

The Dental Plan

The Dental Plan is designed to provide you and your family with access to high quality, cost-effective dental care. The plan offers coverage for you and your enrolled dependents for a wide range of preventive care, basic and major restorative care, and orthodontia dental services (for children under age 19 only), depending on the option you choose.

This section will provide you with a better understanding of how your Dental 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.

Important Terms

As you read this summary of the JPMorgan Chase Dental 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.

Terms	Definition
Abutment	A tooth or root that retains or supports a bridge, or removable prosthesis.
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 for 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>
Bitewing	Dental X-ray showing approximately the coronal (crown) halves of the upper and lower teeth.
Bridge	A prosthesis restoring the continuity of the dental arch by replacing one or more artificial teeth suspended between — and attached to — abutments that provide support and stability.
Claims Administrator	The company, or its affiliate, that provides certain claims administration services for the Dental Plan.
Coinsurance	The way you share costs for certain coverage options after you meet the annual or lifetime deductible. Certain Dental Plan options pay either a percentage of reasonable and customary (R&C) charges or a percentage of the in-network dentist's negotiated fees for covered services, and you pay the remainder. The actual percentage depends on the option you've chosen and the type of covered service.
Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA)	A federal law that allows you and/or your covered dependents to continue Dental 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.

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Terms	Definition
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). • Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee). These rules do not apply to any private insurance you may have.
Covered Expenses	<p>The reasonable and customary (R&C) charges for necessary covered services or supplies that qualify for full or partial reimbursement under the Dental Plan option.</p>
Covered Services	<p>Dental procedures that are generally reimbursable by the JPMorgan Chase Dental Plan when they are "necessary." (See the definition of "necessary services" in this section.) While the plan provides coverage for numerous services and supplies, there are limitations on what's covered. For example, a crown, bridge, or gold restoration is not covered if a tooth was prepared for it before the person became covered under the Dental Plan. So, while a service or supply may be necessary, it may not be covered under the JPMorgan Chase Dental Plan. Please see "What Is Covered" on page 25 for more details.</p>
Deductible	<p>The amount you pay in a calendar year for covered expenses before the Preferred Dentist Program (PDP) Option or the Traditional Indemnity Option begins to pay benefits. Amounts in excess of reasonable and customary (R&C) charges do not count toward the deductible.</p>
Denture	<p>Artificial teeth replacing missing natural teeth.</p>
Eligible Dependents	<p>Under the Dental Plan, your eligible dependents can include your spouse, a qualified adult dependent (including a domestic partner or an extended family member), and your dependent children. Please see "Your Eligible Dependents" in the "Medical Plan" section of this Guide for more information.</p>
Explanation of Benefits (EOB)	<p>A statement that the claims administrator prepares, which documents your claim and provides a description of benefits paid and not paid under the Dental Plan.</p>
Fully-Insured	<p>Dental Plan options for which the benefit payments are the responsibility of the insurance carrier (DMO and DHMO).</p>

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Terms	Definition
In-Network/ Out-of-Network	Terms referring to whether a covered service is performed by a dentist who is part of the network associated with the Dental Plan (“in-network”) or by a dentist 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 Annual Benefit	The most the Preferred Dentist Program (PDP) Option or the Traditional Indemnity Option (combined) will pay for covered preventive and restorative services for each participant in a year.
Maximum Lifetime Orthodontia Benefit	<p>The most the Preferred Dentist Program (PDP) Option or the Traditional Indemnity Option (combined) will pay for covered orthodontia services for each participant’s lifetime.</p> <p>Any benefits that have been applied to a maximum provision under a dental plan of your heritage organization will also be applied to the lifetime maximum for this Dental Plan.</p>
Missing Tooth Exclusion	<p>An ineligible charge for a partial or full removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth missing before the person became covered under the Dental Plan. This exclusion does not apply if the denture, bridge, or bridgework also includes replacement of a natural tooth that:</p> <ul style="list-style-type: none"> • Is removed while the person is covered; and • Was not an abutment to a partial denture, removable bridge, or fixed bridge installed during the prior five years.
Necessary Services	<p>Services or supplies that are accepted and used by the dental community as appropriate for the condition being treated or diagnosed. The services or supplies also must be prescribed by a dentist for the diagnosis or treatment of the condition to be considered necessary. Some prescribed services may not be considered necessary and may not be covered under the JPMorgan Chase Dental Plan. The claims administrator or claims payer will determine whether a service or supply is necessary.</p> <p>Finally, to be considered necessary, a service or supply cannot be educational or experimental in nature in terms of generally accepted dental standards.</p>
Non-Duplication of Benefits	The Dental 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 Dental 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 Dental 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 for more information.
Palliative	A service or treatment that reduces the harmful effects of a condition — usually an acute (emergency) situation.
Periodontal Disease	A condition that weakens and destroys the gum, bone, and membrane which surround and support the teeth, such as pyorrhea, gingivitis, or Vincent’s disease.

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Terms	Definition
Pre-Determination	An itemization of the proposed course of treatment (including recent pre-treatment X-rays), which you should submit before work is begun, if you anticipate that charges will be more than \$300. A dental consultant will review the proposed treatment before work begins and the claims administrator will inform you and your dentist of the amount of covered charges. That way, you'll understand the benefits that will be paid before treatment begins. Benefits will be paid according to the plan provisions in effect when the services are actually rendered. The amount may change if the treatment changes from that which was predetermined. Except in the case of an emergency, you may not want to begin the course of treatment until you know what amount your JPMorgan Chase Dental Plan option will pay.
Prophylaxis	Prevention of disease by removal of tartar, stains, and other extraneous materials from the teeth, or the cleaning of the teeth by a dentist or by a dental hygienist.
Prosthesis	In general, something that replaces a missing part of the body. The dental specialty dealing with replacement of teeth is called prosthodontics.
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 11 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 under the Dental Plan. 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	How JPMorgan Chase pays for dental claims under the PDP and Traditional Indemnity Options.

Some Quick Facts

<p>Your Choices</p>	<p>Preferred Dentist Program (PDP) Option: The PDP Option, administered by MetLife, lets you choose between receiving in-network or out-of-network care each time you need dental work. You will generally pay less for your care when you use a MetLife in-network dental provider for two reasons:</p> <ul style="list-style-type: none"> • In-network care is generally covered at a higher percentage with lower annual deductibles than out-of-network care; and • Network dentists have agreed to charge lower, negotiated fees for their services when treating JPMorgan Chase Dental Plan participants. <p>Dental Maintenance Organization (DMO) Option: The DMO Option, administered by Aetna Inc., offers you a broad range of dental services on a pre-paid basis. You agree to receive care solely from dentists associated with the DMO network, and in return, you will have no deductibles to meet and no claim forms to file. The DMO administrator actively works to keep dental care costs low by requiring DMO dentists to meet strict quality standards, screening for cost-effective practice patterns, and negotiating fees charged for services. In some areas, a Dental Health Maintenance Organization (DHMO), administered by First Commonwealth, may be offered in addition to a DMO.</p> <p>Traditional Indemnity Option: The Traditional Indemnity Option, administered by MetLife, pays a percentage of covered preventive services (e.g., oral exams, cleanings, and some X-rays) up to the reasonable and customary (R&C) amount, subject to certain annual maximums. For covered restorative services, you must first meet an annual deductible; for orthodontia, you must first meet a separate lifetime deductible. Then this option pays a percentage of the cost up to the R&C amount, subject to certain annual or lifetime maximums. You can choose to use any dentist you like. However, since the total cost of care under this option is higher than under the PDP Option, the amount you pay for coverage will likely be higher.</p> <p>Please Note: This option also contains a preferred dentist feature. Although the benefit percentage paid by this option is the same whether or not you use a network dentist, your overall costs will probably be reduced because you will be charged lower, negotiated fees by in-network providers.</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 One Adult; • Employee Plus Child(ren); or • Employee Plus One 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"> • Preventive care services, such as oral exams, fluoride treatment, prophylaxis, X-rays (excluding intra-oral X-rays), sealants, and emergency palliative treatment. • Basic restorative care services, such as fillings, extractions, root canal treatments, oral surgery, anesthesia, and antibiotic injections. • Major restorative care services, such as services to replace lost teeth, and inlays, onlays, and crowns, and their repair or recementing. • Orthodontia services (for children under age 19).

Participating in the Dental Plan

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

Eligibility

Your participation in the Dental 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.

Dental Plan Options

You can choose your dental coverage from among the following options, depending on your home zip code:

- Preferred Dentist Program (PDP) Option;
- Dental Maintenance Organization (DMO) Option*;
- Traditional Indemnity Option; and
- No Coverage.

**In some areas, a Dental Health Maintenance Organization (DHMO) Option may also be offered.*

Coverage Categories

When you enroll in the Dental 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); or
- Employee Plus Adult Plus Child(ren).

Provider Directories

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

Please Note: *You should always check with your dental health care provider to ensure that he or she plans to continue participating in the network of the Dental Option you choose. If your dental 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 Dental Plan, you can also cover your eligible dependents, but only under the same option you choose for yourself. For details about your eligible dependents, please see “Your Eligible Dependents” in the “Medical Plan” section of this Guide.

Please Note: Colorado and Texas state mandates allow extended coverage under the Aetna DMO Plan. In Colorado, dependent children may be covered to age 24. In Texas, dependent children may be covered to age 25.

Cost of Coverage

You and JPMorgan Chase share the cost of coverage under each of the Dental Plan options. JPMorgan Chase determines the cost of coverage for the plan each year based on claims experience, administrative fees, and other cost-related factors. You pay for coverage with before-tax dollars. Your cost for coverage depends on the option and coverage category you select. Each year, your annual benefits enrollment materials will show the cost for each option offered under each of the coverage categories.

Your contributions toward the cost of coverage start when your coverage begins. (Please see “When Coverage Begins” on page 11 for more information.) 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 sickness or leave of absence, you will be directly billed by JPMorgan Chase for any required contributions on an after-tax basis.

If you become totally and permanently disabled and are eligible for benefits from the Long-Term Disability Plan, you’re treated as having “benefits-eligible” status for certain benefits. In the case of the Dental Plan, you’ll be eligible to continue coverage while receiving benefits from the Long-Term Disability Plan. You will be directly billed by JPMorgan Chase for any required contributions on an after-tax basis.

Cost for Qualified Adult Coverage

If you’re covering a qualified adult (as described in the “Medical Plan” section of this Guide), there are some cost implications of which you should be aware. Specifically, in most 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 dental 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.

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.

How to Enroll

Participation in the Dental 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 11 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 election 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. Please see "Qualified Change in Status" on page 11 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 Dental 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 dental coverage until the next annual benefits enrollment period unless you have a qualified change in status. Please see "Qualified Change in Status" on page 11 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 Dental Plan mid-year and you do not enroll within the designated 31-day period, you won't be able to choose dental coverage until the next annual benefits enrollment period. Please see "Qualified Change in Status" on page 11 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 at 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.

Qualified Change in Status

The Dental 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 Dental Plan are listed in the following table.

Dental Plan Changes for Qualified Change in Status

Event	Dental Plan Changes
Spouse and Children	
You get married	<ul style="list-style-type: none"> Add coverage for you and/or your eligible dependents Change Dental 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 Dental 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 who have lost other coverage Change Dental 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 other dependents who are no longer eligible
A dependent child is no longer eligible for coverage*	Cancel coverage for your dependent child
You move out of a Dental Plan option service area	Change Dental Plan option for you and your covered dependent children. (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 Dental Plan option
You end a domestic partner relationship	Cancel coverage for your domestic partner and your domestic partner's eligible dependent children
Qualified Adult Dependents — Extended Family Member	
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 Dental Plan option
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 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 Dental Plan because they have other dental coverage. HIPAA's special enrollment rights apply in certain cases where you and/or your dependents decline Dental Plan coverage because you have dental 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 Dental Plan, you may enroll for dental coverage within 31 days of one of the following events:

- You and/or your eligible dependents lose other group dental 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 group coverage available to you ends;
- The other coverage was provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the COBRA coverage period ends; or

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

If the Dental Plan receives a judgment, decree, or order — including a Qualified Medical Child Support Order (QMCSO) — requiring the plan to provide dental coverage to your child or foster child who is your dependent, the Dental Plan will automatically change your dental benefit 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 benefit elections under the Dental Plan, to the extent permitted by the Internal Revenue Code (IRC) and the Dental Plan.

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.

JPMorgan Chase may only use and disclose protected health information received from the Dental Plan claims administrators in ways that are permitted by, required by, and consistent with HIPAA privacy regulations.

For details about HIPAA privacy regulations and your rights with regard to this information, please see “HIPAA Privacy Rights and Protected Health Information” in the “Medical Plan” section of this Guide.

The Preferred Dentist Program (PDP) Option

The Preferred Dentist Program (PDP) Option is one of the options available under the JPMorgan Chase Dental Plan. The other coverage options include the Traditional Indemnity Option and the Dental Maintenance Organization (DMO) Option, and in some areas, the Dental Health Maintenance Organization (DHMO) Option. The PDP Option is administered by MetLife and lets you choose between receiving in-network or out-of-network care each time you need dental work. You will generally pay less for your care when you use a MetLife in-network dental provider for two reasons:

- In-network care is generally covered at a higher percentage with lower annual deductibles than out-of-network care; and
- Network dentists have agreed to charge lower, negotiated fees for their services.

With the PDP Option...

- You can receive in-network or out-of-network care at any time and still receive benefits.
- In-network preventive care is covered at 100% with no deductible.
- There's no deductible for out-of-network preventive care.
- Combined in-network and out-of-network annual limits apply to preventive and restorative care.
- Combined in-network and out-of-network lifetime limits apply to orthodontia benefits.
- There are no ID cards.
- Claim forms are not needed for in-network providers.

How the PDP Option Works

The PDP Option has networks of participating dentists and other dental providers who have agreed to a negotiated fee arrangement for covered dental services when treating JPMorgan Chase participants. However, you can also choose to receive care from any other dental provider and still receive benefits. If you're interested in enrolling in the PDP Option, you should obtain a participating provider directory.

You may view an online provider directory by visiting the Benefits Web Center via My Rewards @ Work, and clicking on the "Provider Directories" link.

You may also request a print copy of the directory by contacting MetLife at any time. Please see the "Plan Administration" section of this Guide for contact information.

This directory will list the dentists who are members of their network.

Please Note: If your dentist leaves the network during the year, you won't be able to change to another option until the next annual benefits enrollment period (or earlier if you experience a qualified change in status that allows you to change Dental Plan options). The way benefits are paid depends on whether you receive your care in-network or out-of-network. The following chart shows how the PDP Option pays benefits.

How the PDP Option Pays Benefits

Benefit Provision	In-Network	Out-of-Network
Annual Deductible		
• Preventive	• None	• None
• Restorative	• \$25 individual; \$75 family	• \$75 individual; \$225 family
• Orthodontia	• \$50 individual/lifetime	• \$150 individual/lifetime
Preventive (no deductible)	100% coverage*	70% coverage*
• Oral exams	• Maximum 2/calendar year	• Maximum 2/calendar year
• Prophylaxis	• Maximum 2/calendar year	• Maximum 2/calendar year
• Fluoride	• Maximum 1/calendar year under age 19	• Maximum 1/calendar year under age 19
• Full mouth X-ray	• Maximum 1/every 36 months	• Maximum 1/every 36 months
• Bitewing X-ray	• Maximum 1/calendar year**	• Maximum 1/calendar year**
• Sealants	• Maximum 2 treatments per tooth (permanent molars only)/lifetime; under age 19	• Maximum 2 treatments per tooth (permanent molars only)/lifetime; under age 19
Basic restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)	80% coverage, after deductible*	60% coverage, after deductible*
Major restorative (dentures, inlays, onlays, crowns, bridges)	60% coverage, after deductible*	50% coverage, after deductible*
Orthodontia ***	50% coverage, after deductible*	50% coverage, after deductible*
Maximum Benefits		
• Combined annual for preventive and restorative	• Maximum \$1,500****	• Maximum \$1,500****
• Lifetime for orthodontia	• Maximum \$2,500****	• Maximum \$2,000****

* All in-network percentages above apply to dentists' negotiated fees. All out-of-network percentages apply to reasonable and customary (R&C) charges.

** Two times per calendar year for covered participants under age 19.

*** For covered dependent children under age 19.

**** Reflects a combined amount for both in-network and out-of-network; includes any benefits already applied to any lifetime maximum for orthodontia under the Dental Plan of a heritage organization.

Please Note: Wherever benefits are limited to a certain number of visits, combined in-network and out-of-network visits will count toward the benefit limit. For more details on coverage limitations, see "What Is *Not* Covered" on page 27.

Annual Deductible

Under the PDP and Traditional Indemnity 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.
- 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 (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.

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.

Please Note: There are separate deductibles (in-network and out-of-network) for restorative care and orthodontia.

An Example: Amounts Applied Toward In-Network Restorative Care Deductibles

On behalf of you	\$25
On behalf of your spouse/qualified adult	\$25
On behalf of child #1	\$15
On behalf of child #2	\$10
Total	\$75

In this example, four people have met the family annual deductible for in-network restorative care. So, any other covered person's in-network restorative care would be reimbursed by the plan, even if it were on behalf of a person who has not yet met the \$25 individual annual deductible. No other covered family members need to meet their in-network restorative care deductible for the rest of the year. Please Note: No more than \$25 of expenses per individual will be applied towards the family deductible.

Coinsurance

After you meet the applicable deductible, the plan will pay a percentage of in-network dentists' negotiated fees, or, for out-of-network expenses, a percentage of the reasonable and customary (R&C) charges for eligible expenses (see "Important Terms" on page 3 for the definition of "reasonable and customary"). The exact percentage depends on the type of care and whether the care was received on an in-network or out-of-network basis. Please see "How the PDP Option Pays Benefits" on page 15 for the applicable coinsurance rate. You'll pay the remaining amount as coinsurance, plus any amounts above R&C charges.

Maximum Benefits

There are limits on the benefits you can receive from the PDP Option. The maximum for combined in-network and out-of-network benefits is \$1,500 per person per year for preventive and restorative care. The lifetime maximum benefit for orthodontia is \$2,500 per person in-network and \$2,000 per person out-of-network. These lifetime orthodontia maximums reflect a combined amount for both in-network and out-of-network care. [All the benefits you receive under the PDP Option and the Traditional Indemnity Option are added together for the lifetime orthodontia maximum.]

Any benefits that have been applied to a maximum provision under a dental plan of your heritage organization will also be applied to the lifetime maximums for this Dental Plan.

An Important Note on the Lifetime Orthodontia Maximum Under the PDP Option

If you switch your participation from the PDP Option to the Traditional Indemnity Option or vice versa, you do not gain a new lifetime orthodontia maximum. Any benefits paid under one option will apply against the other. The most you can ever receive in orthodontia benefits under the Dental Plan for each eligible dependent child under age 19 is \$2,500.

For example, assume you've received \$2,000 in orthodontia benefits for one dependent child under the Traditional Indemnity Option, the maximum payable under this option. Then, you elect coverage under the PDP Option during the next annual benefits enrollment period. The most the PDP Option will pay toward that dependent child's orthodontia expenses is the difference between what was paid under the Traditional Indemnity Option and the PDP's lifetime orthodontia maximums — \$2,500 for in-network expenses and \$2,000 for out-of-network expenses.

In this case, if care is received in-network, the most the PDP Option will pay for that dependent child's orthodontia expenses is \$500 ($\$2,500 - \$2,000 = \500). However, the PDP would not pay anything more for care received out-of-network for that dependent child, since the lifetime orthodontia maximum had already been met under the Traditional Indemnity Option.

The Dental Maintenance Organization (DMO) Option

The Dental Maintenance Organization (DMO) Option is one of the options available under the JPMorgan Chase Dental Plan. The other coverage options include the Preferred Dentist Program (PDP) Option, the Traditional Indemnity Option, and in some areas, the Dental Health Maintenance Organization (DHMO) Option. The DMO Option is available and administered in most locations by Aetna, Inc. and offers you a broad range of dental services on a pre-paid basis. You agree to receive care solely from dentists associated with the DMO Option network, and in return, you will have no deductibles to meet and no claim forms to file. The DMO administrator actively works to keep dental care costs low by requiring DMO dentists to meet strict quality standards, screening for cost-effective practice patterns, and negotiating fees charged for services.

How the DMO Option Works

If you decide to enroll in a DMO option for the first time or add new dependents for coverage under this option, you need to select a primary care dentist. Remember: You can choose a different DMO dentist for yourself and each covered dependent.

You may view an online provider directory by visiting the Benefits Web Center via My Rewards @ Work, and clicking on the “Provider Directories” link.

You may also request a print copy of the provider directory by contacting the DMO at any time. See the “Plan Administration” section of this Guide for contact information.

With the DMO Option...

- Preventive care is covered at 100%.
- There are no annual deductibles.
- There are no claim forms to file.
- There are no lifetime limits on benefits (except orthodontia and sealants).
- You only receive benefits if you use a DMO dentist; however, you can change your DMO dentist at any time. (**Please Note:** Requests to change your DMO dentist must be received by the 15th of the month in order to take effect the first of the next month.)
- You and your dependents can each have different DMO dentists.
- You and your dependents will receive a DMO ID card following your enrollment.

If you enroll in the DMO Option, you agree to receive care solely from dentists participating in the managed care network. (**Please Note:** Limited out-of-network coverage may be available based on state mandates. Check your Aetna DMO/First Commonwealth DHMO coverage certificate or contact customer service at the number on your ID card for details.) Here is how the DMO Option pays benefits:

How the DMO Option Pays Benefits

Benefit Provision	Coverage
Annual Deductible	
• Preventive	• None
• Restorative	• None
• Orthodontia	• None
Preventive	100% coverage
• Oral exams	• Maximum 2/calendar year
• Fluoride	• Maximum 2/calendar year under age 19 only
• Prophylaxis	• Maximum 2/calendar year
• Full mouth X-ray	• Maximum 1/every 36 months
• Bitewing X-ray	• Maximum 2/calendar year
• Sealants	• Maximum 2 treatments per tooth (permanent molars only)/lifetime under age 19
Basic restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)	80% coverage
Major restorative (dentures, inlays, onlays, crowns, bridges)	60% coverage
Orthodontia*	50% coverage
Maximum Benefits	
• Combined annual for preventive and restorative	• No maximum
• Lifetime for orthodontia*	• One course of treatment per individual per lifetime

* For covered dependent children under age 19. If banding occurred prior to age 19, the remaining course of treatment will be considered for coverage.

The Dental Health Maintenance Organization (DHMO) Option

The First Commonwealth DHMO may also be offered in Illinois, parts of Indiana, and Wisconsin. The DMO and the DHMO work the same way, but the way each pays for certain benefits may differ.

Benefit Provision	Coverage
Annual deductible	
• Preventive	• None
• Restorative	• None
• Orthodontia	• None
Preventive	100% coverage
• Oral exams	• Limited to once every six months
• Fluoride	• Limited to once every six months
• Prophylaxis	• Limited to once every six months
• Full mouth X-ray	• Limited to once every six months
• Bitewing X-ray	• Limited to once every six months
• Sealants	• Limited to 1 treatment every 18 months to permanent posterior teeth; under age 17
Basic restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)	85% coverage
Major restorative (dentures, inlays, onlays, crowns, bridges)	65% coverage (50% for cosmetic services)
Orthodontia*	• Check with the plan for fixed payment schedule of covered services
Maximum Benefits	
• Combined annual for preventive and restorative	• No maximum
• Lifetime for orthodontia*	• One full course of treatment per individual (24 continuous months)

* For covered dependent children under age 19. If banding occurred prior to age 19, the remaining course of treatment will be considered for coverage.

The Traditional Indemnity Option

The Traditional Indemnity Option is one of the options available under the JPMorgan Chase Dental Plan. The other coverage options include the Preferred Dentist Program (PDP) Option, the Dental Maintenance Organization (DMO) Option, and in some areas, the Dental Health Maintenance Organization (DHMO) Option. The Traditional Indemnity Option is administered by MetLife and pays a percentage of covered preventive services (e.g., oral exams, cleanings, and some X-rays) up to the reasonable and customary (R&C) amount, subject to certain annual maximums. For covered restorative and orthodontia services, you must first meet an annual deductible, then this option pays a percentage of the cost up to the R&C amount, subject to certain annual/lifetime maximums. You can choose any dentist you like. However, since the total cost of care under this option is higher than under the PDP Option, the amount you pay for coverage will likely be higher.

You should note that this option also contains a preferred dentist feature. Although the benefit percentage paid by this option is the same whether or not you use a network dentist, your overall costs will probably be reduced because you will be charged lower, negotiated fees by in-network providers.

With the Traditional Indemnity Option...

- You can use any dentist you like at any time and still receive benefits.
- Benefits for restorative and orthodontic care begin after you meet an annual deductible.
- There's no annual deductible for preventive care.
- Claim forms are generally required to receive benefits.
- There's an annual limit on preventive and restorative care.
- There's a lifetime limit on orthodontia benefits.
- There are no ID cards.

With the Preferred Dentist Feature of the Traditional Indemnity Option:

- Reduced fees are available when using a preferred dentist.
- Claim forms are usually not required when using a preferred dentist.

How the Traditional Indemnity Option Works

The Traditional Indemnity Option reimburses you a percentage of your eligible dental expenses — subject to reasonable and customary (R&C) limits, up to an annual maximum of \$1,500 for preventive and restorative care — after you pay the applicable annual deductible. Your deductible amount depends on the type of dental care you receive, as shown below.

How the Traditional Indemnity Option Pays Benefits

Benefit Provision	Coverage
Annual individual deductible	
<ul style="list-style-type: none"> Preventive 	<ul style="list-style-type: none"> None
<ul style="list-style-type: none"> Restorative 	<ul style="list-style-type: none"> \$75 individual; \$225 family
<ul style="list-style-type: none"> Orthodontia* 	<ul style="list-style-type: none"> \$150 individual/lifetime
Preventive	90% coverage
<ul style="list-style-type: none"> Oral exams 	<ul style="list-style-type: none"> Maximum 2/calendar year
<ul style="list-style-type: none"> Fluoride 	<ul style="list-style-type: none"> Maximum 1/calendar year; under age 19 only
<ul style="list-style-type: none"> Prophylaxis 	<ul style="list-style-type: none"> Maximum 2/calendar year
<ul style="list-style-type: none"> Full mouth X-ray 	<ul style="list-style-type: none"> Maximum 1/every 36 months
<ul style="list-style-type: none"> Bitewing X-ray 	<ul style="list-style-type: none"> Maximum 1/calendar year**
<ul style="list-style-type: none"> Sealants 	<ul style="list-style-type: none"> Maximum 2 treatments per tooth (permanent molars only)/lifetime under age 19
Basic restorative (fillings, extractions, root canal, periodontal, oral surgery, anesthesia)	75% coverage, after deductible
Major restorative (dentures, inlays, onlays, crowns, bridges)	50% coverage, after deductible
Orthodontia***	50% coverage, after deductible*
Maximum benefits	
<ul style="list-style-type: none"> Combined annual for preventive and restorative 	<ul style="list-style-type: none"> Maximum \$1,500
<ul style="list-style-type: none"> Lifetime for orthodontia*** 	<ul style="list-style-type: none"> Maximum \$2,000

* For covered dependent children under age 19.

** Two times per calendar year for covered participants under age 19.

*** Includes any benefits already applied to any lifetime maximum for orthodontia under the Dental Plan of a heritage organization.

All percentages above apply to reasonable and customary (R&C) charges.

Annual Deductible

Under the PDP and Traditional Indemnity 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.
- 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 (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.

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.

Please Note: There are separate deductibles (in-network and out-of-network) for restorative care and orthodontia.

An Example: Amounts Applied Toward Restorative Care Deductibles

On behalf of you	\$75
On behalf of your spouse/qualified adult	\$75
On behalf of child #1	\$50
On behalf of child #2	\$25
Total	\$225

In this example, four people have met their family annual deductible for restorative care. So, any other covered person's restorative care would be reimbursed by the plan, even if it were on behalf of a person who has not yet met the \$75 individual annual deductible. No other covered family members need to meet their in-network restorative care deductible for the rest of the year. Please Note: No more than \$75 of expenses per individual will be applied toward the family deductible.

Coinsurance

After you meet the applicable deductible, the plan will pay a percentage of reasonable and customary (R&C) charges for covered services (see "Important Terms" on page 3 for the definitions of "reasonable and customary" and "covered services"). The exact percentage depends on the type of care. Please see "How the Traditional Indemnity Option Pays Benefits" on page 22 for the applicable coinsurance rate. You'll pay the remaining amount as coinsurance, plus any amounts above R&C charges.

Maximum Benefits

There are limits on the benefits you can receive from the Traditional Indemnity Option. The annual maximum for preventive and restorative services combined is \$1,500. The lifetime maximum benefit for orthodontia is \$2,000 per person. [All the orthodontia benefits you receive for the Traditional Indemnity and the Preferred Dentist Program (PDP) Options are added together for the lifetime orthodontia maximum.]

Any benefits that have been applied to a maximum provision under a dental plan of your heritage organization will also be applied to the lifetime maximums for this Dental Plan.

An Important Note on the Lifetime Orthodontia Maximum Under the Traditional Indemnity Option

If you switch your participation from the Traditional Indemnity Option to the Preferred Dentist Program (PDP) Option or vice versa, you do not gain a new lifetime orthodontia maximum. Any benefits paid under one option will apply against the other. Please see "How the Traditional Indemnity Option Pays Benefits" on page 22 for an example.

What Is Covered

Each of the Dental Plan options covers a wide variety of services, as long as the services are necessary and their costs do not exceed reasonable and customary (R&C) charges. (Please see “Important Terms” on page 3 for the definitions of “necessary services” and “reasonable and customary charges.”) Covered services under each JPMorgan Chase Dental Plan option may differ slightly from the lists below. **The following lists include examples of covered services, but the lists are not exhaustive and coverage remains subject to any plan requirements or limitations.** For specific information on each option’s covered services, please contact the option’s claims administrator directly, using the telephone numbers provided under “Where to Submit Claims” on page 34. The list of covered services may change at any time.

Preventive Care Services

Covered preventive care services include:

- Bitewing X-rays;
- Emergency palliative treatment;
- Fluoride treatments under age 19 only;
- Full mouth X-rays;
- Oral exams;
- Space maintainers under age 19 only;
- Prophylaxis; and
- Sealants.

Basic Restorative Care Services

Covered basic restorative care services include:

- Consultations (two per calendar year);
- Administration of general anesthesia in conjunction with oral surgery when necessary;
- Extractions;
- Fillings;
- Injections of antibiotic drugs;
- Most periodontal or other gum disease treatment;
- Periodontal maintenance (four visits per calendar year, combined with regular cleanings);
- Oral surgery (except as covered by the JPMorgan Chase Medical Plan);
- Periodontal scaling/root planing (one per quadrant per 24 months);
- Periodontal surgery (one per quadrant per 36 months);
- Relines/rebases (one per denture per 36 months, after six months from installation);
- Repair or recementing of crowns, inlays, or onlays; dentures; or bridgework; and
- Root canal treatments.

Major Restorative Care Services

Covered major restorative care services include:

- Only appliances related to temporomandibular joint syndrome (TMJ) and only to a lifetime maximum of \$500. Adjustments and diagnostics for TMJ are not separately eligible under the PDP and Traditional Indemnity Options. Limited services related to TMJ are eligible for coverage under the DMO Option. Contact the DMO Claims Administrator for specific details;
- Replacement dentures and bridges — if the original appliance is at least five years old and cannot be repaired;
- Services necessary to replace teeth lost while coverage is in effect;
- Crowns/inlays/onlays (one per tooth per five calendar years);
- Treatment for harmful habits; and
- Treatment for accidental injury. (Eligible dental expenses are covered under the Dental Plan; eligible medical expenses are covered under the Medical Plan.)
- Implant(s). Benefits may also be available for the final restoration or prosthesis (crown or partial denture) over the implant. A pre-treatment estimate should be submitted for a dental consultant to evaluate the claim to determine if any benefits are payable. **(The DMO and DHMO Options do not cover implants.)**

Please Note: Generally benefits will be limited to the R&C charge for the least expensive method of treatment that is appropriate and that meets acceptable dental standards — as determined by the claims administrator.

What Is *Not* Covered

While the JPMorgan Chase Dental Plan options cover a wide range of dental services, some expenses are not covered by the Dental Plan. These include but are not limited to those listed below. This list of excluded services may change at any time.

- Any of the following services:
 - A gold restoration or crown, unless:
 - It is treatment for decay or traumatic injury, and teeth can't be restored with a filling material; or
 - The tooth is an abutment to a covered partial denture or fixed bridge;
 - An appliance — or modification of one — if an impression for it was made before the person became covered.
- Any of the following services incurred more than 31 days after the date the person's coverage ends:
 - A crown, bridge, or gold restoration for which the tooth was prepared while the person was covered;
 - An appliance — or alteration of one — for which an impression was made while the person was covered; or
 - Root canal therapy for which the pulp chamber was opened while the person was covered.
- Charges in connection with:
 - A charge for a service to the extent that it is more than the usual charge made by the provider for the service when there is no insurance;
 - Appliances or restorations needed to alter vertical dimensions or restore occlusion, or for the purposes of splinting or correcting attrition, abrasion, or erosion; or
 - Replacement of lost, missing, or stolen appliances or appliances that have been damaged due to abuse, misuse, or neglect.
- Treatment for problems of the jaw joint, including:
 - Craniomandibular disorder;
 - Temporomandibular joint syndrome (TMJ), other than what is noted in "What Is Covered"; or
 - Other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves, and other tissues related to that joint.
- Expenses submitted later than December 31 of the year following the year in which services were provided.
- Installation of prosthetic devices (including bridges and crowns) while not covered or which were installed more than 31 days after coverage ends.
- Loss — or portion of a loss — for which mandatory automobile no-fault benefits are recovered or recoverable.
- Loss — or portion of a loss — resulting from war or act of war, declared or undeclared.

- Partial or full removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth (including congenitally missing teeth) missing before the person became covered under this plan. The exclusion does not apply if the denture, bridge, or bridgework also includes replacement of a natural tooth that:
 - Is removed while the person is covered; and
 - Was not an abutment to a partial denture, removable bridge, or fixed bridge installed during the prior five years.
- Procedures related to occupational illness or injury.
- Replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for a replacement or modification of a crown or gold restoration or inlay/onlay within five years after that denture, bridgework, crown, inlay/onlay, or gold restoration was installed.
- Expenses or charges with respect to services rendered by hospitals, clinics, laboratories (except dental X-rays are covered), or other institutions.
- Services and supplies included as covered medical expenses under:
 - Any other employer-sponsored plan that covers you, including Medicare;
 - Any other governmental health program, except Medicaid; or
 - Your JPMorgan Chase Medical Plan option.
- Services and supplies rendered in a veteran's facility or government hospital, or services furnished in whole or in part under the laws of the United States or any of its state or political subdivisions.
- Services furnished for cosmetic purposes. Facings on crowns or pontics — which are behind the second bicuspid — will always be considered cosmetic. This limitation does not apply if the service is needed as a result of accidental injuries sustained while a person is covered.
- Services not reasonably necessary as determined by the claims administrator.
- Services to the extent that a benefit for those services is provided under any other program paid in full or in part, directly or indirectly, by JPMorgan Chase. This includes insured and uninsured programs. If a program provides benefits in the form of services, the cash value of each service rendered is considered the benefit provided for that charge.
- Services to the extent that the charges are above the prevailing charge in the area for dental care of a comparable nature. A charge is above the prevailing charge to the extent that it's above the range of charges generally made in the area for dental care of a comparable nature. The area and that range are determined by the claims administrator.
- Treatment by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, a trustee, or a similar person or group.
- Expenses in connection with services, procedures, drugs, or other supplies that are determined by the claims administrator to be experimental, or still under clinical investigation by health professionals.

- Charges for oral hygiene programs, completion of claim forms by the provider on your behalf, and broken appointments.
- Services provided by a relative, or for which a charge would not normally be made.
- Treatment by anyone except a licensed dentist (except for cleaning or scaling of teeth and topical application of fluoride performed by a licensed dental hygienist, if rendered under the supervision and guidance of a licensed dentist).

In addition, the DMO Option does not cover services provided to a person age five or older if that person becomes covered other than:

- As described for any period of enrollment agreed to by JPMorgan Chase and Aetna, Inc. This limitation does not apply to charges incurred:
 - After the end of the 12-month period starting on the date the person became covered;
 - As a result of accidental injuries sustained while the person was covered; or
 - Preventive service, unless listed above.
- During the first 31 days the person is eligible for this coverage.

Other Limitations

Replacements of — or additions to — existing dentures or bridgework will be covered under the JPMorgan Chase Dental Plan only if at least one of the following conditions exists:

- The present denture or bridgework cannot be made serviceable, and it is at least five years old;
- It's necessary to replace teeth extracted after the present denture or bridgework was installed; or
- Replacement by a permanent denture is needed because the present denture is temporary, and replacement occurs within 12 months after the date the temporary denture was installed.

If You Are Covered by More Than One Dental Plan

The JPMorgan Chase Dental Plan has a provision to ensure that payments from all of your group dental plans don't exceed the amount the JPMorgan Chase Dental Plan would pay if it were your only coverage. The following rules do not apply to any private, personal insurance you may have. They are in addition to the maximum annual benefits for covered preventive and restorative services and the maximum lifetime benefits for covered orthodontia services, included under each option.

Non-Duplication of Benefits

The JPMorgan Chase Dental 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 Dental Plan will ensure that, in total, you receive benefits up to what you would have received with the Dental 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.

Here's an example of how the Dental Plan coordinates benefits with other dental plans:

Assume your spouse/domestic partner has a necessary covered procedure with a reasonable and customary (R&C) charge of \$100 after meeting any deductible. If your spouse's/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 Dental Plan option (which we'll assume is your spouse's/domestic partner's secondary coverage) would pay 75% for this necessary procedure. In this case, your spouse/qualified adult normally would receive a \$75 benefit (75% of \$100) from the Dental Plan option. However, since your spouse/qualified adult already received \$70 from her or his primary plan, she or he would receive the balance (\$5) from the JPMorgan Chase Dental Plan. If, however, your Dental Plan option considered the R&C charge to be \$80, no additional benefit would be payable, as the Dental Plan would pay 75% of \$80, or \$60. As that amount would have already been paid by your spouse's/domestic partner's plan, no additional benefit would be payable from the Dental Plan.

Determining Primary Coverage

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

- As an active JPMorgan Chase employee, the Dental Plan will be primary for you and consider claims for your dental expenses first.
- 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, 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 “Medical Support Orders” on page 31 for more information on a qualified medical child support order.)
- If your other dental 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.

Medical Support Orders

The Dental Plan recognizes medical support orders that satisfy certain legal 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 Dental Plan provides benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the Dental Plan has the right to recover these payments from you. You should know that an 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 Dental Plan is to provide benefits for eligible dental expenses that are not covered by any third party. If a covered person or agency receives payment from any third party for any dental expenses that have already been paid by the Dental Plan, the covered person or agency will have to reimburse the Dental 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 Dental 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 Dental Plan has the right to pursue subrogation against any person or insurer. The covered person agrees to help the Dental Plan use this right when requested.

Right of Reimbursement

In addition to its subrogation rights, the Dental Plan is entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for dental expenses that have been paid by the Dental Plan.

Claiming Benefits

The following explains when and how to file claims for dental expenses under the PDP and the Traditional Indemnity Options. If you're enrolled in a DMO or DHMO, you usually don't need to file a claim. For more information on your rights with respect to claims, please see the "Plan Administration" section of this Guide.

Your Dental Identification (ID) Cards

If you enroll in the DMO or the DHMO Option, you will receive a personalized identification (ID) card from Aetna, Inc. or First Commonwealth. Carry your ID card(s) with you at all times since it contains information that will help verify your coverage. (There are no ID cards for the PDP or the Traditional Indemnity Options.)

How to File Claim

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

PDP Option	<ul style="list-style-type: none">• In-Network Benefits: Generally, you do not have to file a claim form.• Out-of-Network Benefits: Generally, you must file a claim form. (Some dentists may submit claims electronically; you should check with your dentist.) 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 from your PDP administrator upon request. See "Where to Submit Claims" on page 34 for your option administrator's phone and address information.
Dental Maintenance Organization (DMO) Option and Dental Health Maintenance Organization (DHMO) Option	You do not have to file a claim form.
Traditional Indemnity Option	Generally, you must file a claim form. (Some dentists may submit claims electronically; you should check with your dentist.) 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 from your claims administrator upon request. See "Where to Submit Claims" on page 34 for your option administrator's phone and address information.

To have your claim considered for benefits, you need to file your claim by December 31 of the year following the year in which 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.

If your dentist submits a paper claim, make sure he or she uses the proper claim form, and that your work location, Social Security number, and signature are included with the information provided. Payment of benefits can be made to you or your dentist. If payment is to be made to your dentist, you should specify this on your claim form by signing the form and dating the appropriate box. If you don't indicate who the payment should be made to, it will be made to you.

Where to Submit Claims

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

The claims administrators' contact information for the PDP Option, the DMO, the DHMO, and the Traditional Indemnity Option, is listed in the following table:

Claims Administrators' Contact Information

Claims Administrator	Address and Telephone Number
MetLife Preferred Dentist Program (PDP) Option	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 1-888-673-9582
Aetna, Inc. Dental Maintenance Organization (DMO) Option	Aetna, Inc. P.O. Box 14094 Lexington, KY 40512 1-800-741-4781
First Commonwealth Dental Health Maintenance Organization (DHMO) Option	First Commonwealth P.O. Box 3319 Chicago, IL 60654 1-866-494-4542
MetLife Traditional Indemnity Option	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 1-888-673-9582

Appealing Claims

If a claim for reimbursement under the Dental 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.

Additional Plan Information

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

Your benefits as a participant in the Dental Plan are provided under the terms of the official plan document, insurance policies, and/or contracts, 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 Benefits Appeals Committee for the JPMorgan Chase Benefits Program, has any authority to interpret the terms of the written Dental Plan document (or other plan documentation) or to make any promises to you about them. The claims administrator or Benefits Appeals Committee has complete authority in their sole and absolute discretion to construe and interpret the terms of the Dental Plan and any underlying insurance policies and/or contracts, including the eligibility to participate in the Dental 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 Dental Plan coverage may be affected in certain situations, for example, if you have a qualified change in status.

<p>If Your Work Status Changes</p>	<p>Your Dental 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 dental 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.)</p>
<p>If You Go on Disability Leave</p>	<p>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 Dental Plan. JPMorgan Chase will deduct any required contributions for dental coverage from the pay you receive during this period on a before-tax basis.</p>
<p>If You Go on Long-Term Disability</p>	<p>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.</p> <p>Your dental coverage will continue only if you are receiving LTD benefits under the LTD Plan and you make timely payments. 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).</p>
<p>If You Go on Unpaid Leave</p>	<p>For an approved leave of absence, you’ll still be covered by the Dental Plan. JPMorgan Chase will directly bill you for any required contributions on an after-tax basis.</p> <p>If you do not make the required contributions to continue your Dental Plan coverage, your coverage will be canceled. However, your coverage may be automatically reinstated when you return to work.</p> <p>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).</p>
<p>If You Leave JPMorgan Chase</p>	<p>If your employment with JPMorgan Chase terminates, participation for you and your covered dependents usually ends on the last day of the month in which you end active employment. However, under certain circumstances, you may be eligible to continue Dental Plan participation for a certain period of time under COBRA on an after-tax basis or as a retiree. (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 Dental Plan unless you choose to continue your participation under COBRA or under the Retiree Dental Plan.</p>

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If You Leave JPMorgan Chase (continued)	If you receive severance under the Severance Pay Plan and sign a Release, any elected dental 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 want to elect to continue dental coverage under COBRA for up to 18 months.
If You Retire from JPMorgan Chase	You need to meet minimum age and service requirements and have active dental coverage to be eligible for retiree dental coverage. For more information, please refer to the As You Retire Guide available on Company Home > HR & Personal > Pay & Benefits > Library.
If You Work Past Age 65	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 Dental Plan.
If You Divorce or Become Legally Separated	<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.)</p> <p>If you divorce or become legally separated, certain court orders could require you to provide dental benefits to covered dependent children. JPMorgan Chase is legally required to recognize qualified medical child support orders within the limits of the Dental Plan. If you're a party in a divorce settlement that involves the Dental Plan, you should have your attorney contact the Benefits Call Center to make sure the appropriate documents are filed and that the court order in question is actually a qualified medical child support order that complies with governing legislation. Please see "Medical Support Orders" on page 31 for more information.</p>
If You Die	<p>If you die while actively employed at JPMorgan Chase, any dependents who were covered under your Dental 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 Dental 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> <p>Any dependents who were enrolled in the Dental Plan at the time of your death may be eligible to continue coverage under the Retiree Dental Plan if, at the time of death:</p> <ul style="list-style-type: none"> • You have already met the eligibility requirements for general retirement eligibility; or • You have 25 years of cumulative service with JPMorgan Chase. Cumulative service means the period of service with JPMorgan Chase that may include service with predecessor heritage organizations as outlined by the following conditions:

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If You Die (continued)

- If employed by Manufacturers Hanover Corporation or one of its participating subsidiaries or Chemical Banking Corporation or one of its participating subsidiaries on the date of their merger (December 31, 1991), then only prior service with the specific heritage organization employing you on that merger date (December 31, 1991) will count as cumulative service. Service with the other heritage organizations will not count.
- If employed by Chemical Banking Corporation or one of its participating subsidiaries or The Chase Manhattan Corporation or one of its participating subsidiaries on the date of their merger (March 31, 1996), then only prior service with the specific heritage organization employing you on that merger date (March 31, 1996) will count as cumulative service, as follows:
 - If employed by Chemical Banking Corporation or one of its participating subsidiaries as of March 31, 1996, service recognized for pay credit purposes under the Chemical Retirement Plan on such date will count as cumulative service; or
 - If employed by The Chase Manhattan Corporation or one of its participating subsidiaries as of March 31, 1996, service recognized for benefit service purposes under the Chase Retirement Plan on such date will count as cumulative service.
- If employed by The Chase Manhattan Corporation or one of its participating subsidiaries or J.P. Morgan or one of its participating subsidiaries, on the date of their merger (December 31, 2000), then only prior service with the specific heritage organization employing you on that merger date (December 31, 2000) will count as cumulative service, as follows:
 - If employed by The Chase Manhattan Corporation or one of its participating subsidiaries as of December 31, 2000, service recognized for pay credit purposes under the Chase Retirement Plan on such date will count as cumulative service;
 - If employed by J.P. Morgan or one of its participating subsidiaries as of December 31, 2000, service recognized for vesting purposes under the J.P. Morgan Retirement Plan on such date will count as cumulative service.
- If employed by JPMorgan Chase & Co. or one of its participating subsidiaries or Bank One Corporation or one of its participating subsidiaries on the date of their merger (July 1, 2004), then only prior service with the specific heritage organization employing you on that merger date (July 1, 2004) will count as cumulative service, as follows:
 - If employed by JPMorgan Chase & Co. or one of its participating subsidiaries as of July 1, 2004, service recognized for pay credit purposes under the JPMorgan Chase Retirement Plan on such date will count as cumulative service; or

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If You Die (continued)

- If employed by Bank One Corporation or one of its participating subsidiaries as of July 1, 2004, service recognized for pay credit purposes under Bank One Personal Pension Account Plan on such date will count as cumulative service.
- If you were not employed by a heritage organization on any of the merger dates referred to above and are or have been re-employed, then your employer for purposes of the above rules will be the heritage organization that most recently employed you prior to your reemployment date, except that all service with such prior heritage organization will be recognized.
- Service with a company at the time of its acquisition (as opposed to a merger) may or may not count toward cumulative service, depending on the terms of the purchase agreement and the plan.

When Coverage Ends

Coverage under any JPMorgan Chase Dental 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 Dental Plan;
- The Dental 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” in the “Medical Plan” section of this Guide. 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). (Please see “Your Eligible Dependents” on page 9 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” in the “Medical Plan” section of this Guide.

Please see “If Your Situation Changes” on page 36 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 dental coverage at your own expense (102% of the full cost of coverage) 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 Dental 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.

Right to Amend

JPMorgan Chase reserves the right to amend, modify (including cost of coverage), reduce or curtail benefits under, or terminate the Dental Plan at any time for any reason by act of the Executive Vice President, Compensation and Benefits. In addition, the Dental 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.