refer you to a network specialist in your area.
- Unlike EPO Options, HMOs may be subject to state-mandated benefits and dependent age exceptions.

It's your responsibility to ensure that the HMO Option you choose meets your needs in terms of cost, benefits provided, prescription drug coverage, and physician and hospital network.

How the HMO Option Works

If you enroll in an HMO Option, you and your eligible dependents will have access to the full range of the HMO's covered services whenever you need them. This includes care at the HMO's:

- Affiliated hospitals;
- Physicians' offices; and
- Medical centers.

Many HMOs require you to choose a primary care physician (PCP) for yourself and your covered dependents to coordinate services received through the HMO. Your PCP plays an important role as your main contact for obtaining and coordinating care. If the HMO Option you choose requires selection of a PCP, you can select one online when you enroll or by calling your HMO directly. You can generally change your PCP at any time, but check with your HMO for details. You may view an online provider directory by visiting the Benefits Web Center on My Rewards @ Work and going to Manage Your Health Care > Find a Doctor, or by directly visiting the HMO Option's web site. You may also request a print copy at any time by contacting the appropriate HMO Option's claims administrator and requesting information from a Service Representative.

Please Note: Even though a network's service providers may change during the year, the fact that your physician drops out of your network is not an allowable reason to change your Medical Plan option. You won't be able to change to another option until the next annual benefits enrollment period, unless you experience a qualifying event.

A Note on Prescription Drug Coverage

If you elect coverage under the PPO/POS High or Low Option, the EPO Option, or the Traditional Indemnity Option, your prescription drug coverage is provided through the JPMorgan Chase Prescription Drug Plan. However, if you elect coverage under the HMO Option, your prescription drug coverage is provided through your HMO.

Many HMO Options offer prescription drug coverage based on the use of a formulary, which is a list of preferred prescription drugs. Please contact the HMO Option's Member Services department for more information on prescription drug coverage or check the HMO Option's web site.

HMO Covered Services

Upon your request, each of the available HMO Options will provide you with descriptive brochures, provider directories, and other informational materials describing:

- The HMO's covered services;
- Any required copayments or coinsurance; and
- The HMO's network of participating providers.

In addition, each HMO has slightly different coverage, copayments, and pre-authorization and utilization reviews.

Emergency and Out-of-Area Care

Each of the available HMO Options has special provisions for emergency care and out-of-area care (for example, if you're on vacation or traveling on business). Each HMO Option's descriptive materials will provide more information concerning these provisions.

The EPO Option

EPOs work much like HMOs in that most in-network services are fully paid after a copayment, out-of-network services are generally not covered, and there are generally no deductibles or claim forms to file. However, EPOs are not subject to state-mandated benefits or dependent age exceptions. In addition, some EPOs require a PCP referral for specialist care. Please check with your claims administrator to see if this applies to you.

It's your responsibility to ensure that the EPO you choose meets your needs in terms of cost, benefits provided, prescription drug coverage, and physician and hospital network. Make sure providers are convenient to where you live and work.

How the EPO Option Works

If you enroll in an EPO Option, you and your eligible dependents will have access to the full range of the EPO's covered services whenever you need them. This includes care at the EPO's:

- Affiliated hospitals;
- Physicians' offices; and
- Medical centers.

Some EPOs require you to choose a primary care physician (PCP) for yourself and your covered dependents to coordinate services received through the EPO. Your PCP plays an important role as your main contact for obtaining and coordinating care. If the EPO Option you choose requires selection of a PCP, you can select one online when you enroll or by calling your EPO directly. You can generally change your PCP at any time, but check with your EPO for details. You may view an online provider directory by visiting the Benefits Web Center on My Rewards @ Work and going to Manage Your Health Care > Find a Doctor, or by directly visiting the EPO Option's web site. You may also request a print copy at any time by contacting the appropriate EPO Option's claims administrator and requesting information from a Service Representative.

Please Note: Even though a network's service providers can change during the year, you won't be able to change to another option until the next annual benefits enrollment period, unless you experience a qualifying event.

How the EPO Option Pays Benefits

The chart below shows the “standard” coverage under the EPO Option.

Please Note: Each EPO Option may have slightly different coverage, visit maximums, copayments, pre-authorization, and utilization reviews.

Benefit Provision	Coverage
Annual Deductible	None
Coinsurance Percentage	100%
Annual Out-of-Pocket Maximum	None
Lifetime Maximum	Unlimited
Outpatient Services	
Well-Child Care	100% coverage after \$20 primary care office visit copayment for PCP visit/\$30 copayment specialist office visit
Doctor’s Office Visits	100% coverage after \$20 primary care office visit copayment for PCP visit/\$30 copayment specialist office visit
X-rays and Labs	100% coverage after \$20 primary care office visit copayment if during PCP visit/\$30 copayment if during specialist office visit
Routine Mammograms	100% coverage after \$20 primary care office visit copayment for PCP visit/\$30 copayment specialist office visit
Fertility Services	100% coverage up to \$20,000 lifetime maximum; copay based on place of service. Check with claims administrator for covered procedures; preauthorization may be required.
Routine Eye Exams	Check with claims administrator
Speech, Physical, or Occupational Therapy (Limited to a maximum of 40 visits/calendar year per therapy type.)	100% coverage after \$30 copayment per visit
Chiropractic Care (Must be medically necessary; coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to a maximum of 20 visits/calendar year.)	100% coverage after \$30 copayment per visit
Mental Health Care (Limited to maximum of 30 visits/calendar year.)	100% coverage after \$30 copayment per visit
Substance Abuse Care (Limited to maximum of 30 visits/calendar year.)	100% coverage after \$30 copayment per visit
Inpatient Services	
Acute Hospital Care	100% coverage after \$250 per admission copay
Skilled Nursing Facility	100% coverage after \$250 per admission copay; contact claims administrator for authorization requirements or limits

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Benefit Provision	Coverage
Hospice Care	100% coverage; contact claims administrator for authorization requirements or limits
Mental Health Care (Limited to maximum of 30 days/calendar year.)	100% coverage after \$250 per admission copay
Substance Abuse Care (Limited to maximum of 30 days/calendar year.)	100% coverage after \$250 per admission copay
Other Services	
Emergency Room	100% coverage after \$100 copayment per visit (copayment waived if admitted). Not covered if not considered an emergency.
Home Health Care	100% coverage; contact claims administrator for authorization requirements or limits
Durable Medical Equipment and Prosthetics	100% coverage; contact claims administrator for authorization requirements or limits
Prescription Drugs	Please see “The Prescription Drug Plan” on page 60.

Each EPO may have slightly different coverage, copayments, and pre-authorization and utilization reviews. Please contact the claims administrator for details.

Emergency and Out-of-Area Care

Each of the available EPO Options may have special provisions for emergency care and out-of-area care (for example, if you're on vacation or traveling on business). Please contact your EPO Option for more information concerning these provisions. (Please see the “Claims Administrators' Contact Information” on page 80.)

The Traditional Indemnity Option

The Traditional Indemnity Option is one of the options available under the JPMorgan Chase Medical Plan. The Traditional Indemnity Option is administered by UnitedHealthcare and reimburses you a percentage of your reasonable and customary (R&C) expenses for medically necessary covered services after you pay an annual deductible.

At the time of hire (or plan eligibility) and during each annual benefits enrollment period, you'll have access to information about the Traditional Indemnity Option's coverage provisions, including benefits and costs. Before enrolling for coverage, please review that information so that you can compare the key features of the Traditional Indemnity Option and your other JPMorgan Chase Medical Plan Options.

With the Traditional Indemnity Option:

- You can use any doctor at any time and still receive benefits for covered services.
- Benefits begin after you meet an annual deductible.
- Preventive care benefits are provided up to a maximum of \$200 per year without paying a deductible. (This includes well-child and adult care office visits.)
- You must notify the claims administrator before a non-emergency hospital admission.
- Claim forms are required.
- There are limits on your annual out-of-pocket expenses.

How the Traditional Indemnity Option Works

With the Traditional Indemnity Option, you must first meet an annual deductible, then the option pays a percentage of covered services up to the reasonable and customary (R&C) amount, subject to certain annual maximums. You can choose to use any doctor. However, since the total cost of care under this option is higher than under the other Medical Plan options, your overall costs will likely be higher.

You should note that this option also contains a preferred provider feature. Although the benefit percentage paid under this option is the same whether or not you use a preferred provider, your overall costs will probably be reduced by using a preferred provider because you will be charged lower, negotiated fees. Please see "Preferred Provider Feature" on page 48 for more information.

With the Preferred Provider Feature Under the Traditional Indemnity Option

- *Reduced fees are available when using a network provider.*
- *Claim forms are usually not required when using a network provider.*

How the Traditional Indemnity Option Pays Benefits

The following chart shows how the Traditional Indemnity Option pays benefits. For additional information, please see "What Is Covered Under All Medical Plan Options (Except the HMO Option)" on page 50.

Benefit Provision	Coverage
Annual Deductible (No individual family member may satisfy more than the single deductible amount.)	<ul style="list-style-type: none"> • \$600 individual • \$1,200 individual + one • \$1,200 individual + children • \$1,800 family
Coinsurance Percentage	80%
Annual Out-of-Pocket Maximum*	<ul style="list-style-type: none"> • \$2,400 individual • \$4,800 individual + one • \$4,800 individual + children • \$7,200 family
Lifetime Maximum	\$2,000,000 per individual
Outpatient Services	
Well-Child/Adult Care Office Visits	100% coverage, limited to one exam/calendar year per individual; maximum \$200/year; combined maximum with routine exams
Doctor's Office Visits (Includes tests, supplies, and other services authorized by the plan and provided during the visit, consultations, specialist referrals, and second surgical opinions.)	80% coverage after deductible
X-rays and Labs (When performed to diagnose a medical problem or treat an illness or injury.)	80% coverage after deductible
Routine Mammograms (Check with claims administrator for age and frequency limitations.)	100% coverage, limited to one exam/calendar year
Fertility Services (Includes diagnostic procedures, in vitro fertilization, artificial insemination, etc.; limited to maximum of \$20,000/lifetime for each covered individual.)	80% coverage after deductible
Routine Eye Exams	Not covered
Speech, Physical, or Occupational Therapy (Limited to 40 visits/calendar year per therapy type.)	80% coverage after deductible

* Excludes annual deductible.

All percentages above generally apply to reasonable and customary charges.

(continued on next page)

Benefit Provision	Coverage
Outpatient Services (continued)	
Chiropractic Care (Must be medically necessary; coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to a maximum of 20 visits/calendar year.)	80% coverage after deductible
Mental Health Care (Limited to Maximum of 40 visits/calendar year.)	80% coverage after deductible
Substance Abuse Care (Limited to \$20,000/lifetime maximum for inpatient and outpatient care for each covered individual.)	80% coverage after deductible
Inpatient Services	
Acute Hospital Care (Based on hospital's standard rate for semi-private or common rooms, except for isolation of communicable diseases. Pre-certification requirements may apply.)	80% coverage after deductible
Skilled Nursing Facility (Must be ordered by physician as medically necessary; includes charges for services and supplies provided while patient is under continuous care and requires 24-hour nursing care and room and board; limited to maximum of 365 days/lifetime for each covered individual.)	80% coverage after deductible
Hospice Care	80% coverage after deductible
Mental Health Care (Limited to 30 days/calendar year)	80% coverage after deductible
Substance Abuse Care (Limited to maximum of \$20,000/lifetime for inpatient and outpatient care for each covered individual.)	80% coverage after deductible

All percentages above generally apply to reasonable and customary charges.

(continued on next page)

Benefit Provision	Coverage
Other Services	
Emergency Room (For sudden and serious medical conditions approved by claims administrator as required for emergency care.)	100% coverage after \$100 copayment; waived if admitted 80% coverage after deductible if <i>not</i> considered an emergency
Home Health Care (Medically necessary only; may require pre-certification; limited to maximum of 200 visits/calendar year; one visit = four hours.)	80% coverage after deductible
Durable Medical Equipment and Prosthetics	80% coverage after deductible
Prescription Drugs	Please see “The Prescription Drug Plan” on page 60.

All percentages above generally apply to reasonable and customary charges.

Annual Deductible

Before you receive benefits from the Traditional Indemnity Option (except for covered preventive care services, such as routine exams, well-child care, and routine mammograms), you need to pay the annual deductible with respect to medically necessary services. Amounts above reasonable and customary (R&C) charges or for non-covered services do not count toward your deductible.

Under the Traditional Indemnity Option, if you elect coverage for yourself or yourself plus one dependent:

- Each covered person must pay all eligible expenses until the individual deductible is met. Then, eligible expenses are covered at the coinsurance indicated for that expense. Expenses for each covered individual are not combined.
- After a covered person meets the individual deductible amount, that person will pay no further deductible.

If you elect coverage for yourself plus two or more dependents:

- All expenses incurred by you and/or your covered dependents combine to meet the appropriate total deductible (employee plus children or family deductible).
- If no one person meets the individual deductible, but combined participant expenses meet the total deductible amount, no further deductible is required.
- After a covered person meets the individual deductible amount, that person will pay no further deductible.

The maximum deductible any one covered person must pay is equal to the individual amount. After one person meets the individual deductible, that person will pay no further deductible, but other covered persons must continue to pay deductibles until the total is satisfied.

An Example: Amounts Applied Toward Family Deductible

On behalf of you	\$600
On behalf of your spouse/qualified adult	\$500
On behalf of one child	\$400
On behalf of a second child	\$300
TOTAL	\$1,800

In this example, one person has met the \$600 individual deductible (you), and the combined costs have reached \$1,800. So, any reasonable and customary (R&C) charges for medically necessary covered services would be reimbursable by the Traditional Indemnity Option, even if they were on behalf of a person who has not yet met the \$600 individual deductible. No other covered family members need to meet their individual deductible for the rest of the year.

Annual Out-of-Pocket Maximum

Under the Traditional Indemnity Option, this is the maximum amount (excluding items such as annual deductible and copayments) you must pay in a calendar year toward each covered person's eligible expenses. Only reasonable and customary (R&C) charges for medically necessary services will count towards the annual out-of-pocket maximum. Amounts above R&C charges do not count toward your annual out-of-pocket maximum.

If you elect coverage for yourself or yourself plus one dependent:

- Each covered person must pay all eligible out-of-pocket expenses until the individual maximum is met. Eligible out-of-pocket expenses are then covered at 100% for that person.
- After a covered person meets the individual out-of-pocket maximum, that person will pay no further out-of-pocket expenses.

If you elect for yourself plus two or more dependents:

- All eligible out-of-pocket expenses paid by you and/or your covered dependents combine to meet the appropriate total maximum amount (employee plus children or family).
- If no one person meets the individual maximum, but combined participant out-of-pocket payments meet the total amount, eligible out-of-pocket expenses are then covered at 100%.
- After a covered person meets the individual out-of-pocket maximum, that person will pay no further out-of-pocket expenses.

The maximum out-of-pocket expense any one covered person must pay is equal to the individual amount. After one person's expenses reach the individual out-of-pocket maximum, eligible out-of-pocket expenses are then covered at 100% for that person, but other covered persons must continue to pay out-of-pocket expenses until the total family out-of-pocket maximum is satisfied.

An Example: Amounts Applied Toward Family Out-of-Pocket Maximum

On behalf of you	\$2,400
On behalf of your spouse/qualified adult	\$2,000
On behalf of one child	\$2,000
On behalf of a second child	\$800
TOTAL	\$7,200

In this example, one person has met the \$2,400 individual out-of-pocket maximum (you), and the combined out-of-pocket costs have reached \$7,200. So, any reasonable and customary (R&C) charges for medically necessary covered services would be reimbursable at 100% by the Traditional Indemnity Option, even if they were on behalf of a person who has not yet met the individual out-of-pocket maximum. No other covered family members need to meet their individual out-of-pocket maximum for the rest of the year

Maximum Lifetime Benefit

The maximum lifetime benefit for each individual covered under the Traditional Indemnity Option is **\$2,000,000**. This includes the **\$20,000** lifetime fertility services maximum and the **\$20,000** lifetime substance abuse care maximum.

An Important Note on the Lifetime Maximum

The Medical Plan's lifetime maximum (overall, fertility services and substance abuse care) reflects services received across the following plans:

- PPO/POS High or Low Option
- Traditional Indemnity Option
- Medicare Indemnity Options combined

You do not gain a new maximum if you switch your coverage between options.

Important Note

Any benefits that have been applied to a lifetime maximum provision under a medical plan of your heritage organization will be applied to the lifetime maximums of the JPMorgan Chase Medical Plan.

Hospital Notification

Under the Traditional Indemnity Option, you must contact UnitedHealthcare within 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 must also contact UnitedHealthcare if a maternity stay will exceed 48 hours for the mother and newborn child following a vaginal delivery, or 96 hours for the mother and newborn child following a Cesarean section delivery.

To provide notification, please contact UnitedHealthcare at the number listed in the "Claims Administrators' Contact Information" on page 80.

Preferred Provider Feature

The Traditional Indemnity Option includes a preferred provider feature that allows employees access to certain preferred providers (physicians, hospitals, and other medical professionals) at more favorable rates than if they choose a provider who does not participate in the network. The Preferred Provider feature is available as an additional benefit of the Traditional Indemnity Option, and participants continue to have complete freedom of choice in determining which providers to use.

If you choose to visit a preferred provider, you'll generally receive health care at more favorable rates, and claim forms are usually not required. The provider has contractually agreed to a reduced fee and will be reimbursed according to his or her arrangement. If you do not visit a preferred provider, there's no penalty or reduction in your benefits. And, you don't need to select a primary care physician.

If you choose coverage under the Traditional Indemnity Option, the PPO symbol will appear on your medical identification (ID) card. It's important to show your provider (that is, your hospital, physician, laboratory, etc.) your UnitedHealthcare identification card at the time you receive services. If you visit a provider within the UnitedHealthcare PPO network and identify yourself with the UnitedHealthcare identification card, you generally won't have to file a claim for reimbursement; the provider will generally file for you.

You'll be billed by your provider for the balance of any applicable deductible, coinsurance amounts, or expenses not covered. After your claim has been paid, you'll also receive an explanation of benefits (EOB) that highlights how much you saved by using a network provider.

You may view an online provider directory by visiting the Benefits Web Center on My Rewards @ Work and going to Manage Your Health Care > Find a Doctor, or by directly visiting UnitedHealthcare's web site. You may also request a print copy at any time by contacting United Healthcare and requesting information from a Service Representative. For more information about the UnitedHealthcare PPO network, or to request a PPO network directory, call UnitedHealthcare Customer Service at the number listed in the "Claims Administrators' Contact Information" on page 80.

Please Note: Even though a network's service providers can change during the year, you won't be able to change to another option until the next annual benefits enrollment period.

What Is Covered Under All Medical Plan Options (Except the HMO Option)

The Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options, Exclusive Provider Organization (EPO) Option, the Traditional Indemnity Option, and the Medicare Indemnity Option cover a wide variety of services, as long as the services are medically necessary. See the definition of “medically necessary” in “Important Terms” beginning on page 4. 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. (Please see “Claims Administrators’ Contact Information” on page 80 for more information.) For information on how an HMO Option covers medical services, please see the supplementary materials specific to your HMO Option that will be sent to you by the HMO Option in which you enroll.

Inpatient Hospital and Related Services

The PPO/POS High and Low Options, the EPO Option, the Traditional Indemnity Option, and the Medicare Indemnity Option cover medically necessary inpatient hospital admissions for an unlimited number of days. Under the PPO/POS High and Low Options, the EPO Option, and the Traditional Indemnity Option, hospital pre-notification is required for non-emergency admissions. Covered services include, but are not limited to the following services, subject to any limitations or requirements of the plan:

- Allergy testing and treatment, when provided as part of inpatient care for another covered condition and based on medical necessity;
- Anesthetics and their administration;
- Bariatric surgery subject to claims administrator guidelines;
- Basic metabolic examinations;
- Certain dental surgeries that are medical in nature and required to be performed in a hospital setting or medical doctor’s office, if the surgery is needed because of a congenital disorder or accidental injury and treatment is received within 12 months of the accident, and charges are not covered by the JPMorgan Chase Dental Plan;
- 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

Certain Limitations

Keep in mind that certain services listed here are limited to a specific number of visits or days of treatment. Any services that have such limits (for example, chiropractic treatment) are determined by medical necessity. In other words, the treatment must be medically necessary, even if the number of visits or days of treatment is within the prescribed limitations. The limitations are described within each coverage chart.

- Reconstruct a breast after mastectomy. Coverage for the following services is available under the Medical Plan in a manner determined in consultation with you and your physician:
 - Reconstruction of the breast on which the mastectomy was performed;
 - Surgery and reconstruction for the other breast to produce a symmetrical appearance; and
 - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas.
- Diagnostic services, including:
 - EEG, EKG, and other diagnostic medical procedures;
 - Laboratory and pathology tests; and
 - Radiology services.
- Electrocardiographic and physiotherapeutic equipment;
- Hemodialysis for kidney failure;
- Intensive care unit service if medically necessary;
- 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;
 - Care required due to miscarriage or ectopic pregnancy;
 - Coverage of eligible expenses if your dependent 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;
 - Circumcision by a licensed provider (for your covered newborn child); 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.)
- Operative and surgical procedures by a licensed provider for the treatment of a disease or injury, including pre-operative preparation and post-operative care;
- Pre-admission testing when completed within seven days of hospital admission;
- Semi-private room and board; and
- Take-home drugs and medications.

The list is subject to change at any time. If you are enrolled in an EPO option, please contact your option's claims administrator.

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 or newborn child 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) 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 dependent(s) (including your spouse) 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

As with inpatient services, the PPO/POS High and Low Options, the EPO Option, and the Traditional Indemnity Option cover many of the same medically necessary outpatient services. Covered services include, but are not limited to the following services, subject to any limitations or requirements of the plan:

- Acupuncture when used as a form of pain control and performed by a licensed provider;
- 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 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;
- 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;
- Occupational therapy rendered by a licensed therapist;
- Outpatient surgery and related follow-up care;
- Physical therapy rendered by a licensed therapist;
- 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; and
- Temporomandibular joint syndrome (TMJ) medical in nature treatment only; including exams, X-rays, injections, anesthetics, physical therapy, and oral surgery up to \$1,000 combined in-network and out-of-network.

This list is subject to change at any time. If you are enrolled in an EPO option, please contact your option's claims administrator.

Multiple Surgical Procedure Reduction Policy

The Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options, EPO Option, Traditional Indemnity Option, and the Medicare Indemnity Option 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 the reasonable and customary (R&C) amount for the primary or major surgical procedure;

50% of the R&C amount for the secondary procedure; and

If more than two procedures are performed, please check with your claims administrator for coverage details.

Preventive Care Services

The PPO/POS High and Low Options, the EPO Option, the Traditional Indemnity Option, and the Medicare Indemnity Option cover preventive care services, although benefits levels may differ substantially. Please check with your claims administrator for any age or frequency limitations. (Please see “Claims Administrators’ Contact Information” on page 80 for more information.) These services include:

- Routine care including:
 - PAP tests;
 - Prostate exams;
 - Flexible sigmoidoscopy;
 - Screening colonoscopy;
 - Routine physical exams (office visit with appropriate laboratory and radiology services); and
 - Mammography screenings.
- Well-child/adult care office visits (plus immunizations and labs).

This list is subject to change at any time. If you are enrolled in an EPO option, please contact your option’s claims administrator.

Under the Traditional Indemnity Option, there is a combined annual \$200 per-person maximum on the benefits and services described above (other than mammography screenings).

Other Covered Services

The PPO/POS High and Low Options, the EPO Option, the Traditional Indemnity Option, and the Medicare Indemnity Option 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:

- Hearing aid evaluations and hearing tests (available under the PPO/POS High and Low Options in-network only, Medicare and the Traditional Indemnity Option);
- Hearing aids through age 12 up to \$2,500 every 24 months (available under the PPO/POS High and Low Options in-network only, Medicare, EPO Option, and the Traditional Indemnity Option);
- 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:
 - 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;

- Physical, occupational, speech or respiratory therapy by a licensed qualified therapist;
- Nutrition counseling provided by or under the supervision of a registered dietitian; and
- Medical supplies, laboratory services, drugs and medications prescribed by a physician.
- Jobst stockings (two pair per calendar year for the following conditions only: varicose veins, varicose ulcers, stasis dermatitis, post-phlebitic syndrome, and lymphedema);
- 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; shoe orthotic devices; (for diabetic-related conditions only); hospital bed; ventilator; iron lung ostomy 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;
- Organ and tissue transplants including replacing a non-functioning or damaged organ or tissue with a working organ or tissue from another person. Enhanced 100% benefit levels may be available at certain facilities, if the claims administrator has a specialized transplant program. Covered services include physician and hospital costs, donor search, tests to establish donor suitability, organ harvesting and procurement, and anti-rejection drugs. Eligible travel and lodging expenses for the transplant recipient and a companion are determined by the medical plan claims administrator. 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;
- 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, 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 by the claims administrator and authorized by JPMorgan Chase 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 the PPO/POS High and Low Options, the EPO Option, the Traditional Indemnity Option, and the Medicare Indemnity Option;
- Surgery for the treatment of morbid obesity when determined to be medically appropriate as determined by claims administrator guidelines;
- Urgent care;
- Voluntary sterilization; and
- Wigs, following chemotherapy or radiation, or due to a diagnosis of Alopecia.

This 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 under the PPO/POS High and Low Options, the Medicare Indemnity Option, and the Traditional Indemnity Option. 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 that's 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.
- 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, up to a maximum bereavement benefit per family unit of \$250. 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.

This list is subject to change at any time. If you are enrolled in an EPO option, please contact your option's claims administrator.

Important Note

While the services listed here are covered by the Medical Plan, they must be "medically necessary." Please see the definition of "medically necessary" in "Important Terms" beginning on page 4.

Mental Health Care/Substance Abuse Care

Under the PPO/POS High and Low Options, EPO Option, Traditional Indemnity Option, and Medicare Indemnity Option, mental health care received in-network will be coordinated through the network's referral procedure for mental health care.

If you do not use the network, you'll receive reimbursement for a portion of reasonable and customary (R&C) charges incurred for medically necessary services related to mental health care after meeting the deductible.

If you are enrolled in an EPO Option, you must use an in-network provider to receive benefits.

Infertility Treatment Procedures

There are special covered procedures under the PPO/POS High and Low Options, the EPO Option, and the Traditional Indemnity Option that induce pregnancy but do not treat the underlying medical condition. They include (but are not limited to) artificial insemination and in-vitro fertilization. Fertility services are subject to a \$20,000 combined lifetime maximum benefit. This limit applies to all benefits received from the PPO/POS High or Low Option, EPO Option, the Traditional Indemnity Option, and Medicare Indemnity Option, combined in a lifetime, 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. Please contact your option's claims administrator for specific details.

Infertility Diagnostic Services

Diagnostic services to determine or cure the underlying medical conditions are covered in the same manner as any other reasonable and customary (R&C), medically necessary services. If you use the network, the services you receive will be coordinated through your network's referral procedure for fertility services. If you do not use the network, you can visit any infertility treatment provider. If you are enrolled in an EPO Option, you must use an in-network provider to receive benefits.

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 copayments. 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.

Substance Abuse Lifetime Maximum

The \$20,000 lifetime maximum for substance abuse care applies to all benefits received from the PPO/POS High or Low Option, the Traditional Indemnity Option, and the Medicare Indemnity Options combined in a lifetime. It applies regardless of whether the service was received in-network or out-of-network.

What Is *Not* Covered Under All Medical Plan Options (Except the HMO Option)

While the Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options, the EPO Option, the Traditional Indemnity Option, and the Medicare Indemnity Option, 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 by the PPO/POS High and Low Options, Medicare, the EPO Option, or the Traditional Indemnity Option include, but are not limited to:

- Care from a person who is a member of your family or your spouse'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 as related to diabetes); or treatment of corns, calluses, or chronic foot strain;
- Cosmetic surgery treatment, except to repair damage from accident or injury; to 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;
- Donor expenses with regard to fertility 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 a copayment, the plan will not pay any benefit to you or a licensed provider);
- Expenses in excess of reasonable and customary (R&C) charges;
- 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 "Important Terms" on page 4 for the definition of "Experimental, Investigational, or Unproven Services");
- Gender reassignment surgery;
- Hospital admissions and other services that began before the participant's effective date of coverage under the Medical Plan;
- 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;
- Personal hospital services, such as television, telephone, etc.;

- Private duty nursing received on an inpatient basis;
- Refractive eye examinations for new lenses or the cost of eyeglasses or contacts;
- 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 more information about services covered under the JPMorgan Chase Dental 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;
- Treatment related to an illness or injury received as a result of war, declared or undeclared, or any act of war;
- Treatments, services, or supplies that are not medically necessary or not approved by a licensed provider; and
- Unbundled medical expenses — charges billed separately when considered by the claims administrator in its sole discretion to be part of a global procedure.

This list is subject to change at any time. If you are enrolled in an EPO option, please contact your option’s claims administrator.

The Prescription Drug Plan

If you elect coverage in the PPO/POS High or Low Option, the EPO Option, the Traditional Indemnity Option, or the Medicare Indemnity Option, your prescription drug coverage is provided through the Prescription Drug Plan, administered by Caremark. This coverage gives you the option of having prescriptions filled at a retail pharmacy or through a convenient Mail Order Program. You will receive a separate prescription drug identification (ID) card, in addition to your Medical Plan Option ID card.

For More Information on the Prescription Drug Plan

Caremark, the plan administrator, can provide answers and assistance to your questions regarding your 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 should also visit Caremark's web site at www.caremark.com via the Internet. After you register, the site allows you to:

- View your personal prescription drug history;
- Estimate retail and mail order drug costs;
- Order/refill/check the status of prescriptions being filled via the Mail Order Program;
- Look for participating retail pharmacies;
- Print temporary Caremark ID cards;
- Research drug information;
- Set up personal e-mail reminders for refills; and
- Identify prescription drug cost savings opportunities.

Prior to enrolling, you can visit www.caremark.com/jpmc for information on the Prescription Drug Plan.

Please Note: If you elect coverage under the HMO Option, please contact your HMO for information about the prescription drug coverage provided. (Please see "Claims Administrators' Contact Information" on page 80.) Each option may offer different coverage.

How the Prescription Drug Plan Works

The Prescription Drug Plan pays benefits based on discounted, in-network prices. So, if you use a pharmacy that does not accept your prescription drug plan, you'll pay more than you have to, and will be required to submit a claim form for reimbursement of eligible expenses. When you receive your personalized Prescription Drug Plan identification (ID) card, you will also receive a list of local pharmacies that participate in the network. In addition, the following provisions apply:

- **Annual Deductible for Retail Prescriptions.** An annual deductible of \$50 per individual (with a maximum of \$150 per family) applies to all prescriptions filled at retail pharmacies. You must pay this amount before the plan will begin paying benefits for retail prescriptions. (The annual deductible does not apply to mail-order prescriptions.) You only pay the deductible once per calendar year. You do not pay a deductible for each prescription you have filled.
- **Copayment for “Generic” Drugs.** You pay a copayment for generic drugs. Copayments are the portion of covered costs you must pay (expressed as a fixed dollar amount). If the cost of the drug is less than the copayment, you'll pay the lower amount.
- **Coinsurance for “Brand” Drugs.** You pay coinsurance for preferred brand drugs and non-preferred brand drugs. Coinsurance is the portion of covered costs you must pay (expressed as a percentage). (Please see the chart under “Prescription Drug Coverage Provisions” on page 63 for details on the percentage of cost the plan will pay.)
- **Per prescription maximum.** For preferred drugs and non-preferred brand drugs, the amount you will pay for each individual prescription has a maximum. This is designed as a safeguard against the cost of very expensive types of preferred brand and non-preferred brand drugs at the point an individual prescription is filled.
- **Annual out-of-pocket maximum.** This caps your annual cost under the Prescription Drug Plan for covered prescription drugs to \$2,000 per person (up to a maximum of \$6,000 for family coverage). Once you reach this limit, you do not have to pay anything further for your covered drugs for the remainder of the calendar year. The out-of-pocket maximum considers the copayments and coinsurance you pay for covered drugs. It does not include the annual retail deductible or costs for non-covered drugs such as proton pump inhibitors (PPIs) or non-sedating antihistamine (NSA) drugs. **Please Note:** This maximum is not combined with Medical Plan out-of-pocket costs/limits.

Please see the chart under “Prescription Drug Coverage Provisions” on page 63 for further details of coverage provisions under the Prescription Drug Plan.

What Is a “Preferred” Brand Drug?

If there is not generic drug available, there may be more than one brand name drug to treat a condition.

“Preferred” brand drugs, sometimes called formulary drugs, have been determined by Caremark to be clinically appropriate and cost effective. Non-preferred brand drugs are considered by Caremark to be less cost effective and are therefore covered at a lower benefit level. If you and/or one of your dependents is currently taking a brand drug, please visit www.caremark.com via the Internet or speak with a Caremark Customer Care Representative at 1-866-209-6093 to determine if the drug is preferred or non-preferred and to estimate costs for specific drugs.

Brand vs. Generic Drugs

Federal law requires both generic and brand drugs to meet the same standards of strength, dosage, safety, and effectiveness. Generic drugs typically cost less than brand name drugs and are generally considered to be equally as effective.

Brand Drugs: *Drugs that are manufactured and marketed under a product name by a pharmaceutical company. Typically, the company holds a patent on the drug's chemical components for a specified period of time.*

Generic Drugs: *According to the U.S. Food and Drug Administration (FDA), a generic drug is a copy that is identical to a brand-name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use.*

Receiving Benefits

Retail Network Pharmacy Benefits

These benefits are available through participating retail network pharmacies only. Your retail network purchases are limited to a 30-day supply for each prescription filled. Prescriptions of a longer duration are generally filled through the Mail Order Program.

If a pharmacy's reasonable and customary (R&C) price is less than the copayment for any generic drug, you'll pay the lower price.

If the drug is only dispensed in a package exceeding a 30-day supply, coinsurance or a copayment applies to each 30-day supply. For example, you'll pay three copayments if a generic drug is packaged in a 90-day supply.

Retail Non-Network Benefits

If you purchase your prescription drugs through a non-network pharmacy or do not show your Caremark identification (ID) card at a network pharmacy, you will have to pay for the prescription and then file a claim form for reimbursement. The Prescription Drug Plan will reimburse you the same amount it would have paid to a participating pharmacy. You will pay the difference between what the non-network pharmacy charges and what the plan reimburses.

Claim forms for reimbursement are available on Company Home > HR & Personal > Pay & Benefits > Library > Claim Forms & Filing Tips, or by calling Caremark Customer Care at 1-866-209-6093. Please mail your completed claim form to:

Caremark Claims Department
P.O. Box 686005
San Antonio, TX 78268-6005

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

Mail Order Program

The Caremark Mail Order Program is designed to provide you with discounted long-term maintenance drugs through the mail. Some examples of long-term maintenance drugs are those used to control or treat:

- Arthritis;
- High cholesterol;
- Diabetic conditions; and
- High blood pressure.

There is no annual deductible for prescription drugs purchased through the Mail Order Program.

Please Note: Although proton pump inhibitor (PPI), H₂ Blocker, and non-sedating antihistamine (NSA) drugs are not covered under the Prescription Drug Plan, you can still obtain these and other non-covered drugs (versus the over-the-counter alternative) with a prescription from your doctor at discounted prices through the Mail Order Program.

Important Reminder

Prescription drug benefits are based on discounted, in-network pharmacy prices. So, 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 will be required to submit a claim form for reimbursement of the eligible expense.

Your mail order copayment covers up to a 90-day supply of your prescription. An order form is available on Company Home > HR & Personal > Pay & Benefits > Claim Forms & Filing Tips, or by calling Caremark Customer Care at 1-866-209-6093. Please mail your prescriptions with your completed order form to:

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

Use the Mail Order Program for Long-Term/Maintenance Drugs

If your doctor prescribes your drug for 90 days or longer, consider asking him or her for a prescription that can be submitted to the Caremark Mail Order Program. Not only can you get a 90-day supply delivered conveniently right to your home address, but you will generally pay less out of pocket than you would pay for the same supply at a retail pharmacy. You can find information on how to have prescriptions filled through the Mail Order Program at www.caremark.com via the Internet.

Availability of the Mail Order Program Outside the United States

The Caremark Mail Order Program is not available to PPO/POS High and Low Option, EPO Option, Traditional Indemnity Option, and Medicare Indemnity Option, participants who live outside the domestic United States. Because of this limitation, the retail network drug benefit is available to participants who reside outside the domestic United States for a 90-day supply after filing a claim form for reimbursement with Caremark.

Prescription Drug Coverage Provisions

The table below shows how drugs are covered under the Prescription Drug Plan

Prescription Drug Coverage Provisions

Retail (up to a 30-day supply)

Annual Deductible	You pay \$50 per individual (\$150 maximum for family coverage)
Generic	You pay a \$10 copayment or actual cost of drug if less than \$10 (JPMorgan Chase pays the balance of costs)
Preferred* Brand	You pay 30% coinsurance up to \$100 per prescription maximum (JPMorgan Chase pays 70% coinsurance plus costs above per prescription maximum)
Non-Preferred* Brand	You pay 45% coinsurance up to \$150 per prescription maximum (JPMorgan Chase pays 55% coinsurance plus costs above per prescription maximum)

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Prescription Drug Coverage Provisions

Mail Order (up to a 90-day supply)

Annual Deductible	None
Generic	You pay a \$20 copayment or actual cost of drug if less than \$20 (JPMorgan Chase pays the balance of costs)
Preferred* Brand	You pay 30% coinsurance up to \$250 per prescription maximum (JPMorgan Chase pays 70% coinsurance plus costs above per prescription maximum)
Non-Preferred* Brand	You pay 45% coinsurance up to \$375 per prescription maximum (JPMorgan Chase pays 55% coinsurance plus costs above per prescription maximum)
Annual Out-of-Pocket Maximum	\$2,000 per individual (\$6,000 maximum for family coverage); includes copayments and coinsurance for covered drugs; does not include the annual retail deductible or costs for non-covered drugs. Also, not combined with JPMorgan Chase Medical Plan out-of-pocket costs/limits. (JPMorgan Chase pays the balance of costs above the annual out-of-pocket maximum.)

* "Preferred" brand drugs, sometimes called "formulary" drugs, have been determined to be therapeutically equivalent to non-preferred brand drugs, but more cost effective than their non-preferred counterparts. Therefore, preferred brand drugs are covered at a higher benefit level.

Types of Drugs Covered and Not Covered Under the Plan

The following chart shows types of certain common drugs and their current coverage status (“covered” or “not covered”) under the Prescription Drug Plan. For the most current information on the types of drugs covered under the plan, please visit www.caremark.com via the Internet. **This list may change at any time.**

Type of Drug:	Status Under the Plan:
	Covered
Acne Medications (such as Retin-A, Differin, Tazorac, Tretinoin, Avita)	Covered through age 35; then prior authorization required
Contraceptives	Covered
Diabetic Supplies	Covered — except alcohol wipes and glucose monitors
Diet Medications (anorexiant and anti-obesity)	Covered but requires prior authorization
Fertility Drugs (exclusive of treatment)	Covered up to a \$10,000 lifetime maximum (combined retail and mail order) per person
Growth Hormones	Covered but requires prior authorization as being used pursuant to Federal Drug Administration (FDA) and the manufacturer's guidelines for the diagnosis in question
Legend Vitamins	Covered
Male Impotency Drugs	Covered at 8 units per 30 days (24 units per 90 days using mail order)
Mifeprex	Not Covered
Prescription Smoking Cessation Products	Covered
Raptiva	Covered but requires prior authorization
Respiratory Therapy Supplies	Covered — except nebulizers
Xolair	Covered but requires prior authorization

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The JPMorgan Chase Drug List

If you don't currently have a prescription, but anticipate that you will need one the next time you visit your doctor, consider bringing along a copy of the JPMorgan Chase "Drug List" to your appointment. This is a list of preferred brand drugs that are selected based upon providing the most cost effective option for your needs. This list is not all-inclusive — but instead represents the most commonly used drugs. Because the list is typically updated every three months in January, April, July, and October, please ensure that you have the most current list when you talk with your doctor. You can access the JPMorgan Chase list from www.caremark.com via the Internet.

Type of Drug:	Status Under the Plan:
	Not Covered
Allergy Serums	Not Covered
Blood Plasma/Blood Transfusion Agents	Not Covered
Botox and Myoblock	Not Covered for cosmetic purposes; requires prior authorization for other uses
Cosmetic Products (such as depigmenting agents, hair growth stimulants, hair removal agents)	Not Covered
H ₂ Blockers (such as Pepcid AC)	Not Covered*
Non-Sedating Antihistamines (NSAs) (such as Clarinex and Allegra)	Not Covered
Nutritional Supplements (injectable or oral)	Not Covered
Proton Pump Inhibitors (PPIs) (such as Prilosec OTC Tagamet, and Nexium)	Not Covered*
Renova	Not Covered
Rx Devices other than respiratory (such as elastic bandages and supports, GI-GU ostomy and irrigation supplies, other Rx devices)	Not Covered
Vaccines/Toxoids	Not Covered

* Capsule and liquid forms of H₂ Blocker and PPI drugs are covered for plan participants age six and younger who may have difficulty swallowing over-the-counter medicines that are only available in tablet form. In addition, coverage for these drugs may be available for those suffering from Barrett's Esophagus, Severe Erosive Esophagus, or Pathological Hypersecretory conditions (such as Zollinger-Ellison, Systemic Mastocytosis, and Multiple Endocrine Adenomas). Individuals (or their representatives) diagnosed with one of these conditions should contact Caremark at 1-866-209-6093 about the documentation required from a doctor to be considered for a coverage exception.

Important Note

Because safe and effective over-the-counter alternatives are now available (e.g., Prilosec OTC, Pepcid AC, and Claritin), the JPMorgan Chase Prescription Drug Plan no longer covers proton pump inhibitors (PPIs), H₂ Blocker drugs, or non-sedating antihistamine (NSA) drugs. While individuals and their doctors may have a preference for certain medications, the applicable over-the-counter drugs are generally recognized as being therapeutically interchangeable with their branded prescription counterparts when used in equivalent doses.

Please Note: Capsule and liquid forms of PPIs and H₂ Blocker drugs will continue to be covered for plan participants age six and younger who may have difficulty swallowing over-the-counter medicines that are only available in tablet form. In addition, coverage for these drugs may be available for those suffering from Barrett's Esophagus, Severe Erosive Esophagitis, or Pathological Hypersecretory Conditions (such as Zollinger-Ellison, Systemic Mastocytosis, and Multiple Endocrine Adenomas). Individuals diagnosed with one of these conditions should contact a Caremark Customer Care Representative at 1-866-209-6093 about the documentation required from your doctor to be considered for a coverage exception.

Special Medical Plan Options If You're Disabled and Eligible for Medicare

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. (Please see “Determining Primary Coverage” on page 75 for more information on coordination of benefits with Medicare.) In addition, you are 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;
- Medicare Advantage Health Maintenance Organization (HMO) Option*, if available;
- Medicare Supplement Health Maintenance Organization (HMO) Option*, if available; and
- Medicare Supplement Exclusive Provider Organization (EPO) Option*, if available.

* In some areas, an Exclusive Provider Organization (EPO) may be offered in addition to or in lieu of an HMO. EPOs work much like an HMO in that there are no out-of-network benefits in an EPO except for emergency care. However, state-mandated benefits and eligibility exceptions may apply to an HMO but not an EPO. Your Medical Plan ID card may indicate HMO even if the option operates as an EPO.

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 one individual is disabled and eligible for Medicare and the others are not. This is called “split coverage.” However, at all other times everyone must be covered under the same option.

If you are eligible for the Medicare options listed above, you will be notified.

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. See the chart under “How the Medicare Indemnity Options Pay Benefits” on page 69 to compare the key provisions of the two Medicare Indemnity Options.

An Important Note on the Plan's Lifetime Maximum

The Medical Plan's lifetime maximum (overall, fertility services and substance abuse care) reflects services received across the following plans:

- PPO/POS High or Low Option
- Traditional Indemnity Option
- Medicare Indemnity Options combined

You do not gain a new maximum if you switch your coverage between options.

Important Note

Any benefits that have been applied to a lifetime maximum provision under a medical plan of your heritage organization will be applied to the lifetime maximums of the JPMorgan Chase Medical Plan.

With the Medicare Indemnity High Option:

- You can use any doctor you like at any time and still receive benefits for covered services.
- Benefits begin after you meet an annual deductible.
- Preventive care benefits are provided up to \$200 per year without paying a deductible.
- You must notify the claims administrator before a non-emergency hospital admission.
- Claim forms are required.
- There are limits on your annual out-of-pocket expenses.

Medicare Indemnity Low Option

This option differs from the Medicare Indemnity High Option in the amount of your contributions, your deductibles, and some covered expenses. 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 out-of-pocket 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 chart under "How the Medicare Indemnity Options Pay Benefits" on page 69 to compare the key provisions of the two Medicare Indemnity Options.

With the Medicare Indemnity Low Option:

- You can use any doctor you like at any time and still receive benefits for covered services.
- Benefits begin after you meet an annual deductible.
- You need to notify the claims administrator before a non-emergency hospital admission.
- Claim forms are required.
- There are limits on your annual out-of-pocket expenses.
- Your contributions for coverage are lower than under the Medicare Indemnity High Option. However, you have higher deductibles and out-of-pocket maximums, and the plan reimburses a lower percentage of eligible expenses.

How the Medicare Indemnity Options Pay Benefits

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

Benefit Provision	Medicare Indemnity High Option	Medicare Indemnity Low Option
Annual Deductible	\$500 individual \$1,000 individual + one \$1,000 individual + children \$1,500 family	\$1,500 individual \$3,000 individual + one \$3,000 individual + children \$4,500 family
Coinsurance Percentage	90%	85%
Annual Out-of-Pocket Maximum*	\$2,500 individual \$5,000 individual + adult \$5,000 individual + children \$7,500 family	\$5,000 individual \$10,000 individual + adult \$10,000 individual + children \$15,000 family
Lifetime Maximum**	\$2,000,000 per individual	\$2,000,000 per individual
Outpatient Services		
Routine Exams	100% coverage; maximum \$200 per year; combined maximum with well-child care; not subject to deductible	Not covered
Well-Child Care	100% coverage; maximum \$200 per year; combined maximum with routine exams; not subject to deductible	85% coverage after deductible
Doctor's Office Visits (Includes tests, supplies, and other services authorized by the plan and provided during the visit, consultations, specialist referrals, and second surgical opinions.)	90% coverage after deductible	85% coverage after deductible
X-rays and Labs (When performed to diagnose a medical problem or treat an illness or injury.)	90% coverage after deductible	85% coverage after deductible
Routine Mammograms (Check with claims administrator for age and frequency limitations.)	100% coverage; maximum one per calendar year	100% coverage; maximum one per calendar year

* Excludes annual deductible.

** Combined lifetime maximum across all Medical Plan Options.

All percentages above generally apply to reasonable and customary charges and Medicare-allowable charges. You are responsible for 100% of all expenses above reasonable and customary charges.

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Benefit Provision	Medicare Indemnity High Option	Medicare Indemnity Low Option
Outpatient Services (continued)		
Fertility Services (Includes diagnostic procedures, in vitro fertilization, artificial insemination, etc.; limited to maximum of \$20,000/lifetime for each covered individual.)	90% coverage after deductible	85% coverage after deductible
Routine Eye Exams	Not covered	Not covered
Speech, Physical, or Occupational Therapy (Limited to a maximum of 40 visits/calendar year per therapy type.)	90% coverage after deductible	85% coverage after deductible
Chiropractic Care (Must be medically necessary; coverage ends when medical recovery is achieved and treatment is for maintenance or managing pain; limited to a maximum of 20 visits/calendar year.)	90% coverage after deductible	85% coverage after deductible
Mental Health Care (Limited to Maximum of 40 visits/calendar year.)	90% coverage after deductible	85% coverage after deductible
Substance Abuse Care (Limited to \$20,000/lifetime maximum for inpatient and outpatient care for each covered individual.)	90% coverage after deductible	85% coverage after deductible
Inpatient Services		
Acute Hospital Care	90% coverage after deductible	85% coverage after deductible
Skilled Nursing Facility (Limited to maximum of 120 days/lifetime for each covered individual.)	90% coverage after deductible	85% coverage after deductible
Hospice Care	90% coverage after deductible	85% coverage after deductible
Mental Health Care (Limited to a maximum of 30 days/calendar year.)	90% coverage after deductible	85% coverage after deductible
Substance Abuse Care (Limited to a maximum of \$20,000/lifetime for inpatient and outpatient care for each covered individual.)	90% coverage after deductible	85% coverage after deductible

All percentages above generally apply to reasonable and customary charges and Medicare-allowable charges. You are responsible for 100% of all expenses above reasonable and customary charges.

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Benefit Provision	Medicare Indemnity High Option	Medicare Indemnity Low Option
Other Services		
Emergency Room (For sudden and serious medical conditions approved by claims administrators as required for emergency care.)	90% coverage after deductible	85% coverage after deductible
Home Health Care (Medically necessary only; may require pre-certification; limited to maximum of 200 visits/calendar year; one visit = four hours.)	90% coverage after deductible	85% coverage after deductible
Durable Medical Equipment and Prosthetics	90% coverage after deductible	85% coverage after deductible
Prescription Drugs	Please see “The Prescription Drug Plan” on page 60.	Please see “The Prescription Drug Plan” on page 60.

All percentages above generally apply to reasonable and customary charges and Medicare-allowable charges. You are responsible for 100% of all expenses above reasonable and customary charges.

Other Provisions

Please see “How the Traditional Indemnity Option Works” on page 43 for hospital notification, and the preferred provider feature. You should also review “What Is Covered Under All Medical Plan Options (Except the HMO Option)” on page 50 to review what the Indemnity Plans cover.

Medicare HMOs and EPOs for Medicare-Eligible Retirees

JPMorgan Chase offers a number of HMOs and EPOs that provide coverage for participants who are Medicare-eligible. Most of these HMOs and EPOs are designed to coordinate benefits with Medicare. (Please see “Determining Primary Coverage” on page 75.) There are two kinds of HMO-type plans offered to Medicare-eligible retirees:

- Medicare Advantage Plans (HMOs only); and
- Medicare Supplement Plans (HMOs and EPOs).

If you enroll in one of the HMO plans, you will receive separate materials directly from the HMO in which you enroll, including a Summary Plan Description specific to that HMO. These materials will provide specific details on your HMO’s benefits, including your rights as a plan participant. For more information about how HMOs and EPOs work, see “The Health Maintenance Organization (HMO) Option and the Exclusive Provider Organization (EPO) Option” on page 38.

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.

Medicare Supplement Plans (HMO and EPO)

The Medicare Supplement Plans (HMO and EPO) supplement the benefits of Original Medicare (Medicare Part A and Part B). These options are designed to coordinate benefits with Medicare and typically provide additional benefits in areas where Medicare has limited coverage (such as hospital deductibles and prescription drug coverage).

Medicare Overview

Medicare is a federal health insurance program designed to assist disabled people and senior citizens in paying for some of their medical care. Medicare is composed of 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., semiprivate 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 2006 monthly premium for Medicare Part B is \$88.50 (premiums are subject to change on an annual basis).
- **Medicare Part D (Medicare Prescription Drug Program).** Effective January 1, 2006, a new Medicare Prescription Drug Program (Medicare Part D) was added to the current 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.

Medicare has outlined a “standard” way that Medicare prescription drug plans will 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.

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.

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 the Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options, the EPO Option, the Traditional Indemnity Option, and the Medicare Indemnity Option. (The HMO Option may also have rules for coordinating benefits. Contact your HMO Option directly for details.) 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 claims administrator for help. (Please see "Claims Administrators' Contact Information" on page 80.)

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 — the Traditional Indemnity Option (which we'll assume is your spouse/domestic partner's secondary coverage) — 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 Traditional Indemnity Option 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:

- As an active JPMorgan Chase employee, the Medical Plan will be primary for you and consider claims for your medical expenses first. Even if you or a covered dependent becomes entitled to Medicare while you're an active employee, the Medical Plan will remain the primary plan.
- If your covered dependent has a claim, the plan covering your dependent as an employee will be considered primary to this plan.
- If your claim is for a covered dependent 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 month and birthday only) 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 dependent child. If there is no court decree, the plan of the parent who has custody of the covered dependent child will be considered primary for the covered dependent child. (Please see "Qualified Medical Support Orders" on page 77 for more information on a qualified medical child support order.)
- 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 your benefits coordinate with Medicare if you or a covered dependent are Medicare-eligible due to a disability, or because you or the dependent have end stage renal disease (ESRD). For information about how the Medical Plan and Medicare coordinate if you work as an active employee after age 65, see "If Your Situation Changes" on page 82.

Coordination with Medicare Parts A and B If You Are Disabled

Entitlement to Medicare coverage is automatic for anyone who receives Social Security Disability Income for 24 months. (You 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). These provisions also apply to your Medicare-eligible dependents if you are disabled.

Here's an example of how coordination of benefits works between Medicare and the JPMorgan Chase Medical Plan if you are disabled and become entitled to Medicare, using the following assumptions:

- You have \$1,000 in eligible medical expenses, not including outpatient prescription drugs;
- These expenses are covered under Medicare Part B at 80%;
- You participate in the Medicare Indemnity High Option, which generally covers 90% of eligible expenses; 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 Medicare, no additional benefits would be payable.)
- This means that you are responsible for the remaining \$100 of total expenses.

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. For details on how coverage under the Medical Plan coordinates with coverage under Medicare if you work as an active JPMorgan Chase employee past age 65, please see "If Your Situation Changes" on page 82 for more information.

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

* 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, 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 do not elect Medicare Part B, benefits for the Medicare-eligible individual will be provided on a Medicare primary basis.

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. Your JPMorgan Chase Medical Plan coverage pays secondary. 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).

Qualified Medical Support Orders

The Medical Plan recognizes qualified medical support orders that satisfy certain requirements. Medical support orders are orders issued by a court of competent jurisdiction or issued through a state administrative process or state government and, with respect to a child of an employee, provide for health care coverage or enforce a law related to medical child support. If the order satisfies the plan's procedural requirements and certain legal requirements, then the child will be enrolled for coverage. A participant or beneficiary may obtain a description of the procedures governing medical support order determinations, without charge, from JPMorgan Chase, through the Benefits Call Center.

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. Assignment of your claim to a third party does not exempt you from your responsibility for repayment of overpayments.

Subrogation of Benefits

The purpose of the Medical Plan is to provide benefits for eligible medical expenses that are not covered by any third party. If a covered person or agency receives payment from any third party for any medical expenses that have already been paid by the Medical Plan, the covered person or agency will have to reimburse the Medical Plan for the full amount of those expenses. However, if the payment received from the third party (minus attorney's fees and other legal expenses) is not enough to reimburse the Medical Plan for the full amount it paid in benefits, the covered person will have to reimburse the plan with the amount that is left after attorney's fees and other legal expenses are paid. This is known as subrogation of benefits. The Medical Plan has the right to pursue subrogation against any person or insurer. The covered person agrees to help the plan use this right when requested.

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.

Claiming Benefits

The following explains when and how to file claims for medical expenses under the Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options and the Traditional Indemnity Option. If you're enrolled in an HMO/EPO, you usually don't need to file a claim.

Your Medical Identification (ID) Card

If you elect coverage under a Preferred Provider Organization (PPO)/Point-of-Service (POS) Option, an Exclusive Provider Organization (EPO) Option, the Traditional Indemnity Option, prescription drug benefits will be administered by Caremark, and you will receive two separate ID cards (one for medical services and the other for prescription drug benefits). If you elect coverage under an HMO Option, prescription drug benefits will be administered by the HMO, and you will only receive one ID card from your HMO.

Please Note: In some cases, your ID card may show a plan name that differs from the name JPMorgan Chase has given that plan. For example, your ID card may indicate HMO even if the option operates as an EPO. (You can access the Benefits Web Center to determine whether an option is an HMO or EPO.)

When Claim Forms Are Required

Rules regarding claims depend on which Medical Plan option you're enrolled in and where you receive your care, as follows:

PPO/POS High and Low Options	<ul style="list-style-type: none">• In-Network Benefits: You generally do not have to file a claim form.• Out-of-Network Benefits: You must file a claim form. Once the claims administrator has reviewed and approved your completed claim form, you'll be reimbursed for the appropriate portion of the cost. Claim forms for out-of-network benefits are available on Company Home > HR & Personal > Pay & Benefits > Claim Forms and Filing Tips or from your claims administrator upon request. <p>Please Note: For preferred network providers, claims processing times may vary. Please contact your claims administrator for further details. Please see "Claims Administrators' Contact Information" on page 80 for more information.</p>
HMO/EPO Option	<ul style="list-style-type: none">• You generally do not have to file a claim form.
Traditional Indemnity Option and Medicare Indemnity High and Low Options	<ul style="list-style-type: none">• You must file a claim form. Once the claims administrator has reviewed and approved your completed claim form, you'll be reimbursed for the appropriate portion of the cost.• Claim forms are available on Company Home > HR & Personal > Pay & Benefits > Claim Forms and Filing Tips or from your claims administrator upon request. Please see "Claims Administrators' Contact Information" on page 80 for your claims administrator's contact information.
Prescription Drug (PPO/POS, EPO, and Indemnity Options)	<ul style="list-style-type: none">• You must file a claim form if:<ul style="list-style-type: none">— You purchase your prescription drugs through a non-network pharmacy; or— You do not show your Caremark ID card at a network pharmacy. In this case, you will have to pay for the prescription and then file a claim form for reimbursement.• Reimbursement forms are available on Company Home > HR & Personal > Pay & Benefits > Claim Forms and Filing Tips, or by calling Caremark at 1-866-209-6093.

How to File Claims

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. Separate claim forms must be submitted for each family member for whom a claim is made. After you submit a claim, you will receive a written explanation of how the benefit was paid.

Here's how different types of services should be treated:

- **Non-Hospital Services.** Present your medical ID card. You should file a claim when you or your covered dependents incur eligible expenses. It's not necessary to accumulate claims to meet your annual deductible before filing your claim forms.
- **Hospital Services.** If you're admitted to the hospital, present your medical ID card. The hospital will submit claims directly to the claims administrator. The hospital will bill you for the portion of expenses you are responsible for that are not covered by the Medical Plan.

Where to Submit Claims

Where you send your completed claims depends on which Medical Plan option you're enrolled in and which organization administers your claims.

The claims administrator contact information for the PPO/POS High and Low Options, Traditional Indemnity Option, Medicare Indemnity Option, and the Prescription Drug Plan is listed in the following table.

Claims Administrators' Contact Information

Claims Administrator	Address and Telephone Number
Preferred Provider Organization (PPO)/Point-of-Service (POS) High and Low Options	
UnitedHealthcare — National (all states not listed below)	UnitedHealthcare JPMorgan Chase Dedicated Service Center P.O. Box 740800 Atlanta, GA 30374-0800 1-800-272-8970
Empire BlueCross BlueShield Louisiana, Michigan, Western New York	Empire BlueCross BlueShield P.O. Box 5075 Middletown, NY 10940-9075 1-866-446-1532
Anthem BlueCross BlueShield Ohio, Indiana, Kentucky	Anthem BlueCross BlueShield P.O. Box 37010 Louisville, KY 40233-7010 1-866-236-4372
Aetna, Inc. Texas, Delaware, Maryland, West Virginia	Aetna, Inc. P.O. Box 981109 El Paso, TX 79998-1109 1-888-238-6275
Health Maintenance Organization (HMO) Option	Refer to the "Plan Administration" section of this Guide.
Exclusive Provider Organization (EPO) Option	Refer to the "Plan Administration" section of this Guide.
Traditional Indemnity Option (including Medicare Indemnity Options)	
UnitedHealthcare	UnitedHealthcare JPMorgan Chase Dedicated Service Center P.O. Box 740800 Atlanta, GA 30374-0800 1-800-272-8970
Prescription Drug (PPO/POS, EPO, and Indemnity Options)	
Prescription Drug Plan	Caremark P.O. Box 659576 San Antonio, TX 78265-9576 1-866-209-6093

Appealing Claims

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

JPMorgan Chase is not involved in deciding appeals for any benefit claim denied under the EPO and HMO Options of the Medical Plan. All fiduciary responsibility and decisions regarding a claim for a denied benefit under these plans rest solely with the applicable claims administrator.

Additional Plan Information

Your primary contact for all matters relating to the general administration of the JPMorgan Chase Medical Plan is the Benefits Call Center.

Your benefits as a participant in the Medical Plan (and Prescription Drug Plan) are provided under the terms of the official plan text and insurance policies, and/or contracts, if any, issued to JPMorgan Chase. If there is any discrepancy between the official plan documents and this summary, the official plan documents control.

Please Note: No person or group (other than the claims administrator, plan administrator, or Employee Benefits Appeals Committee for the JPMorgan Chase Benefits Program) has any authority to interpret the terms of the written Medical Plan document (or other plan documentation) or to make any promises to you about them. The claims administrator or Employee Benefits Appeals Committee has complete authority in their 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 claims administrator and Employee Benefits Appeals Committee for the JPMorgan Chase Benefits Program are final and binding upon all affected parties.

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 at the end 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 as amended (COBRA). (Please see the “Plan Administration” section of this Guide for more information on COBRA.)
If You Go on Disability Leave	Under the Disability Leave Policy, 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 semimonthly rate 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 on an after-tax basis.) You will pay for this coverage on a direct-bill basis with JPMorgan Chase. Your medical coverage will continue while you are receiving LTD benefits under the LTD Plan. Be sure to consider this carefully before you decline coverage under the LTD Plan. (Please see the “Long-Term Disability” section of this Guide for more information.)
If You Go on Unpaid Leave	For an approved leave of absence, you’ll still be covered by the Medical Plan. 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 (unless you leave JPMorgan Chase due to retirement). However, under certain circumstances, you may 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.) Expenses incurred after you leave JPMorgan Chase cannot be reimbursed by the Medical Plan unless you choose to continue your participation under COBRA.

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<p>If You Leave JPMorgan Chase (continued)</p>	<p>If you receive severance under the Severance Pay Plan and sign a Release, any elected medical coverage (and/or Employee Assistance Program coverage) may continue at active employee rates on a before-tax basis through the period you receive severance payments. When your severance payments end, you may elect to continue medical coverage and/or Employee Assistance Program coverage under COBRA for up to 18 months.</p> <p>The Medical Plan and Employee Assistance Program do not cover health care services or supplies you receive after your coverage ends, unless you continue your coverage under COBRA.</p>
<p>If You Retire from JPMorgan Chase</p>	<p>You need to meet minimum age and service requirements and have active medical coverage at the time of retirement to be eligible for retiree medical coverage. For more information, please refer to the As You Retire Guide available on Company Home > HR & Personal > Pay & Benefits > Library.</p>
<p>If You Work Past Age 65</p>	<p>If you continue to work for JPMorgan Chase after you reach age 65 (and/or if your spouse reaches age 65 while you're still working at JPMorgan Chase), you and your spouse can continue to be covered under the Medical Plan. If you or your spouse enrolls in Medicare at that time, Medicare coverage will provide secondary benefits to the JPMorgan Chase Medical Plan.</p> <p>If you're covered under both the Medical Plan and Medicare, you need to submit your claims for benefits 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.</p> <p>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 when you leave JPMorgan Chase. For more information about Medicare, contact your local Social Security office.</p>
<p>If You Divorce or Become Legally Separated</p>	<p>If your spouse and/or dependent 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.)</p> <p>If you divorce or become legally separated, certain court orders could require you to provide medical benefits to covered dependent 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. See "Qualified Medical Support Orders" on page 77 for more information.</p>
<p>If You Die</p>	<p>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 end 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.)</p>

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If You Die (continued)

In addition, any dependents who were enrolled in the Medical Plan at the time of your death 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 Company Home > HR & Personal > Pay & Benefits > Library.); 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** available on Company Home > HR & Personal > Pay & Benefits > Library); 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** for details of these additional requirements.

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 (unless you are receiving severance benefits under the Severance Pay Plan);
- You no longer meet the eligibility requirements of the Medical Plan;
- The Medical Plan is discontinued;
- Your long-term disability benefits under the Long-Term Disability Plan end; or
- You die.

Coverage for your dependents ends when they no longer meet the eligibility requirements described in “Your Eligible Dependents” on page 13. For your spouse, this means the end of the month in which you die (unless you are eligible for retiree medical coverage) or divorce. For a dependent child, this means the end of the month in which he or she:

- Turns age 23 (except for those states that mandate coverage to a later age for those enrolled in an HMO plan, as defined by JPMorgan Chase). Please see “Your Eligible Dependents” on page 13 for more information;
- Marries;
- Is no longer dependent on you for support; or
- Is no longer eligible for coverage under a Qualified Medical Child Support Order (QMCSO).

Coverage for a qualified adult ends at the end of the month in which the qualified adult ceases to meet the eligibility requirements described in “Your Eligible Dependents” on page 13.

Please see “If Your Situation Changes” on page 82 for details on how coverage is affected in certain situations.

Continuing Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA), you and your covered dependents have the right to continue medical coverage at your own expense (102% of the full cost) for a certain period of time if your JPMorgan Chase-provided coverage ends. (For qualified adult dependents, JPMorgan Chase may provide COBRA-like coverage if the qualified adult was covered under the JPMorgan Chase Medical Plan at the time that coverage ended.) 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.

Converting to an Individual Policy

By converting your medical coverage to an individual policy, you and/or your dependents purchase an individual policy directly from the claims administrator. If the plan you are enrolled in is a fully-insured HMO option, you may be able to convert to an individual policy. Conversion is not available under the other plan options. See the “Plan Administration” section of this Guide to determine whether your plan is fully insured.

You and your eligible dependents may convert medical coverage to an individual policy either:

- Within 31 days of termination of employment, in lieu of choosing COBRA continuation coverage; or
- Within 31 days of the termination of COBRA continuation coverage.

You may not convert to an individual policy if COBRA coverage ends because other group coverage is obtained or if coverage is terminated because of non-payment of COBRA contributions.

Contact your option's claims administrator for more information about converting your coverage and the rates for an individual policy. Please see “Claims Administrators' Contact Information” on page 80 for more information.

The Employee Assistance Program (EAP)

Regardless of your decisions around JPMorgan Chase Medical Plan coverage, the Employee Assistance Program (EAP) is available to help you and your eligible dependents with concerns about stress, depression, or anxiety; marital, relationship, or family problems; alcohol or drug abuse; job-related conflicts; and financial or legal difficulties. Counselors are professionally trained, licensed, or certified mental health professionals.

The EAP counselor will help you assess your situation to determine a direction to resolve the problem, which can include short-term counseling, stress management training, and/or referral to outside resources. All services provided by the EAP are free. 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 EAP is voluntary and completely confidential as required by law and JPMorgan Chase policy. On-site EAP counselors are available at:

On-site EAP Locations	
New York, NY	1-212-464-2685
Chicago, IL	1-312-732-6266
Columbus, OH	1-614-248-9511
Elgin, IL	1-847-488-5610
Phoenix, AZ	Downtown: 1-602-221-4537 S.H.O.C.: 1-602-627-8737
Tempe, AZ	1-480-902-6150
Westerville, OH	1-614-244-6779
Wilmington, DE	1-302-282-1353

All Other Domestic Locations and Canada

Call the off-site provider, ComPsych, at 1-800-276-0760. TDD: 1-800-697-03531

When EAP 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 as amended (COBRA).

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

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 Executive Vice President, Compensation and Benefits. 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 of employment or a guarantee of employment between JPMorgan Chase and any employee.

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