

Your Guide to the JPMorgan Chase Expatriate Medical and Dental Plan Options

JPMorgan Chase offers a variety of benefits plan options to expatriate employees. Your eligibility for benefits depends on your expatriate group:

If You Are a...	You Are Eligible for...
U.S. Home-Based Expatriate	<ul style="list-style-type: none"> All U.S. benefits Health and Income Protection Plans, except for the U.S. Medical and Dental Plan options, and the Transportation Spending Account(s) The Expatriate Medical Plan and Dental Plan options
Non-U.S. Home-Based Expatriate Assigned to the United States	<ul style="list-style-type: none"> The Vision Plan, Spending Accounts (Health Care, Child/Elder Care, and Transportation), and Group Legal Services Plan The Expatriate Medical Plan and Dental Plan options
Non-U.S. Home-Based Expatriate Assigned Outside the United States	<ul style="list-style-type: none"> The Expatriate Medical Plan and Dental Plan options

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 If calling from outside the United States: 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>If you contact the Benefits Call Center after normal business hours, you can leave a message and a Service Representative will return your call within two business days.</p> <p>You may also submit a question by e-mail by using the "Contact Us" function in the "Tools" section of the Benefits Web Center. (See column at right for instructions on accessing the Benefits Web Center.)</p>	<p><i>From Work:</i> Go to Company Home > My Rewards @ Work > Benefits Web Center</p> <p><i>From Home:</i> Go to www.MyRewardsAtWork.com via the Internet</p>

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The JPMorgan Chase U.S. 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 U.S. Benefits Program. The JPMorgan Chase Expatriate Medical and Dental Plan options are available to most full-time and part-time expatriate 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. This information does not include all of the details contained in the applicable insurance contracts, plan documents, and trust agreements. If there is any discrepancy between this information and the governing documents, the governing documents will control. JPMorgan Chase & Co. expressly reserves the right to amend, modify, reduce, change, or terminate its benefits and plans at any time. The JPMorgan Chase U.S. Benefits Program does not create a contract or guarantee of employment between JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.

Important Terms

As you read this summary of the JPMorgan Chase Expatriate Medical and Dental Plan options, you'll come across some important terms related to each plan. To help you better understand the plans, many of those important terms are defined here.

Term	Definition
Before-Tax Contributions	<p>U.S. home-based expatriate employees, or expatriate employees who are assigned to the United States, pay for coverage with before-tax dollars — contributions that are taken from your pay before U.S. federal (and, in most cases, state and local) taxes are withheld. Before-tax dollars are also generally taken from your pay before U.S. Social Security taxes are withheld. This lowers your U.S. taxable income and your U.S. 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 U.S. Social Security purposes. Therefore, your future U.S. Social Security benefit could be slightly reduced if your total earnings for the year are less than the Social Security wage base (\$102,000 for 2008). However, this reduction is nominal and may be outweighed by the immediate tax savings resulting from using before-tax dollars to pay for your benefits.</p>
Claims Administrator	<p>The company that provides certain claims administration services for the Medical Plan and Dental Plan.</p>
Coinsurance	<p>The way you share costs for certain covered services after you meet the annual deductible. The Medical and Dental Plans pay a percentage of reasonable and customary (R&C) charges for medically necessary services, and you pay the remainder. The actual percentage depends on the type of covered service.</p>
Consolidated Omnibus Budget Reconciliation Act of 1985 as Amended (COBRA)	<p>A United States federal law that allows you and/or your covered dependents to continue Medical and/or Dental Plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for medical and/or dental continuation coverage.</p>
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, or dependent child covered as an active employee of another employer, that employer's coverage is considered primary for him or her. • For children covered as dependents under two plans, the primary plan is the plan of the parent whose birthday falls earlier in the year (based on month and day only, not year). <p>Specific rules may vary, depending on whether the patient is an employee in active status (or the dependent of an employee) or covered by Medicare.</p>

Term	Definition
Copay or Copayment	The amount you pay toward certain health care services under the Medical and Dental Plans. For example, the Medical Plan requires a \$10 copayment for X-rays and labs (for in-network care received in the U.S. or care received outside the U.S.).
Covered Expenses	The reasonable and customary (R&C) charges for medically necessary covered services or supplies that qualify for full or partial reimbursement under the Medical and/or Dental Plans.
Covered Services	Medical or dental procedures that are generally reimbursable by the JPMorgan Chase Expatriate Medical and/or Dental Plans when they are “medically necessary.” While the plans provide coverage for numerous services and supplies, there are limitations on what’s covered. For example, experimental treatments, most cosmetic surgery expenses, and inpatient and outpatient private duty nursing are not covered under the Medical Plan. So, while a service or supply may be medically necessary, it may not be covered under the plans.
Custodial Care	Medical or non-medical services that do not seek to cure, are provided during periods when the medical condition of the patient is not changing, or do not require continued administration by medical personnel. An example of custodial care is assistance in the activities of daily living.
Deductible	The amount you pay in a calendar year for covered expenses before the Medical or Dental Plan begins to pay benefits. Amounts in excess of reasonable and customary (R&C) charges do not count toward the deductible.
Domestic Partner	<p>You may cover a “domestic partner” as an eligible dependent under the Medical and/or Dental Plans if you’re not currently covering a spouse. You and your domestic partner must:</p> <ul style="list-style-type: none"> • Be age 18 or older; • Have lived together for at least six months and have a serious, committed relationship; • Be financially interdependent; • Not be related to each other in a way that would prohibit legal marriage; and • Not be legally married to, or the domestic partner of, anyone else. <p>OR</p> <ul style="list-style-type: none"> • Have registered as domestic partners pursuant to a domestic partnership ordinance or law of a state or local government, or under the laws of a foreign jurisdiction. <p>You must certify that your domestic partner meets the eligibility rules as defined under the plans before coverage can begin. You may also be asked to certify that your domestic partner and/or your domestic partner’s children qualify as a tax dependent as determined by the United States Internal Revenue Code to avoid any applicable imputed income.</p> <p>Please see the Domestic Partner Coverage Guide for additional information on covering a domestic partner.</p>
Eligible Dependents	Under the Medical and Dental Plans, your eligible dependents can include your spouse or domestic partner, and your dependent children. Please see “Your Eligible Dependents” on page 8 for more information.

Term	Definition
Experimental, Investigational, or Unproven Services	<p>Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the claims administrator makes a determination regarding coverage in a particular case, are determined to be:</p> <ul style="list-style-type: none"> • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or • Subject to review and approval by any institutional review board for the proposed use; or • The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations regardless of whether the trial is actually subject to FDA oversight; or • Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed. <p>The claims administrator, in its judgment, may determine an experimental, investigational, or unproven service to be covered under the Medical Plan for treating a “life-threatening” sickness or condition if the claims administrator determines that a service:</p> <ul style="list-style-type: none"> • Is safe with promising effectiveness; and • Is provided in a clinically controlled research setting; and • Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. <p>Please Note: For the purpose of this definition, the term “life-threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.</p>
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 Medical and/or Dental Plans.</p>
Full-Time Student	<p>Generally, a full-time student is defined as a dependent enrolled in an educational institution on a full-time basis at the time services are received. An educational institution is defined as a school maintaining a regular faculty, an established curriculum, and having an organized student body in attendance. It includes high schools, colleges, technical schools, and similar institutions but not on-the-job training. JPMorgan Chase will use the educational institution’s definition of a full-time student. During the summer term, when few students are enrolled, coverage will be based on enrollment during the previous term, unless the student has completed his or her full course of studies.</p>
Hospice Care Program	<p>A program that tends to the needs of a terminally ill patient as an alternative to traditional health care, while meeting medically necessary and acceptable standards of quality and sound principles of health care administration. The program must be a written plan of hospice care for a covered person, and it must be approved by the appropriate claims administrator.</p>
Hospital	<p>An institution legally licensed as a hospital — other than a facility owned or operated by the United States Government — that’s engaged primarily in providing bed patients with diagnosis and treatment under the supervision of licensed physicians. The hospital must have 24-hour-a-day registered graduate nursing services and facilities for major surgery. Institutions that don’t meet this definition don’t qualify as hospitals.</p>

Term	Definition
In-Network/ Out-of-Network	Terms referring to whether a covered service is performed by a provider who is part of the networks associated with the Medical and Dental Plans or by a provider who is not part of the networks (“out-of-network”). When a service is performed in-network, benefits are generally paid at a higher level than they are when a service is performed out-of-network.
Maximum Lifetime Benefit	The most the Medical or Dental Plan option will pay for covered services in each participant’s lifetime.
Medically Necessary or Medical Necessity	<p>Health care services and supplies that are determined by the claims administrator to be medically appropriate and:</p> <ul style="list-style-type: none"> • Necessary to meet the basic health needs of the covered person; • Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply; • Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator; • Consistent with the diagnosis of the condition; • Required for reasons other than the convenience of the covered person or her or his physician; and • Demonstrated through prevailing peer-reviewed medical literature to be either: <ul style="list-style-type: none"> — Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or — Safe with promising effectiveness: <ul style="list-style-type: none"> - For treating a life-threatening sickness or condition; - In a clinically controlled research setting; and - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. <p>Please Note: For the purpose of this definition, the term “life-threatening” is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.</p> <p>The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or condition does not mean that it is a medically necessary service or supply as defined above. The definition of “medically necessary” used here relates only to coverage and may differ from the way in which a physician engaged in the practice of medicine may define “medically necessary.”</p> <p>Finally, to be considered necessary, a service or supply cannot be educational or experimental in nature in terms of generally accepted medical standards.</p>
Medicare	Generally, government-provided medical coverage for retired, elderly, or disabled Americans. Technically, Medicare is the Health Insurance for the Aged and Disabled provisions of Title XVIII of the Social Security Act of the United States, as enacted or later amended. Coverage is available to most U.S. residents age 65 and above, those with a disability, and those with end-stage renal disease (ESRD) who do not have primary plan coverage available to them through an employer-sponsored plan such as the JPMorgan Chase Medical Plan. Generally, Medicare is the primary coverage for those individuals who are age 65 and above, unless these individuals are actively working.

Term	Definition
Non-Duplication of Benefits	The Medical and/or Dental Plans do not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. You are entitled to receive benefits up to what you would have received under the Medical or 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 Medical or Dental Plan, the claims administrator will reduce the amount of coverage that you would otherwise receive under these plans by any amount you receive from your primary coverage. Please see the definition of “Coordination of Benefits” in this section.
Out-of-Pocket Maximum	The most you would need to pay in a calendar year for medically necessary covered services under the Medical Plan for in-network or out-of-network care. Once the out-of-pocket maximum is reached, the Medical Plan will pay 100% of reasonable and customary (R&C) charges for medically necessary covered services for the rest of the year. However, amounts that you pay toward your deductible, and amounts above R&C charges, do not count toward your out-of-pocket maximum.
Primary Plan	The plan that provides initial coverage to the participant. If the participant is covered under both the JPMorgan Chase Expatriate Medical Plan and/or Dental Plan options and the plan of another employer, the rules of the primary plan govern when determining the coordination of benefits between the two plans.
Qualified Change in Status	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.). 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 14 for more information.
Reasonable and Customary (R&C) Charges	The actual charges that are considered for payment when you receive medically necessary care for covered services under the Medical and/or Dental Plans. R&C means the prevailing charge for most providers in the same or a similar geographic area for the same or similar service or supply. These charges are subject to change at any time without notice. Reimbursement is based on the lower of this amount and the provider’s actual charge. If your provider charges more than the R&C charges considered under the 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.
Skilled Nursing Facility	An institution that primarily provides skilled nursing care and related services for people who require medical or nursing care and that rehabilitates injured, disabled, or sick people.

Participating in the Expatriate Medical Plan and Dental Plan Options

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

Coverage Categories

JPMorgan Chase provides a range of coverage levels. Your coverage level is based on the number of dependents you enroll and includes the following coverage categories:

- Employee Only;
- Employee Plus One Adult;
- Employee Plus Child(ren); or
- Employee Plus One Adult Plus Child(ren).

You can enroll yourself and your eligible dependents in the Expatriate Medical Plan option and/or the Expatriate Dental Plan option. You can also elect “No Coverage” for one or both of these options.

Your Eligible Dependents

In addition to covering yourself under the Medical and/or Dental Plans, you can also cover your eligible dependents, but only under the same option you choose for yourself.

Your eligible dependents include:

- Your spouse to whom you’re legally married or your domestic partner;
- Your unmarried dependent children up to the end of the month in which they reach:
 - age 19; or
 - age 21 if they are not eligible for benefits through their own employer; or
 - age 23 if they are a “full-time student” (Please see the definition of “full-time student” in “Important Terms” beginning on page 3.)
- Your unmarried dependent child who is not capable of supporting himself or herself due to a mental or physical disability that began before the age limits described above and who is fully dependent on you for financial support.

If JPMorgan Chase also employs your spouse, domestic partner, or dependent child, he or she can be covered as an employee or as your dependent, but not as both. If you want to cover your eligible dependent child(ren), you or your spouse/domestic partner (but not both of you) may elect to provide this coverage.

Dependent Children

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

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

Please Note: If you are covering the child of a domestic partner who is *not* a tax dependent, imputed income for that child will be applied. Please see the **Domestic Partner Coverage Guide** for more information (access information below).

Domestic Partners

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

You and your domestic partner must:

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

OR

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

In addition, you can enroll children of a domestic partner, as long as they meet the eligibility requirements of being your dependent children as described above, and the domestic partner is also enrolled. In the event that you reside in a location that does not recognize legal adoption with respect to a child of a domestic partner, coverage will be available provided that you submit, in writing, that your jurisdiction of residency does not permit adoption with respect to domestic partner relationships, and that if this restriction did not exist, you would otherwise adopt the child. This condition only applies if you do not cover the domestic partner.

For more information on covering a domestic partner, please refer to the **Domestic Partner Coverage Guide**, available online under the Key Resources Box:

For employees in Asia Pacific: Go to Company Home > HR & Personal > Pay & Recognition > Expatriate Programs > Expatriate Benefits

For employees in Europe, the Middle East, and Africa: Go to Company Home > HR & Personal > Compensation & Benefits > Global Compensation & Benefits > Expatriate Programs > Expatriate Benefits

For employees in all other locations: Go to Company Home > HR & Personal > Pay and Benefits > Additional Programs > Expatriate Programs > Expatriate Benefits

You may also contact the Benefits Call Center to request a copy of the Guide.

Cost of Coverage

You and JPMorgan Chase share the cost of coverage under the Expatriate Medical Plan and Dental Plan options. During your designated enrollment period, the cost under each of the coverage categories for each option offered will be available on the Benefits Web Center via My Rewards @ Work. Your cost each plan year depends on the options you choose and the number and type of eligible dependents you cover.

U.S. home-based expatriate employees or expatriate employees who are assigned to the U.S. pay for coverage with before-tax dollars, which means your U.S. federal, state, and local income taxes (if applicable) are reduced.

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

When Contributions Begin

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

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

Cost for Domestic Partner Coverage

If you're covering a domestic partner as described in "Your Eligible Dependents" on page 8, there are some cost implications of which you should be aware. Specifically, in many cases a "Domestic Partner" will not satisfy the definition of "Dependent" under the U.S. Internal Revenue Code (IRC). As a result, in most states, if you are subject to U.S. tax withholding, U.S. federal law requires JPMorgan Chase to report the entire value of the medical coverage for a "Domestic Partner" to the Internal Revenue Service 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.

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

Favorable Tax Treatment in Certain States

Based on the availability of more favorable tax treatment in certain states, employees who certify that their domestic partner and/or domestic partner's children are tax-qualified in the following states (based on the individual state's requirements) will not be subject to state imputed income tax related to benefits coverage for their domestic partner:

- California
- Connecticut
- Massachusetts

Enrolling a Domestic Partner

*For more information on enrolling and the tax consequences of covering a domestic partner, please refer to the **Domestic Partner Coverage Guide** available on Key Resources > Domestic Partner Coverage Guide via the "Expatriates Benefits" page on HR & Personal.*

If you are located outside of the U.S., you must change your personal intranet user information to North America to access this Guide.

- New Jersey
- Oregon
- Vermont
- Washington, D.C.

Please Note: In order to be eligible for this state income tax treatment, you must contact the Benefits Call Center to certify that your domestic partner and partner's child(ren) (if applicable) qualify for this tax treatment.

For more information, please refer to the **Domestic Partner Coverage Guide**, which describes the eligibility requirements and enrollment process for domestic partner coverage under the JPMorgan Chase Benefits Program. You can view the Guide at Key Resources > Domestic Partner Guide via the "Expatriate Benefits" page on HR & Personal. (See "Domestic Partners" on page 9 for access instructions for your region.)

Smoker Status

When you enroll for coverage, and each year at annual benefits enrollment, you will be asked to verify the smoker status of yourself and your covered dependents as a non-smoker or smoker. **Please Note:** While you must verify your smoker and/or non-smoker status, your cost of coverage under the Expatriate Medical Plan option will be the lower non-smoker rates, regardless of whether you certify as a smoker or non-smoker. To be considered a non-smoker, you and/or any covered dependents must be smoke-free for at least 12 months as of January 1 of that plan year, or complete an approved smoking cessation program.

Smoking cessation programs are available throughout the year. For more information on smoking cessation programs and requirements, change your personal intranet profile to North America and go to Company Home > HR & Personal > Life & Well Being > Personal Health > Smoking Cessation Program.

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

How Smoker Is Defined

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

How to Enroll

Participation in the Medical Plan is optional.

If You:	What You Need to Do to Enroll:
<p>Are an Expatriate Employee</p>	<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 14 for more information.</p>
<p>Are a Newly Hired U.S. Home-Based Expatriate Employee or New to Expatriate Status</p>	<p>If you've just joined JPMorgan Chase or are new to expatriate status 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 or within 31 days of commencing an expatriate assignment, 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:</p> <p>For employees in Asia Pacific: Go to Company Home > HR & Personal > Pay & Recognition > Expatriate Programs > Expatriate Benefits</p> <p>For employees in Europe, the Middle East, and Africa: Go to Company Home > HR & Personal > Compensation & Benefits > Global Compensation & Benefits > Expatriate Programs > Expatriate Benefits</p> <p>For employees in all other locations: Go to Company Home > HR & Personal > Pay and Benefits > Additional Programs > Expatriate Programs > Expatriate Benefits</p>
<p>Have a Qualified Change in Status</p>	<p>If you're enrolling during the year because 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 by calling the Benefits Call Center and speaking with a Service Representative. Please see "Qualified Change in Status" on page 14 for more information.</p>

If You Do Not Enroll

If You:	What Happens If You Do Not Enroll:
Are an Expatriate Employee	If you're already participating in the Medical and/or 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.
Are a Newly Eligible or Newly Hired Expatriate Employee	If you're a new hire or newly eligible employee and do not enroll within the designated 31-day eligibility period, coverage for certain benefits will be effective as of the date you contact the Benefits Call Center. Please see "Qualified Change in Status" on page 14 for more information.
Have a Qualified Change in Status	If you have a qualified change in status that allows you to enroll in the Medical and/or Dental Plan mid-year and you do not enroll within the designated 31-day period, coverage for certain benefits will be effective as of the date you contact the Benefits Call Center. Please see "Qualified Change in Status" on page 14 for more information.

When Coverage Begins

If You:	When the Coverage You Elect Begins:
Are an Expatriate Employee	The coverage you elect during the annual benefits enrollment period takes effect the beginning of the following plan year (January 1).
Are a Newly Eligible or Newly Hired Expatriate Employee	The coverage you elect as a new expatriate employee becomes effective on the date of your transfer to expatriate status.
Have a Qualified Change in Status	The coverage you elect as a result of a qualified change in status (such as marriage or the birth or adoption of a child) or work status change (such as an adjustment to your regularly scheduled work hours) will take effect the day of the qualifying event, if you enroll within 31 days of the event and if you have already met the plans' eligibility requirements.

Please Note: The Expatriate Medical Plan option covers pre-existing conditions. So, under this option, your coverage for any pre-existing condition begins as soon as you enroll.

Qualified Change in Status

The 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 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 miss the 31-day deadline, coverage for certain benefits will be effective as of the date you contact the Benefits Call Center.

If you have a qualified change in status and want to change your elections, please see the **Benefits Status Change Guide** available online under the Key Resources Box:

For employees in Asia Pacific: Go to Company Home > HR & Personal > Pay & Recognition > Expatriate Programs > Expatriate Benefits

For employees in Europe, the Middle East, and Africa: Go to Company Home > HR & Personal > Compensation & Benefits > Global Compensation & Benefits > Expatriate Programs > Expatriate Benefits

For employees in all other locations: Go to Company Home > HR & Personal > Pay and Benefits > Additional Programs > Expatriate Programs > Expatriate Benefits

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 for benefits to be effective the date of the event. If you miss the 31-day deadline, coverage for certain benefits will be effective as of the date you contact the Benefits Call Center. Otherwise, you will not be able to make the change in coverage until the following annual benefits enrollment period.

Please 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.

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

Qualified changes in status for eligible dependents under the Medical and Dental Plans are listed in the following table.

Medical and Dental Plan Changes for Qualified Change in Status	
Event	Medical and/or Dental Plan Changes
Spouse and Children	
You get married	Add coverage for you, spouse, and/or eligible dependent children
You have, adopt, or obtain legal guardianship of a child	Add coverage for you and/or your eligible dependents
You and/or your covered dependents gain other benefits coverage	Cancel coverage for you and/or your covered dependents who have gained other coverage

Medical and Dental Plan Changes for Qualified Change in Status

Event	Medical and/or Dental Plan Changes
You and/or your eligible dependents lose other benefits coverage	Add coverage for you and/or your eligible dependents who have lost other coverage
You get legally separated or divorced	Cancel coverage for your former spouse and/or dependent children who are no longer eligible
A covered family member dies	Cancel coverage for your deceased dependent and any dependent children who are no longer eligible
A dependent child is no longer eligible	Cancel coverage for your dependent child
Domestic Partner	
You add a newly eligible domestic partner	Add coverage for you, your domestic partner, and any eligible dependent children
You end a domestic partner relationship	Cancel coverage for your domestic partner, and your domestic partner's dependent children who are no longer eligible

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

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

A copy of the privacy notice is also available under the Expatriate Library section of the Expatriate Programs page on HR & Personal, or you can contact the Benefits Call Center at any time to request a paper copy. Under HIPAA, protected health information is confidential, personal, identifiable health information about you that is created or received by a claims administrator (like those under the JPMorgan Chase Medical Plan), and is transmitted or maintained in any form. (“Identifiable” means that a person reading the information could reasonably use it to identify an individual.)

Under HIPAA, JPMorgan Chase may only use and disclose Medical Plan participants' protected health information in connection with payment, treatment, and health care operations. In addition, JPMorgan Chase must restrict access to and use of protected health information by all employees/groups except for specific purposes of administering the Medical Plan, including payment and health care operations. In compliance with HIPAA, JPMorgan Chase agrees to:

- Not use or further disclose protected health information other than as permitted or required by law;
- Ensure that any agents (including a subcontractor) to whom the company gives protected health information received from the claims administrators agree to the same restrictions and conditions that apply to JPMorgan Chase with respect to this information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of JPMorgan Chase;
- Report to the claims administrators any use or disclosure of the information that is inconsistent with the designated protected health information uses or disclosures;
- Make available protected health information in accordance with individuals' rights to review their protected health information;
- Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules;
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules;
- Make the company's internal practices, books, and records relating to the use and disclosure of protected health information received from the claims administrators available to the Secretary of Health and Human Services for purposes of determining compliance by the JPMorgan Chase Medical Plan; and
- Return or destroy all protected health information received in any form from the claims administrators. JPMorgan Chase will retain no copies of protected health information when no longer needed for the purpose of a disclosure. An exception may apply if the return or destruction of protected health information is not feasible. However, JPMorgan Chase must limit further uses and disclosures of this information to those purposes that make the return or destruction of the information infeasible.

If you believe that your rights under HIPAA have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the Plan, please complete a HIPAA complaint form (available by contacting the Benefits Call Center) and send it to:

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

HIPAA Special Enrollment Rights

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

If you or your eligible dependent declined coverage under the Medical and/or Dental Plans, you may enroll for coverage within 31 days of one of the following events:

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

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

Qualified Medical Child Support Order

If the Medical Plan and/or Dental Plan receive a judgment, decree, or order — including a Qualified Medical Child Support Order (QMCSO) — requiring the plans to provide health coverage to your child or foster child who is your dependent, the plans will automatically change your benefits elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin 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 plans, to the extent permitted by the United States Internal Revenue Code (IRC) and the Medical and/or Dental Plans.

A participant or beneficiary may obtain a description of the procedures governing medical support order determinations, without charge, from the plan administrator.

Medical and Dental Coverage

Here are some important points to remember about your JPMorgan Chase Expatriate Medical Plan and Dental Plan options.

Highlights of CIGNA International Coverage

For medical benefits, there is no deductible for in-network care received in the United States or for care received outside the United States. The plan offers 100% coverage for preventive medical care for many preventive screenings received in-network in the United States or outside the United States. For dental benefits, there is no deductible for preventive or diagnostic care. These options also offer participants:

- A multilingual, around-the-clock Customer Service hotline to verify benefits in the event of an emergency as well as to assist with hospital admissions. Customer Service Representatives can also be contacted either electronically or via fax.
- Translation services for employees and/or providers who prefer to speak with a Customer Service Representative in a language other than English.
- Preferred provider networks in Hong Kong, the Middle East (Bahrain, Kuwait, Qatar, Saudi Arabia and the United Arab Emirates), Singapore, Spain, and the U.S. and U.K., with direct payment to providers, many that have agreed to provide services at discounted rates.
- Direct payment to a hospital or medical provider (if accepted by the provider).
- Payment of claims in over 100 currencies.
- Expedited claims processing. (Claims submitted for payment in U.S. dollars are generally processed within 10 business days from receipt of complete claim information. Claims submitted for payment in non-U.S. currency will take a few days longer due to currency conversion banking procedures.) There are no additional charges for payment in non-U.S. currency.
- Reimbursement checks, wire transfers that can be sent to your bank account anywhere in the world, and ePayment Plus (international ACH) for depositing funds to your bank account without incurring bank service charges.
- Direct mailing of explanation of benefits statements.
- An international physician referral service.
- One standard claim form for medical, dental, and prescription drug expenses.
- Global health management services, which provide medical advice and consultation.
- Expert second opinion via the Internet through e-Cleveland Clinic.

Identification (ID) Cards

If you elect Medical and/or Dental Plan coverage, you will receive a CIGNA International ID card for each eligible dependent containing important claim filing instructions and telephone numbers for verification of coverage. Please remember to always carry your ID card with you. To replace lost ID cards, please contact CIGNA International Customer Service.

Participants assigned to select countries outside the U.S. where a CIGNALinks® provider network is available may receive a separate ID card to use when seeking care in that CIGNALinks® country.

Participants in select countries where a CIGNALinks® provider network is not available may receive a CIGNALinks® ID Card for use in a nearby CIGNALinks® country.

If you expect to receive care in another country where a CIGNALinks® provider network is available (e.g., your home country), please contact CIGNA International Customer Service to request the appropriate CIGNALinks® ID Card. Please see “In-Network Care — CIGNALinks®” on page 24 for additional information about CIGNALinks®.

CIGNA International will mail your ID card(s) to your home address on record. Therefore, it is important that you update your home address as soon as possible upon relocation by calling *accessHR* at 1-877-JPMChase (1-877-576-2427) or 1-212-552-5100 (GDP# 352-5100) if calling from outside the United States, and speaking with a Service Representative. Service Representatives are available Monday through Friday, from 8 a.m. to 7 p.m. Eastern Time, except certain U.S. holidays.

Please Note: You must change your home address on record as instructed above; you cannot change your address by contacting CIGNA International directly.

24-Hour Customer Service

CIGNA International Customer Service Representatives are available 24 hours a day, seven days a week to verify benefits in the event of an emergency, facilitate hospital admissions, arrange for medical care when needed, and address routine claim inquiries. Translation services are available for employees or medical providers who prefer to speak with a Customer Service Representative in a language other than English.

CIGNA International Customer Service Representatives are available at 1-800-390-7183 or by calling collect at 1-302-797-3644 if calling from outside the United States.

Global Health Management Services

Depending upon your location and needs, CIGNA International can assist you by facilitating hospital admissions (including advance payment of fees), providing a full range of medical advice and consultation, as well as offering medical/dental referrals. Services also include patient advocacy, medical monitoring, case management, replacement/transfer of emergency prescription drugs (outside the United States when legally permissible), and supervision of medically required repatriation/evacuations. All services can be accessed by calling CIGNA International Customer Service.

e-Cleveland Clinic

CIGNA International offers a comprehensive expert second opinion available via the Internet through e-Cleveland Clinic. This online second opinion is provided by physician specialists associated with the e-Cleveland Clinic in Cleveland, Ohio, USA, one of the foremost institutions in the world for treating cancer, heart disease, and other serious illnesses. The specialists are world-renowned for their diagnostic expertise in these and other fields.

Once you have registered to use the CIGNA International Secure Web Site, you have access to the e-Cleveland Clinic web site through a link at this secure site. (For more information about the CIGNA International Secure Web Site, please see "Secure Web Site Service" below.)

You may also contact e-Cleveland Clinic by telephone Monday through Friday, from 8 a.m. to 5 p.m. Eastern Time; AT&T Direct access number 1-800-223-2273 ext. 43223. (Be sure to mention that you participate in a Medical Plan option administered by CIGNA International.)

A second opinion from e-Cleveland Clinic is covered under the Expatriate Medical Plan option, subject to the applicable deductible and/or coinsurance amount.

Secure Web Site Service

CIGNA International offers expatriate employees access to several online services. Registration for the site may be done online at www.cigna.com/expatriates. Please have your CIGNA International ID Card available to begin the online registration process.

Here's what you can do at the site:

- Review your claims (which are refreshed daily, Monday through Friday) as well as your claims payment information.
- Scan your claim form and receipts and send via secure e-mail from the site. (Your claims arrive promptly, which helps expedite receipt of your reimbursement.)
- Download claim forms in 13 languages.
- Review the *International Provider Directory* to assist you in identifying providers with whom you can create a relationship in advance of requiring care — an excellent first step when you arrive in your assignment country. Providers who have signed a formal agreement for direct settlement of claims are noted in the directory (you simply pay your portion of the bill and the provider bills CIGNA International directly for the remainder). In some instances, providers offer discounts on certain services. (If you are sick or injured or need medical advice, it is recommended that you call CIGNA International Customer Service to speak with a doctor experienced in international medicine who can refer you to the most appropriate provider, based on your symptoms and location.)
- Review the *U.S. Preferred Provider Directory* of doctors, dentists, hospitals, and/or clinics that offer discounts on services and have agreed to bill CIGNA International directly for services (you simply pay a small copayment or coinsurance at the time services are rendered).
- Take a tour of more than 190 countries in the Country Guides section of the site. You'll find the latest news for each country, including medical and security alerts, as well as up-to-date health, cultural, general, and travel information.
- Access a wide variety of health and wellness resources through healthinfoseeker.com, where you'll find links to useful information on more than 5,000 health topics.

Filing a Claim for Benefits

Depending upon your provider, claims may need to be paid at the time of service. You will then be reimbursed based on the schedule of benefits described under “How Your Medical Benefits Work” on page 23 of this Guide.

When you or your eligible dependents incur expenses, a claim form must be completed by you and the attending physician. (An itemized bill may be submitted in lieu of the attending physician’s statement.) There is only one CIGNA International claim form to claim reimbursement for medical, dental, and/or prescription drug expenses. The CIGNA International claim form is available under the Expatriate Library section of the Expatriate Programs page on HR & Personal.

All completed claim forms, with original itemized bills, should be sent via fax to the CIGNA International Claim Office at 1-302-797-3150 (or ATT access code 1-800-243-6998) or mailed to:

CIGNA International
P.O. Box 15050
Wilmington, DE 19850-5050
U.S.A.

or sent via courier to:

CIGNA International
590 Naamans Road
Claymont, DE 19703-2308
U.S.A.

You may also e-mail your claim form (you will need to scan your receipts and attach the scanned copies to your e-mail) by using CIGNA’s Secure Web Site Service, as described under “Secure Web Site Service” on page 20.

Claims submitted for payment in U.S. dollars will generally be processed within 10 business days from the date complete information is received by CIGNA International, regardless of the language or currency.

CIGNA International offers ePayment Plus (international ACH), a valuable service designed to complement the existing array of electronic payment options that enable cross-border payments virtually anywhere in the world. In most cases, ePayment Plus provides the added feature of depositing funds to your bank account without incurring bank service charges.

Employees with a bank account in any of the following countries may now elect to receive claim reimbursements electronically (deposited in local currency):

- Belgium
- Canada
- France
- Germany
- Hong Kong
- Portugal
- Singapore
- Spain
- United Kingdom

ePayment Plus includes automatic notification of payments. You can quickly and easily self-enroll in ePayment Plus at the CIGNA International member web site at www.cigna.com/expatriates via the Internet. Please see "Secure Web Site Service" on page 20 for more information about accessing the site.

If a claim reimbursement is deposited directly into your bank account, CIGNA International will send you an explanation of benefits statement as confirmation.

To have your claim considered for benefits, all claims must be filed by December 31 of the year following the year in which services were provided. If you do not meet this deadline, your claim will be denied.

If your claim for reimbursement is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the "Plan Administration" section, available online under the Key Resources Box:

For employees in Asia Pacific: Go to Company Home > HR & Personal > Pay & Recognition > Expatriate Programs > Expatriate Benefits

For employees in Europe, the Middle East, and Africa: Go to Company Home > HR & Personal > Compensation & Benefits > Global Compensation & Benefits > Expatriate Programs > Expatriate Benefits

For employees in all other locations: Go to Company Home > HR & Personal > Pay and Benefits > Additional Programs > Expatriate Programs > Expatriate Benefits

CIGNA International Expatriate Medical Plan Option

Under the CIGNA International Expatriate Medical Plan option, you have access to any licensed hospital or physician around the world. CIGNA International pays medical benefits based on where you receive care.

How Your Medical Benefits Work

If You Receive Care in the United States

When you receive care in the United States, you can choose between receiving care in-network or out-of-network each time you need medical care. You will generally pay less when you use a network provider.

In-Network Care

- You may use a provider in the CIGNA International Preferred Care Network. For information on the Preferred Care Network, call CIGNA International at 1-800-390-7183, or call collect at 1-302-797-3644 if calling from outside the United States. You may also visit the CIGNA International web site at www.cigna.com/expatriates. Please see "Secure Web Site Service" on page 20 for additional information on this site.
- In-network care is generally covered at a higher percentage, and network providers have agreed to charge lower, negotiated fees for their services when treating participants.
- There are no deductibles when you use in-network providers.
- The plan offers 100% coverage for many preventive screenings.
- The plan generally pays 100% of the cost for hospitalization (after a \$250 copayment) and 80% of most other covered services.
- In most instances, the provider will bill CIGNA International directly, so you do not have to file a claim form.

Prescription Drug Purchases in the United States

For prescription drug purchases in the United States, you can use the CIGNA Pharmacy Management network of participating pharmacies to obtain discounted brand-name and generic prescription drugs through more than 45,000 U.S. pharmacies. Simply present your CIGNA International ID card containing the RxPrime logo and account number at any participating network pharmacy to take advantage of this prescription service. When you purchase prescription medications at in-network pharmacies within the U.S., you pay 20% of the discounted price at the point of sale.

If you have questions about the CIGNA Pharmacy Management network, please call CIGNA International Customer Service or visit the CIGNA International web site at www.cigna.com/expatriates via the Internet.

Out-of-Network Expenses

All out-of-network expenses are subject to reasonable and customary (R&C) limits; you are responsible for 100% of all charges above the R&C amounts. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

Out-of-Network Care

- You may use any licensed provider.
- The plan generally pays 70% of eligible expenses after you meet the annual deductible (\$600 individual; \$1,200 individual plus one; \$1,200 individual plus child[ren]; and \$1,800 family).
- You must pay for services at the time you receive care and file claim forms to be reimbursed. Certain providers may accept assignment of benefits and choose to accept payment directly from CIGNA International. You would then be responsible for the difference not paid by the plan.

Annual Deductible

If you elect coverage for yourself or yourself plus one dependent, the annual deductible must be satisfied for each person before benefits begin for that person.

If you elect coverage for yourself plus two or more dependents, all expenses incurred are combined to meet the appropriate total deductible.

Hospital Admission

It is not necessary to call CIGNA International's case manager when entering a hospital outside the United States. However, for non-emergency hospital admissions in the United States, it is necessary to call CIGNA International's case management company, Care Allies/Intracorp. You can reach Care Allies/Intracorp by calling CIGNA International and a Customer Service Representative will route your call. Failure to do so may result in reduced benefits payments.

If You Receive Care Outside the United States

When you receive care in selected countries outside the United States, you can choose between receiving care in a CIGNALinks® network or out-of-network. You will generally pay less when you use a CIGNALinks® network provider.

In-Network Care — CIGNALinks®

CIGNALinks® is a service enhancement to the global Expatriate Medical Plan option. The key to the CIGNALinks® concept is an alliance with a local company. CIGNA International works with local health care companies in selected countries, integrating its global medical plans with the administrative services and provider networks of the local health care company. CIGNA International has entered into alliances with local administrators (and/or insurers) in:

- Australia
- Hong Kong
- Middle East (Bahrain, Kuwait, Qatar, Saudi Arabia, and the United Arab Emirates)
- Singapore
- Spain
- United Kingdom

Basic to CIGNALinks® is a provider network of doctors, hospitals and clinics that have agreed to provide services at discounted rates. When going to a hospital or clinic that is in the network, you simply present your CIGNALinks® ID card, pay any applicable coinsurance, and receive treatment. In most instances, providers in the network will file their claims directly with CIGNA — limiting your out-of-pocket costs when services are rendered.

The schedule of benefits for the Expatriate Medical Plan option will not change in conjunction with CIGNALinks®; however, because of local regulations and considerations, your benefit plan design in certain countries will differ somewhat from your global Expatriate Medical Plan coverage (for example, in certain countries limits on services such as chiropractic care are waived). In the event that a benefit is not covered under your local CIGNALinks® plan design, the claim will be processed by CIGNA International, pursuant to the schedule of benefits of the global Expatriate Medical Plan option.

When receiving care in a CIGNALinks® network, local Customer Service is available during normal business hours, and as always, CIGNA International Customer Service is available 24 hours a day, seven days a week. Contact information for the local CIGNALinks® administrator can be found on your CIGNALinks® ID Card.

Out-of-Network Care

- You may use any licensed provider.
- There are no deductibles.
- The plan offers 100% coverage for many preventive screenings.
- The plan generally pays 100% of the cost for hospitalization (after a \$250 copayment) and 80% of most other covered services.
- You must pay for services at the time you receive care and file claim forms to be reimbursed. Certain providers may accept assignment of benefits and choose to accept payment directly from CIGNA International. You would then be responsible for the difference not paid by the plan.

The CIGNA International Expatriate Medical Plan option pays benefits as follows:

Provision	Care Received Inside the United States		Care Received Outside the United States*
	In-Network	Out-of-Network*	
Annual deductible**	None	\$600 individual \$1,200 individual + one \$1,200 individual + child(ren) \$1,800 family	None
Annual out-of-pocket maximum (stop loss limit)	\$2,500 individual \$5,000 individual + one \$5,000 individual + child(ren) \$7,500 family	\$4,000 individual \$8,000 individual + one \$8,000 individual + child(ren) \$12,000 family	\$2,500 individual \$5,000 individual + one \$5,000 individual + child(ren) \$7,500 family
Lifetime maximum	Unlimited	\$2,000,000 per individual	\$2,000,000 per individual

* All out-of-network expenses are subject to reasonable and customary (R&C) limits; you are responsible for 100% of all charges above R&C amounts. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

** If you elect coverage for yourself or yourself plus one dependent, the annual deductible must be satisfied for each person before benefits begin for that person. If you elect coverage for yourself plus two or more dependents, all expenses incurred are combined to meet the appropriate total deductible.

Provision	Care Received Inside the United States		Care Received Outside the United States*
	In-Network	Out-of-Network*	
Preventive Care			
(A service that is normally considered preventive may be classified and coded as diagnostic rather than preventive medical care by your physician in certain circumstances. A medical service will only be covered at 100% if it is coded preventive. Before receiving any service, you should check with your physician to be sure a procedure is considered, and will be submitted to the claims administrator, as preventive medical care rather than as a diagnostic service.)			
Routine physical exam (maximum varies by age)	100%	Not covered	100%
Well-child care office visits (immunizations until age 18)	100%	Not covered	100%
Routine mammograms (age 40 and over; one per year)	100%	Not covered	100%
OB/GYN (maximum one visit and Pap smear per year)	100%	Not covered	100%
Routine Prostate Specific Antigen (PSA) Test and Digital Rectal Exam (age 40 and over; one exam per year)	100%	Not covered	100%
Fecal Occult Blood Test (age 50 and over; one test per year)	100%	Not covered	100%
Sigmoidoscopy / Colonoscopy (baseline screening at age 50; follow-up screening every five years)	100%	Not covered	100%
Routine eye exams (maximum one exam per year)	100%	Not covered	100%
Routine hearing (maximum one exam every 2 years)	100%	Not covered	100%
Outpatient Services			
Doctor's office visits	80%	70% after deductible	80%
X-rays and labs	100% after \$10 copayment	70% after deductible	100% after \$10 copayment

* All out-of-network expenses are subject to reasonable and customary (R&C) limits; you are responsible for 100% of all charges above R&C amounts. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

** If you elect coverage for yourself or yourself plus one dependent, the annual deductible must be satisfied for each person before benefits begin for that person. If you elect coverage for yourself plus two or more dependents, all expenses incurred are combined to meet the appropriate total deductible.

Provision	Care Received Inside the United States		Care Received Outside the United States*
	In-Network	Out-of-Network*	
Outpatient Services			
Surgery/major medical	80%	70% after deductible	80%
Fertility services (combined \$20,000 lifetime maximum)	80%	70% after deductible	80%
Speech, physical, or occupational therapy — outpatient (maximum 40 visits per year per therapy type)	100% after \$10 copayment per visit	70% after deductible	100% after \$10 copayment per visit
Chiropractic care (maximum 20 visits per year)	80%	70% after deductible	80%
Mental health care (maximum 40 visits per year)	80%	70% after deductible	80%
Substance abuse care (combined \$20,000 lifetime maximum per individual for inpatient and outpatient care)	80%	70% after deductible	80%
Inpatient Services			
Hospital (average semi-private room rate; excluding emergency room care)	100% after \$250 copayment per admission; waived if re-admitted for same condition within 14 days	70% after deductible per admission	100% after \$250 copayment per admission; waived if re-admitted for same condition within 14 days
Surgery/major medical	80%	70% after deductible	80%
Skilled nursing facility (maximum 365 days per lifetime)	100% after \$250 copayment; waived if admitted from hospital	70% after deductible	100% after \$250 copayment; waived if admitted from hospital
Hospice care	100% after \$250 copayment; waived if admitted from hospital	70% after deductible	100% after \$250 copayment; waived if admitted from hospital
Mental health care (maximum 30 days per year)	100% after \$250 copayment per admission	70% after deductible	100% after \$250 copayment per admission
Substance abuse care (combined \$20,000 lifetime maximum per individual for inpatient and outpatient care)	100% after \$250 copayment per admission	70% after deductible	100% after \$250 copayment per admission

* All out-of-network expenses are subject to reasonable and customary (R&C) limits; you are responsible for 100% of all charges above R&C amounts. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

** If you elect coverage for yourself or yourself plus one dependent, the annual deductible must be satisfied for each person before benefits begin for that person. If you elect coverage for yourself plus two or more dependents, all expenses incurred are combined to meet the appropriate total deductible.

Provision	Care Received Inside the United States		Care Received Outside the United States*
	In-Network	Out-of-Network*	
Prescription Drugs			
Prescription drugs (\$10,000 lifetime maximum for prescription drugs prescribed to treat infertility)	80%	80%	80%
Other Services			
Hospital — emergency room	100% after \$100 copayment per visit, must be sudden and serious; waived if admitted. 80% coverage if not considered an emergency	100% after \$100 copayment per visit, must be sudden and serious; waived if admitted 70% coverage, after deductible, if not considered an emergency	100% after \$100 copayment per visit, must be sudden and serious; waived if admitted 80% coverage if not considered an emergency

* All out-of-network expenses are subject to reasonable and customary (R&C) limits; you are responsible for 100% of all charges above R&C amounts. Since in-network charges for covered services have been negotiated with the providers, those charges would always be within the R&C limits.

** If you elect coverage for yourself or yourself plus one dependent, the annual deductible must be satisfied for each person before benefits begin for that person. If you elect coverage for yourself plus two or more dependents, all expenses incurred are combined to meet the appropriate total deductible.

Please Note: Whenever benefits are limited to a certain dollar amount or number of visits/days, care received in-network, out-of-network, and outside the United States will be combined and counted toward the benefit limit.

What's Not Covered

While the JPMorgan Chase Expatriate Medical Plan option covers a wide range of services, some expenses are not covered by the plan. For example, a treatment that is not medically necessary, even if it would otherwise be a covered expense, is not covered. Preventive care when received out-of-network in the United States is also not covered. Certain prescription drugs are not covered including non-sedating antihistamine drugs purchased in the U.S. Please contact CIGNA International at the number listed under "24-Hour Customer Service" on page 19 for more information about services, procedures, charges, and expenses not covered by the Expatriate Medical Plan option. For the definition of "covered services" and "medically necessary," please see the "Important Terms" beginning on page 3.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act of 1998

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

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

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

CIGNA International Expatriate Dental Plan Option

Dental coverage works the same way whether you receive care inside or outside the United States:

- You may use any licensed provider.
- The plan generally pays 100% for preventive and diagnostic care without a deductible.
- The plan generally pays 75% for basic restorative and 50% for major restorative care after you meet an annual deductible (\$75 per individual).
- The plan pays 50% for orthodontic appliances and treatment for dependent children up to age 19 after you meet a lifetime orthodontia deductible (\$150 per child).
- You must pay for services at the time you receive them and file claim forms to be reimbursed. Certain providers may accept assignment of benefits and choose to accept payment directly from CIGNA International. You would then be responsible for the difference not paid by the plan.

Pre-Determination of Benefits

If you anticipate that charges will be more than \$300 for a proposed treatment, a dental consultant can review the proposed treatment before work begins, and the claims administrator will inform you and your dentist of the amount of the covered charges. That way, you'll understand the benefits that will be paid before treatment begins.

The CIGNA International Expatriate Dental Plan option pays benefits as follows:

Provision	Care Received Inside or Outside the United States*
Annual individual deductible	Preventive: None Restorative: \$75 individual/\$225 family Orthodontia: \$150 child/lifetime
Annual maximum benefit (per individual per plan year)	\$1,500
Lifetime maximum (orthodontia benefit)	\$2,500 per dependent child up to age 19
Preventive	100%
• Oral exams	• Maximum two per calendar year
• Fluoride	• Maximum one per calendar year; up to age 19 only
• Prophylaxis	• Maximum two per calendar year
• Full-mouth X-ray	• Maximum one every 36 months
• Bitewing X-ray	• Maximum one per calendar year**
• Sealants	• Maximum two treatments per tooth (permanent molars only)/lifetime up to age 19
Basic restorative care (fillings, extractions, certain X-rays, endodontics, and periodontics)	75% after deductible

* This option pays for a percentage of covered services up to the reasonable and customary (R&C) amount subject to certain annual limits; you are responsible for 100% of all charges above the annual limits and R&C amounts.

** Two per calendar year for children up to age 19.

Provision	Care Received Inside or Outside the United States*
Major restorative care (services to replace lost teeth, including crowns, inlays, tooth implants, bridges, and dentures)	50% after deductible
Orthodontia (for dependent children up to age 19)	50% after \$150 lifetime orthodontia deductible

* This option pays for a percentage of covered services up to the reasonable and customary (R&C) amount subject to certain annual limits; you are responsible for 100% of all charges above the annual limits and R&C amounts.

** Two per calendar year for children up to age 19.

What's Not Covered

While the JPMorgan Chase Expatriate Dental Plan option covers a wide range of services, some expenses are not covered by the plan. Please contact CIGNA International at the number listed under "24-Hour Customer Service" on page 19 for more information about services, procedures, charges, and expenses not covered by the Expatriate Dental Plan option. For the definition of "medically necessary," please see the "Important Terms" beginning on page 3.

If You Are Covered by More Than One Medical and/or Dental Plan

The JPMorgan Chase Expatriate Medical Plan and Dental Plan options have provisions to ensure that payments from all of your group health care plans don't exceed the amount the JPMorgan Chase Plans would pay if they were your only coverage.

The rules described here apply to the JPMorgan Chase Expatriate Medical and Dental Plan options. The following rules do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

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

Determining Primary Coverage

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

- As an active JPMorgan Chase employee, the Medical and/or Dental Plans will be primary for you and consider claims for your 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 will be considered primary. In the event of divorce or legal separation, and in the absence of a qualified medical child support order, the plan covering the parent with court-decreed financial responsibility will be considered primary for the covered dependent child. If there is no court decree, the plan of the parent who has custody of the covered dependent child will be considered primary for the covered dependent child. (Please see "Qualified Medical Child Support Order" on page 17 for more information on a qualified medical child support order.)
- If your other 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 from your primary plan.

Coordination with Medicare

This section describes how your benefits coordinate with Medicare (the United States federal health insurance program for senior citizens and qualifying disabled people) if you or a covered dependent are Medicare-eligible due to a disability, or because you or the dependent have end-stage renal disease (ESRD).

Medicare Overview

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

- **Medicare Part A (Hospital Insurance).** Medicare Part A helps cover approved expenses for basic inpatient care (e.g., semi-private room, general nursing), care in a skilled nursing facility, home health care, and hospice care. In most cases, there’s no monthly premium for Part A. That’s because most people pay Medicare taxes while they are working, which covers the cost of participating in Part A.
- **Medicare Part B (Medical Insurance).** Medicare Part B helps cover expenses for doctor’s services, outpatient care, and other medical services that aren’t covered by Medicare Part A, such as diagnostic tests, ambulatory surgery centers, and second surgical opinions. Participating in Medicare Part B is optional. You must pay a monthly premium to receive Medicare Part B benefits. The monthly premium for Medicare Part B for 2007 is \$93.50 (premiums are subject to change on an annual basis).
- **Medicare Part D (Medicare Prescription Drug Program).** Effective January 1, 2006, a new Medicare Prescription Drug Program (Medicare Part D) was added to the current Original Medicare program (Part A for hospital insurance and Part B for medical insurance). Under Medicare Part D, people with Medicare can purchase coverage for prescription drugs — a benefit that had not been part of Original Medicare.

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

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

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

Important Reminder

Covered services and benefits levels under Medicare are subject to change by the U.S. federal government. Contact your local Social Security office to obtain the most recent information on Medicare costs and coverage.

Medicare has outlined a “standard” way that Medicare prescription drug plans will cover prescription drug expenses. However, it’s important to understand that private health insurance companies offering Medicare prescription drug plans can deviate from the “standard” benefit — as long as their benefits are at least as good as the “standard.” This means that depending on where you live, the Medicare prescription drug plans in your area may vary by the monthly premiums you pay, the types of prescription drugs covered, how much you have to pay out of pocket, and which pharmacies you can use.

Coordination with Medicare Parts A and B If You Are Disabled

Entitlement to Medicare coverage is automatic for anyone who receives Social Security Disability Income for 24 months. Medicare entitlement begins on the first day of the 25th month of disability. If you (or a covered dependent) become entitled to Medicare because of a qualifying disability, Medicare becomes the primary source of medical coverage for the disabled individual 29 months after the disability determination date. This means that Medicare pays benefits first. Then, the JPMorgan Chase Medical Plan pays the difference between what Medicare paid and what the JPMorgan Chase Medical Plan would have paid if it were the only coverage available (in other words, if Medicare did not exist). These provisions also apply to your Medicare-eligible dependents.

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

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

Medicare pays secondary to the JPMorgan Chase Medical Plan only during the first 30 months that you (or your covered dependents) are entitled to Medicare based on end-stage renal disease (ESRD).

Coordination of Benefits with Medicare Part D

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

Right of Recovery

If the Medical and/or Dental Plans provide benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the Medical and Dental Plans have 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 Medical and/or Dental Plans is to provide benefits for eligible health care expenses that are not covered by any third party. If a covered person or agency receives payment from any third party for any expenses that have already been paid by the plans, the covered person or agency will have to reimburse the plans 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 plans for the full amount paid in benefits, the covered person will have to reimburse the plans with the amount that is left after attorney's fees and other legal expenses are paid. This is known as "subrogation of benefits." The JPMorgan Chase Plans have the right to pursue subrogation against any person or insurer. The covered person agrees to help the plan use this right when requested.

Right of Reimbursement

In addition to their subrogation rights, the plans are entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for health care expenses that have been paid by the Medical and/or Dental Plan.

When Coverage Ends

When you retire, or if you are repatriated back to your home country, you will no longer be eligible for coverage under the Expatriate Medical Plan and Dental Plan options, and will therefore need to elect coverage under your local/domestic, home-country Medical Plan and/or Dental Plan. If you were enrolled in the Expatriate Medical and/or Dental Plan options, this coverage will automatically end on the last day of the month in which your assignment ends.

If your employment with JPMorgan Chase terminates, participation for you and your covered dependents usually ends on the last day of the month of active employment. However, under certain circumstances, you may be eligible to continue Medical and/or Dental Plan participation for a certain period of time under the United States Consolidated Omnibus Reconciliation Act (COBRA) of 1985.

Expenses incurred after you leave JPMorgan Chase cannot be reimbursed by the Medical and/or Dental Plans unless you choose to continue your participation under COBRA.

Please Note: Non-U.S. home-based expatriate employees assigned outside the United States and their dependents are not eligible for medical and/or dental continuation coverage under COBRA.

Certificate of Creditable Coverage

Under the United States 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 health care coverage ends. The certificate identifies the names of you and/or your eligible dependents and the duration for which you were covered under the JPMorgan Chase health care benefit plans.

You may need to present this certificate to your new employer at the time you are enrolling for benefits under the new employer's plan, especially if you or your dependents have a pre-existing condition that would limit coverage under your new employer's plan. If you have proof of creditable coverage from another plan, exclusion periods for pre-existing conditions are reduced or eliminated. Without proof of creditable coverage, you may be subject to an exclusion period of 12 months (18 months for late enrollees) after your enrollment date for your new coverage. You should always keep a copy of your HIPAA certificate for your records.

You automatically will be sent a Certificate of Creditable Coverage at the time your coverage ends and again when your continued coverage under COBRA (if elected) ends. You also may request a Certificate of Creditable Coverage from the plan administrator at any time within the 24-month period after your coverage under the benefit plans ends.

Prescription Drug Notice of Creditable Coverage

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

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

Additional Plan Information

If you are a non-U.S. home-based expatriate assigned to the United States, you are also eligible to elect coverage under the Vision Plan, Spending Accounts, and Group Legal Services Plan. **Please Note:** U.S. home-based expatriate employees are not eligible to participate in the Transportation Spending Accounts while they are working outside the United States.

You can find additional information on these plans by changing your personal intranet profile to North America and going to Company Home > HR & Personal > Pay & Benefits > Library > Your Guide to Benefits at JPMorgan Chase.

Right to Amend

JPMorgan Chase reserves the right to amend, modify (including cost of coverage), reduce or curtail benefits under, or terminate the expatriate benefit plan options at any time for any reason by act of the Compensation and Benefits Executive, other authorized officers, or the Board of Directors. In addition, the expatriate benefit plan options do not represent a vested benefit. 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 these options, contact the Benefits Call Center.