JPMORGAN CHASE & CO.

The JPMC U.S. Medical Plan Summary

Effective January 1, 2024

Offered to all U.S. benefits-eligible employees

An Overview

This 2024 JPMC U.S. Medical Plan Summary modifies and changes Your JPMC Benefits Guide and is a summary of material modification (SMM) for the JPMorgan Chase Medical Plan, Option 1 and Option 2 and the Wellness Incentive Program. It supplements, clarifies and amends various sections of the online Benefits Guide and should be referred to as part of that Guide and its Summary Plan Descriptions (SPDs). Please retain this information for your records.

This 2024 JPMC U.S. Medical Plan Summary will remain on My Health throughout 2024 and will soon be posted on Your JPMC Benefits Guide.

Your health and well-being is paramount. That's why JPMorgan Chase is committed to providing you and your family a comprehensive and high-quality Medical Plan & Wellness Incentive Program so you can take care of yourself and your family.

Effective January 1, 2024, U.S. benefits-eligible employees will be offered a new medical plan design, called the JPMC U.S. Medical Plan (Medical Plan). The Medical Plan provides comprehensive coverage for a broad range of health care services and prescription drugs. For many routine services -- such as primary care and specialist office visits, basic lab services, urgent care, and emergency room visits -- there is no in-network deductible or coinsurance; instead, there are fixed dollar copayments ("copays") so you have transparency and predictability of cost prior to receiving care. For less routine services, like inpatient hospitalization and outpatient surgery, there is an annual deductible and coinsurance. And, once you reach your out-of-pocket maximum in a plan year (through amounts paid for copays, coinsurance, and deductible), the Plan pays 100% of your eligible in-network costs for the remainder of that year.

The Medical Plan consists of two options: Option 1 and Option 2, administered by Aetna and Cigna. Both Aetna and Cigna have broad national networks of doctors and hospitals, and both cover medically necessary services and supplies. Aetna and Cigna administer the same plan and payroll contributions are the same. The key differences between Options 1 and 2 are:

- **Option 1** has higher payroll contributions but a lower annual deductible, out-of-pocket maximum and generally lower copays.
- **Option 2** has lower payroll contributions but a higher annual deductible, out-of-pocket maximum and generally higher copays.

Prescription Drug Coverage: CVS Caremark will continue to provide prescription drug coverage whether you're with Aetna or Cigna Option 1 or Option 2. For a list of covered drugs, visit www.caremark.com/jpmc (Aetna/Cigna).

On the following pages, you'll get an overview of both the substance and costs associated with our 2024 Medical Plan and Wellness Program.

The Kaiser HMO Option (for California employees only):
The Kaiser Health Maintenance Organization (HMO) Option has its own doctors, hospitals and providers that are employed by Kaiser Permanente. Care received outside the network is not covered except for emergencies. Payroll contributions fall between Options 1 and 2.
Kaiser Permante manages the prescription drug coverage for the Kaiser HMO. For a list of covered drugs, visit kp.org.
More information about the Kaiser HMO Option is available at my.kp.org/jpmc.
Note: This summary focuses on Medical Plan Option 1 and Option 2.

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How the Plan works

The 2024 Medical Plan is designed with these features in mind:

- **Transparency and predictability of in-network costs for routine and high-volume care.** The new plan will offer in-network routine, urgent and emergency care at fixed-dollar copayments and without a deductible. That means you'll know the amount you need to pay in advance of your visit for services such as primary care office visits, mental health sessions, specialist office visits, lab work, urgent care and emergency room visits.
- **Lower deductibles.** Other medical services – including services like radiology (e.g., MRI), outpatient surgery, and inpatient hospitalization – will be subject to a deductible, then coinsurance. For 2024, we're lowering the deductible for these services.

  Note: If you participated in our Medical Plan as an employee living in Arizona or Ohio, you may not be accustomed to a deductible. However, many services, including your in-network routine, urgent and emergency care, are still covered without a deductible and with a fixed copay in 2024. Additionally, copays for some services (e.g., specialists) are lower in 2024.
- **Lower-out-of-pocket maximums.** We're also lowering the out-of-pocket maximums that employees could pay for all medical services in a year. While very few people have expenses large enough to reach these limits, your out-of-pocket maximum functions as your "financial safety net" and prevents you from having to pay very high health care expenses in the event of a serious medical situation.
- **Prescription Drugs.** The new plan addresses your portion of the cost for prescription drugs in multiple ways:
  - No deductible for prescription drugs and fixed-dollar copayments for all drugs,
  - Covered preventive brand and generic drugs (like insulin and blood thinners) continue to be free to you,
  - Lower generic drug copay of $5 for a month supply and lower copay for preferred brand drugs, and
  - A separate, lower annual out-of-pocket maximum for your spend on prescription drugs.

  Note: Certain prescription drugs received during the course of medical care (e.g. infusions during an office visit or at an outpatient facility) will continue to be covered under medical benefits. Please see pages 6-8 for additional detail.
- **Employee costs are set on a sliding scale.** In addition to the savings outlined above, employee costs for the 2024 Medical Plan will continue to vary based on your total annual cash compensation, with lower deductibles and out-pocket maximums for colleagues making less than $100,000 (in 2023 it was for those earning less than $60,000). Employees earning less than $250,000 Total Annual Cash Compensation (TACC) will see no change or a year over year decrease in medical payroll contributions. Employees earning $250,000 TACC or more will see no more than a 1-5% increase in medical payroll contributions year over year.

Defined Terms

Copay –The fixed dollar amount you pay for certain covered services

Deductible – The amount you pay upfront each calendar year before the Plan generally begins to pay benefits for many expenses.

Coinsurance – The way you and the Plan share costs. You pay a percentage of providers' negotiated fees (the Plan pays a percentage as well).

For **in-network** care:

- You are not required to select or assign a Primary Care Physician (PCP).
- You do not need referrals to see a specialist.
- In-network preventive care, including physical exams and recommended preventive screenings, is covered at 100% with no copays, coinsurance, or deductible.
- For most in-network routine services, you will pay a copayment – a fixed dollar amount associated with each covered service -- with no deductible. Examples include:
  - Primary care, mental health care, and specialist office visits
  - Basic lab services
  - Urgent care and Emergency Room care
- Other medical services are subject to the deductible and then coinsurance after the deductible is met. This includes services like radiology (e.g., MRI), outpatient surgery, inpatient hospitalization, and durable medical equipment (e.g., crutches). See page 4 for details.

Out-of-network information:

- You generally must meet a separate, higher annual deductible before the coinsurance applies for covered services.

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- There is a separate, higher out-of-pocket maximum for out-of-network charges.
- Benefits for out-of-network care are limited to reasonable and customary (R&C) charges after you meet the out-of-network deductible. These R&C charges are based on average claims data in your area and are determined by your health care company to be appropriate fees for medical services. You are responsible for any amount above the R&C charges.
- It's important to understand that if you use out-of-network providers (doctors, facilities or other service providers), it is your responsibility to check with your health care company to see if there is a prior authorization or medical necessity requirement that you need to meet before receiving any out-of-network treatment, service or procedure. Otherwise, the treatment, service or procedure may not be covered by the Plan and you will be responsible for the full cost.
- Prescription drug coverage is not available out-of-network.

Even though there is an out-of-network benefit available, you are strongly encouraged to stay in-network. Selecting out-of-network providers and services cost more for all employees and the Medical Plan. Selecting in-network providers and services will generally reduce your out-of-pocket costs. To find network doctors and provdiers, visit Aetna or Cigna.

Your **Medical Reimbursement Account (MRA):**

Option 1 and Option 2 can be used in conjunction with a MRA you can use to help pay for eligible out-of-pocket medical expenses and prescription drug copays. The MRA is funded by JPMorgan Chase when you take action and complete designated Wellness Incentive Activities. Employees cannot contribute funds to an MRA. More details about the MRA and what you can do to maximize funding for 2024 starts on page 16.

Any 2023 MRA unused balances will roll over to your 2024 MRA and can be used for eligible out-of-pocket medical and prescription drug expenses in the Medical Plan.

Please note, if you are enrolled in the Kaiser HMO in California you will no longer be able to earn new MRA rewards in 2024, however, you will continue to have access to any previous MRA funds in your account to pay for eligible out of pocket expenses.

Overview of Plan Cost Information

There's a lot of good news for 2024: lower deductibles, lower out-of-pocket maximums, and lower prescription drug costs. Here's a little bit more about that, followed by a chart with specific costs:

- **These savings were made possible by new investment of over $100 million in 2024** – on top of the $70 million invested in 2023 for things like enhanced coverage of mental health counseling, prescription drugs, and lower deductibles. This new investment incorporates employee feedback to further enhance our offerings. We are taking the best from our previous offerings and pilots to deliver the services you want at more affordable prices.

- **The firm is generally covering about 80% of plan costs for employees**. Each employee's costs differ depending on a number of factors – including their income level, number of dependents, where they live, choice of Option 1 or Option 2, whether they use tobacco products and whether they complete an annual Wellness Screening and Wellness Assessment. Employees can see their per-pay medical payroll contributions for all medical plan options available to them when they visit the Benefits Web Center to review and enroll during the benefits enrollment period. Please note, the medical payroll contributions you see during enrollment on the Benefits Web Center already reflect savings on 2024 medical payroll contributions for completing the annual Wellness Screening and Wellness Assessment. See page 16 for details.

- **Absent any investments by the firm, employees' medical payroll contributions would have increased approximately 10% on average over 2023.** Employees earning less than $250,000 Total Annual Cash Compensation (TACC) will see no change or a year over year decrease in medical payroll contributions. Employees earning $250,000 TACC or more will see no more than a 1-5% increase in medical payroll contributions year over year.[1]
- **Employee costs set on a sliding scale.** In addition to the savings outlined above, employee costs for this year's Medical Plan Option 1 and Option 2 will continue to vary based on compensation – with lower deductibles and out-pocket maximums for colleagues making less than $100,000 (in 2023 it was for those earning less than $60,000).

1 If your Total Annual Cash Compensation (TACC) increased and caused you to move from one Pay Tier to another (e.g., from under $150,000 to over $150,000), you may see an increase to your employee payroll contributions. See page 10 for additional detail on the Pay Tier sliding scale structure.

Medical Plan Costs and Deductibles

Important! These copay amounts are maximum amounts – if the negotiated cost of the services is less than the copay, then you will pay the lesser amount.

The chart below presents an overview of plan features for the Medical Plan Option 1 and Option 2. This is the in-network plan design; please see page 20 for information on out-of-network benefits.

In-Network Medical Costs and Deductibles	Plan Option 1		Plan Option 2	
	TACC: <$100k	TACC: $100k+	TACC: <$100k	TACC: $100k+
Medical Services Covered at a Fixed Copay and NOT Subject to the Deductible (Routine, Urgent, Emergent Care)				
Preventive Care	Free			
Primary Care Office Visit (PCP, Pediatrician, OB/GYN)	$15			
Telehealth				
Mental Health Office Visits				
Specialist Office Visit	$50	$75	$75	$100
Physical Therapy, Speech Therapy, Occupational Therapy[2]	$25	$25	$35	$35
Chiropractic visit	$50	$50	$50	$50
Basic Labs	$20	$20	$35	$35
Urgent Care	$50	$75	$75	$100
Ambulance	$250	$250	$250	$250
Emergency Room	$300	$500	$600	$800
Medical Deductible for Services Below[3]				
Employee-Only Coverage	$250	$750	$850	$1,750
Employee + Spouse/Domestic Partner or Employee + Child(ren)	$400	$1,400	$1,600	$2,800
Employee + Family (Employee + Spouse/Domestic Partner + Child(ren))	$700	$1,800	$2,300	$4,000
Medical Services Subject to the Deductible (Other Medical Care)				
Inpatient Hospital Admission	If medical deductible is not met, member pays 100% of costs. If medical deductible is met, member pays 20% of costs.			
Outpatient Procedure / Surgery				
Advanced Imaging (CT/MRI), Standard Radiology				
Durable Medical Equipment				

[2] *See details on page 7 (section under Types of Services) for number of visits allowed under the plan design. All PT/ST/OT with a Mental Health/Behavioral Health diagnosis is subject to different plan design.*

[3] *Please see Per Person Rule on page 5*

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Medical Plan Out-of-Pocket Maximums (Safety Net)

The plan's out-of-pocket maximum—your financial "safety net"—limits the total amount you are required to pay out-of-pocket each year, including deductible, coinsurance, and copayments for eligible covered services. There are separate out-of-pocket maximums for medical services and for prescription drugs (please see pages 12-14 for prescription drug plan design features, including out-of-pocket maximums). Note: the chart below reflects in-network medical out--of-pocket maximums; please see page 20 for out-of-network plan design features, including out-of-pocket maximums and page 13 for the prescription drug plan out-of-pocket maximum.

In-Network Medical Out-of-Pocket Maximums	Plan Option 1		Plan Option 2	
	TACC: <$100k	TACC: $100k+	TACC: <$100k	TACC: $100k+
Medical Out of Pocket Maximum (your "safety net," the most you'll pay in a year for medical services; includes what you spend in deductible, copays, and coinsurance)				
Employee Only Coverage	$1,250	$2,000	$2,800	$4,000
Employee + Spouse/Domestic Partner or Employee + Child(ren)	$2,500	$3,400	$4,700	$5,900
Employee + Family (Employee + Spouse/Domestic Partner + Child(ren))	$3,500	$5,100	$6,600	$8,400

Per-Person Rule

For deductibles and out-of-pocket maximums, the "per person" rule allows the employee or any covered dependent(s) (e.g., spouse/domestic partner or child) to reach an individual deductible or out-of-pocket maximum, after which the deductible or out-of-pocket maximum is satisfied for the year for that person. Covered individuals who have not met the deductible or out-of-pocket maximum may combine to meet the remainder of the deductible or out-of-pocket maximum for that particular coverage level. If no one person has met the individual deductible or out-of-pocket maximum, the expenses of all covered individuals can combine to meet the deductible or out-of-pocket maximum for that coverage level. **Note:** There are separate deductibles and out-of-pocket maximums for in-network and out-of-network services. The out-of-network deductible and out-of-pocket maximum calculations do not include amounts above reasonable and customary (R&C) charges if you use out-of-network providers. An R&C limit is based on data in your area and determined to be an appropriate fee for a specific medical service.

Example: John is enrolled in Option 1, has TACC less than $100,000 and is covering his s
pouse and 2 children. John's spouse, Mary, has a complicated surgery and is in an in-network hospital for 4 days with a total charge of $12,000 before medical insurance benefits are calculated. The out-of-pocket expenses related to Mary will be $1,250 – the individual out-of-pocket maximum – not $2,600 ($250 deductible + 20% coinsurance on the remaining $11,750 of hospital charges). Now that Mary has paid $1,250 and met the individual out-of-pocket maximum, all other eligible in-network expenses for Mary for the rest of the year will be covered at 100% by the plan. John and his children will continue to pay deductibles, coinsurance, and, copayments for services they use during the year until: (1) any one of them reaches $1,250 out-of-pocket and that individual will then have met their maximum (similar to Mary), or (2) all three of them combined spend $2,250 ($3,500 family out-of-pocket maximum less $1,250 spent by Mary).

Types of Services

The below chart is intended to describe the types of services that are covered within each Medical Services category defined in the Copay chart on page 4. This list is not exhaustive. For more detailed questions on services, please contact your health care company – Aetna or Cigna.

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Medical Service	Description of Services
Preventive Care	Preventive care services are covered at 100% in-network by the Medical Plan and include : ▪ Routine physical exams ▪ Well-child/adult care office visits ▪ Immunizations ▪ Mammograms and PAP tests ▪ Prostate exams and colonoscopy exams Detailed preventive care flyers from Aetna and Cigna, which will include the types of preventive care and any associated frequency, are available on Aetna and Cigna's websites. Preventive care services are determined by your health care company based on guidelines and clinical recommendations developed for the general population by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and other nationally recognized sources. JPMorgan Chase does not make this determination. Additionally, based on the medical findings resulting from preventive care, services may no longer be considered preventive and thus subject to member cost share.
Primary Care Office Visit (PCP, Pediatrician, OB/GYN)	Primary care office visits are non-preventive care visits with the following types of clinicians: Primary Care physician (PCP), OB/GYNs, GYNs, Pediatricians, Family Practitioners, General Practitioners, Internal Medicine (contracted as PCPs with Aetna/Cigna), Certified Nurse Midwife, Nurse Practitioner, and Physician Assistants (within a PCP's office). Convenience care clinics (e.g., CVS Minute Clinic) are treated as a primary care office visit. "Incidental" labs, such as a swab for strep throat, urine analysis for a urinary tract infection (UTI), etc., are included in the PCP copay (not a separate copay). Other lab work (e.g. blood draw), and all standard radiology (e.g. x-rays) and advanced imaging (e.g. CAT scans) performed during a PCP visit will be assessed a separate copay or deductible then coinsurance based on the type of service.
Telehealth (also known as telemedicine or virtual doctor visit)	Connect to a doctor in minutes - anytime, anywhere - using a smartphone, phone, tablet or computer. Doctors can make diagnoses, provide advice and call in prescriptions to your local pharmacy. Virtual doctor visits are delivered through Aetna (via Teladoc) and Cigna (via MDLive). See Contact Information for details on how to access virtual doctor visits.
Mental Health Office Visit (Outpatient therapy for mental health, chemical, alcohol dependence)	Outpatient mental health/substance use therapy includes office visits with: Psychologists, Psychiatrists, Clinical Social Workers, Drug and Alcohol Counselors, Licensed Professional Counselors, Marriage/Family Therapists, Behavioral Health Nurse Practitioners, and Psychiatric Nurses. Lab work, standard radiology (e.g. x-rays) and advanced imaging (e.g. CAT scans) performed during a mental health, chemical, alcohol dependence outpatient therapy visit will be assessed a separate cost share.
Specialist Office Visit[4]	Office visit with a specialist, such as: Acupuncturist, allergist[5], cardiologist, dermatologist, endocrinologist, oncologist, otorhinolaryngologist/ otolaryngologist (ENT specialist), psychiatrist, rheumatologist, reproductive endocrinologist, etc. (This is not intended to be an exhaustive list of all specialists.)

[4] Certain mental health / substance use services, including Inpatient partial hospitalization, transcranial magnetic stimulation (TMS), electroconvulsive therapy, and Intensive-out-patient (IOP) will be subject to 20% coinsurance, please contact your healthcare company to determine whether a deductible will apply.

[5] An office visit with your allergist is assigned the Specialist Office Visit copay. Any allergy shots or serums delivered during that office visit will be covered by the Specialist Office Visit copay (there will not be a separate copay assigned for this). If you are visiting your allergist's office simply to receive an injection and do not have a corresponding visit with the allergist, the administration of the injection will be assigned a $15 copay.

	Dialysis or an infusion performed during a specialist office visit[6] will be assessed the Specialist Office visit copay; the costs of the associated infused drugs will be subject to a separate copay. ABA therapy will be subject to 20% coinsurance (no deductible)[7], rather than the copayment amounts noted in the chart on Page 4. Minor surgery performed at your specialist's office will be assessed the Specialist Office visit copay. Examples of minor surgery that could be performed at a specialist's office includes: mole removal, ingrown toenail correction, breast biopsy, and vasectomy. Lab work, standard radiology (e.g. x-rays) and advanced imaging (e.g. CAT scans) performed at a specialist office visit will be assessed a separate cost share.
Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT)	Physical, speech and occupational therapy rendered by a licensed therapist, up to a combined total of 60 in- and out-of-network visits per calendar year per therapy type, when the underlying condition/diagnosis is medical in nature. For instance, the plan provides 60 PT visits in total (in- and out-of-network visits combined), 60 ST visits in total (in-network and out-of-network visits combined), etc. For those individuals with a mental health diagnosis[7], associated medical treatments for physical, occupational and speech therapy will not be subject to an annual visit limitation. Further, the cost share for these services will be subject to 20% coinsurance (no deductible)[7] rather than the copayment amounts noted in the chart on page 4.
Chiropractic visit	Chiropractic care when medically necessary as determined by Aetna/Cigna to diagnose or treat illness, injury, or disease. Coverage is limited to 20 visits per year and ends once maximum medical recovery has been achieved and treatment is primarily for maintenance or managing pain.
Basic Labs	Lab work includes tests such as complete blood count (CBC), basal metabolism, lipid panel, liver panel, hemoglobin A1C, etc. Generally, you will be assessed a single copay per blood draw even if multiple tests are performed on that single blood draw. Labs also includes the following: hearing test, heart monitor, pre-admission test and genetic testing (when approved as medically necessary).
Urgent Care	Visits to an urgent care facility. Please contact your health care company for information on in-network urgent care centers.
Ambulance - per ride[8]	Local emergency ambulance service or air ambulance to the nearest hospital if medically necessary and confirmed by a licensed provider. Non-emergency transportation is covered if it is provided by a licensed professional ambulance (either ground or air ambulance as determined appropriate.)
Emergency Room (ER)	All services performed during your emergency room (ER) visit will be covered by the single ER copay. This includes fees related to professional services (e.g. seeing a doctor), facility charges (e.g. cost of the ER itself), lab work, standard radiology, advanced imaging, any medications given in the ER[9], etc. If you go to the emergency room and are subsequently admitted to the hospital, the ER copay will be waived and instead you will be subject to the inpatient hospital admission cost share.
Inpatient Hospital Admission	All services performed during your inpatient hospital stay will be subject to the deductible then coinsurance. Generally, a patient is considered inpatient if formally admitted to the hospital.

[6] The specialist office copay will apply for dialysis/infusions that occur in the specialist's office, when the provider is billing that visit as having occurred in the specialist's office; the cost of any drug infused (and associated administration cost) during an office visit is subject to the applicable specialty prescription drug copay. Some specialists may be associated with an outpatient facility and bill these services as an outpatient facility visit. If that is the case, you will be subject to the Outpatient Procedure/Surgery cost share (deductible then coinsurance). If you are uncertain as to how your provider bills, you can look at a prior Explanation of Benefits (EOB) and then discuss this with your health care company (Aetna or Cigna).

[7] Mental health care or benefits, in accordance with the Mental Health Parity and Addiction Equity Act, are items or services for mental health or substance use disorder conditions, as determined solely within the discretion of the plan administrator, consistent with generally recognized independent standards of current medical practice. Conditions affecting physical health that are related to a mental health condition or substance use disorder are medical/surgical benefits rather than mental health care benefits under the Medical Plan and may therefore be subject to a different cost share. However, for those individuals with a mental health diagnosis, associated medical treatments subject to visit limits (such as physical, occupational and speech therapy) will not be subject to an annual visit limitation.

[8] Cigna administers the ambulance benefit on a per day basis, not per ride.

[9] Prescriptions given to you in the ER that you fill at a pharmacy are subject to the applicable prescription drug co-pays.

	This includes fees related to: ▪ Professional services (costs related to the surgeon, assistant surgeon, anesthesiologist, radiologist, etc.), ▪ Facility charges (e.g. cost of the hospital room itself), ▪ Lab work, standard radiology, advanced imaging, and ▪ Any medications provided while in the hospital If you're provided with a durable medical equipment upon discharge (e.g., crutches or wheelchair), that will be subject to the deductible then coinsurance.
Outpatient Procedure / Surgery	This category includes procedures or surgeries performed in an outpatient facility, without an overnight stay, such as at an ambulatory surgical center. The types of procedures performed at an outpatient facility include, endoscopies (includes colonoscopies), cardiac catheterization, upper gastrointestinal, diagnostic colonoscopy, ovary removal, hernia repair, tonsil removal, cataract, kidney stone removal, etc. (This is not meant to be an exhaustive list of services performed outpatient.) The Outpatient Procedure/Surgery coinsurance includes fees related to professional services (e.g. doctor or surgeon costs) and the facility charges (e.g. cost of the center itself). Lab work, standard radiology (e.g. x-rays) and advanced imaging (e.g. CAT scans) performed at an outpatient facility will be assessed a separate cost share. Dialysis or an infusion performed during at an outpatient facility visit[10] will be assessed the Outpatient Procedure/Surgery cost share.
Advanced Imaging (CT/MRI), Standard Radiology	Advanced imaging includes CAT Scan, MRI, and PET scans. The applicable deductible and coinsurance includes the costs associated with the image itself as well as cost associated with the radiologist's reading of the image. Standard radiology includes radioisotopes, scans, sonograms, pre-admission x-ray, ultrasound, and x-rays and includes the costs associated with the image itself as well as cost associated with the provider's reading of the image. Standard radiology will follow Aetna and Cigna's individual definition of standard radiology; therefore please contact your health care company for a complete list. Advanced imaging and standard radiology performed in a PCP, Specialist and/or Inpatient hospital/Outpatient facility settings will be subject to the deductible then coinsurance. Advanced imaging and standard radiology performed as part of an emergency room (ER) visit will not be assessed a separate copay, instead it will be included in the ER copay.
Durable Medical Equipment (DME)	Durable medical equipment (DME) and supplies ordered or provided by a Physician. DME equipment/supplies or other items covered at the DME coinsuarnce include: crutches; wheelchair; walker; cane; insulin pump; surgical dressings; casts; splints; trusses; orthopedic braces; hearing aids[11]; custom-molded shoe inserts prescribed to treat a condition, disease or illness affecting the function of the foot; hospital bed; ventilator; iron lung; artificial limbs (excluding replacements); artificial eyes and larynx (including fitting); heart pacemaker; ostomy supplies, including pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers and bags; manual pump-operated enema systems and other items necessary to the treatment of an illness or injury that are not excluded under the plans. For more details on covered DMEs, please contact Aetna or Cigna. Prior authorization or pre-certification may be required for coverage of some medical equipment and supplies. Aetna and Cigna may authorize purchase of an item if more cost-effective than rental.

[10] Deductible and coinsurance will apply for dialysis/infusions that occurs in the outpatient facility, including if your specialist bills the infusion/dialysis visit you had with him/her under an outpatient facility code rather than a specialist office visit code. If you are uncertain as to how your provider bills, you can look at a prior Explanation of Benefits (EOB) and then discuss this with your health care company (Aetna or Cigna).

[11] Hearing aids are limited to $3,000 plan benefit every 36 months.

Maternity Benefits

The Medical Plan will pay for most in-network maternity services through a global fee arrangement. Under such an arrangement, the cost share that a member will be assessed are:

- $15 copay for an initial office visit with OB/GYN (i.e., to confirm pregnancy)
- Standard copay or coinsurance for Lab or radiology services (e.g., ultrasounds, amniocentesis, fetal stress tests and other related tests)
- Inpatient hospital stay for delivery and any provider services included in the global maternity fee are subject to the deductible and 20% coinsurance, up to the applicable medical out-of-pocket maximum
- Once the baby is born, separate deductibles and out-of-pocket maximums will apply for care received by the baby

Additional copays or coinsurance may apply for high risk or complex pregnancies.

If the obstetrician is out-of-network and/or does not have a global fee arrangement in place, the member will be charged for each visit and service based upon the cost share for that service.

Family Building Benefits

The Medical Plan provides Family building benefits which include Fertility treatments such as:

- In vitro fertilization (IVF) and intrauterine insemination (IUI), whether or not you have a medical diagnosis of infertility
- Elective fertility preservation (egg and sperm freezing with 12 months of storage)
- Associated prescription medications

Family Building Benefits can provide up to $30,000 for medical procedures and $10,000 for prescription drugs (These are lifetime limits, meaning once this limit is reached, no additional benefits will be available under the Plan). To unlock access to the full Family Building Benefits medical lifetime limit of $30,000, you must enroll with WINFertility and complete a nurse consultation. If these steps are not completed with WINFertility, a reduced medical lifetime limit of $10,000 applies (rather than $30,000). To get started, call WINFertility at 833-439-1517. Representatives are available Monday – Friday, 9:00am – 7:30pm (ET).

Please Note: These are lifetime limits and will carry over under the Medical Plan, and across health care companies.

Amounts paid by the plan (not your out-of-pocket expenses) apply to the Lifetime Family Building benefit maximum.

Under the Medical Plan, cost share will be assessed based on the type and setting of the service you receive. For instance, a visit with a reproductive endocrinologist will be assigned a specialist copay; while in-vitro fertilization will be subject to the the annual deductible then coinsurance.

Organ Transplants and Bariatric Surgery

Organ transplants and bariatric surgery are complex procedures and services that require quality care. As a result, the Medical Plan has in-network hospitals that have been designated as Centers of Excellence because of the high-quality care they consistently provide for these procedures and services.

You must contact your health care company in advance of an organ transplant or bariatric surgery to receive instruction on any required precertification. This applies whether or not you choose a Center of Excellence.

You should also contact your health care company to understand the cost share that will apply.

Total Annual Cash Compensation (TACC)

Under the Medical Plan, Total Annual Cash Compensation (TACC) is used to determine your medical plan pay tier, which impacts your Medical Plan payroll contributions as well as plan design features (deductibles, copay, and out-of-pocket maximums).

Overall, the firm will pay, on average, about 80% of plan costs. Employees, on average, pay the other 20% through payroll contributions. Those who have higher levels of compensation pay more than 20% for medical coverage, while lower-paid employees pay less.

In 2024, there will be changes to the TACC thresholds for Pay Tiers 1-4. As a result, employees earning between $60,000 - $99,999 will be eligible for higher levels of payroll subsidy from JPMorgan Chase as well as improved plan design features.

TIER	TOTAL ANNUAL CASH COMPENSATION	EMPLOYEE PAYS
1	Less than $60,000	Least  Most
2	$60,000 - $79,999	
3	$80,000 - $99,999	
4	$100,000 - $149,999	
5	$150,000 - $249,999	
6	$250,000 - $349,999	
7	$350,000 and above	

Total Annual Cash Compensation and other factors impacting payroll contributions

Total Annual Cash Compensation (TACC) is defined as your annual rate of base salary, plus applicable job differential pay (for example, shift pay) as of each August 1, plus any cash earnings from any incentive plans that are paid to or deferred by you for the previous 12-month period ending each July 31 (for example, annual incentive compensation, commissions, draws, overrides and special recognition payments or incentives). Overtime is not included.

For purposes of determining the Medical Plan contribution pay tier that applies to you, your TACC is recalculated as of each August 1 to take effect the next January 1 and will remain unchanged throughout the year. For most employees hired on or after August 1, TACC will be equal to base salary plus job differentials. You can find your TACC on the Benefits Web Center.

If your TACC increased and caused you to move from one Pay Tier to another (e.g., from under $150,000 to over $150,000), you may see an increase to your employee payroll contributions. Other factors include the Medical Plan option you choose, the number of dependents you're covering, whether you/your covered spouse/domestic partner completes the Initial Wellness Activities by November 17, 2023, whether you/your covered spouse/domestic partner uses tobacco and your regional cost category.

Medical Payroll Contributions

You and JPMorgan Chase share in the cost of coverage under the Medical Plan. Your contributions toward the cost of coverage are deducted from your pay on a before-tax basis before federal (and, in most cases, state and local) income taxes are withheld. The amount you pay in 2024 depends on:

- The Medical Plan Option you choose (Option 1 vs. Option 2); note that the amount you pay in payroll contributions does not differ whether you choose Aetna or Cigna,

- Number and type of eligible dependents you cover,
- Level of your TACC in effect for the plan year,
- Where you live,
- If you and/or your covered spouse/domestic partner completed **both** a biometric Wellness Screening and online Wellness Assessment between November 19, 2022 – November 17, 2023 (11:59pm ET), and/or
- If you and/or covered spouse/domestic partner use tobacco. The 2024 tobacco user surcharge will be $80 per month, or $960 annually, for each adult. If you identify both you and your covered spouse/domestic partner as tobacco users for 2024, the surcharge will be $160 per month or $1,920 annually.

Tobacco Cessation
Get the support you need to quit tobacco by enrolling in the Tobacco Cessation Program. You'll receive coaching over the phone and online support, a copy of a Quit Guide, and free quitting aids at no cost (e.g., patches, gum). You also avoid the 2024 tobacco user surcharge if you complete the 4 intractions for Tobacco Cessation Program by Dec. 8, 2023.

Provided by: Quit for Life through Optum. Call 1-866-QUIT-4-LIFE (1-866-784-8454). You can also access the program through My Health > Wellness Activities & Services.

Dependent Coverage

In addition to covering yourself under the Medical Plan, you can also cover your eligible dependents, but generally only under the same option you choose for yourself. Your eligible dependents under the Medical Plan include:

- Your spouse/domestic partner (see the Covering a Domestic Partner Tip Sheet on **My Health** > Benefits Enrollment > 2024 Benefits Resources); and
- Your and/or your spouse's/domestic partner's children up to the last day of the month in which they reach age 26, regardless of student or marital status, financial dependence on parents, residency with parents, or eligibility for coverage under another health plan. To cover your domestic partner's children, you must elect coverage for your domestic partner.

Please Note: You may continue coverage beyond age 26 for an unmarried child who depends on you for financial support, is enrolled in that benefit and is deemed unable to support him/herself because of a mental or physical disability that began before age 26. Contact your health care company for more information and specific requirements before your dependent turns 26. To continue coverage for a disabled dependent, that dependent must be enrolled in the Plan prior to turning age 26.

Important! You are responsible for understanding the dependent eligibility rules applicable to each Plan and abiding by them. Please see full details on the Dependent Eligibility Requirements Tip Sheet or the Medical Plan Summary Plan Description (SPD) on **My Health**.

If you are adding a dependent to your coverage for 2024, you'll need to provide that dependent's Social Security Number and provide required substantiation documents. Go to **My Health** > Benefits Web Center and you'll be prompted for the Social Security Number when adding each dependent for coverage.

Prescription Drug Coverage

Your prescription drug coverage is part of the Medical Plan (i.e. no separate election required for prescription drug coverage) and is administered by CVS Caremark. There is no out-of-network coverage.

Categories of Prescription Drugs

Your prescription drug coverage depends on the type of drug your doctor prescribes and where you fill your prescription.

Types of Prescription Drugs

Generic Drugs

Generics have equivalent ingredients to brand name drugs, but can cost significantly less.

Preferred Brand Name Drugs

Preferred brand name drugs have been patented by the companies that developed them and placed on a preferred drug list by CVS Caremark. They're generally more expensive than generic drugs but less expensive than non-preferred brand drugs.

Non-Preferred Brand Name Drugs

Non-preferred brand name drugs are brand name medications that are not on CVS Caremark's preferred drug list and are usually more expensive than generics and preferred brand name drugs. Often they have either generic alternatives and/or one or more preferred brand name drug options that may be substituted for the non-preferred brand name drug.

Specialty Drugs

Drugs that are generally used to treat complex medical conditions such as rheumatoid arthritis, multiple sclerosis and psoriasis. These include biological drugs, often require special handling, such as refrigeration, and are generally not available at the majority of pharmacies. Additionally, specialty drugs are usually higher cost.

Overview of Your Prescription Drug Coverage

Important note about the chart below: The copay amounts are maximum amounts. If the drug costs less than the copay, then you pay the lesser amount.

In-Network Prescription Drug Copays and Out-of-Pocket Maximums[12]		Plan Option 1	Plan Option 2
Deductible		**Not Applicable**	
Preventive (generic and brand drugs)[13]		Free	
Retail Pharmacy (non-preventive, up to a 30-day supply)	Generic	$5	$5
	Preferred Brand	$50	$100
	Non-Preferred Brand	$150	$250
	Specialty	$200	$250
Mail-Order Pharmacy or Maintenance Choice (non-preventive, up to a 90-day supply)		2x copays above	2x copays above
Out-of-Pocket Maximum (your "safety net," the most you will pay in a year for prescription drugs)			
Employee-Only Coverage		$1,250	
Employee + Spouse/Domestic Partner or Employee + Child(ren)		$2,000	
Employee + Family (Employee + Spouse/Domestic Partner + Child(ren))		$2,600	

Mandatory Generic Drug Program

The plan contains a **mandatory generic drug program** in which generic drugs are substituted for certain brand name prescription drugs. If you fill your prescription with a brand name drug when a generic equivalent is available, you pay the entire cost difference plus the generic drug copay. **Please Note:** These cost differences will not be limited by copayment or annual out-of-pocket maximum limits. Your physician can contact CVS Caremark to seek a medical exception review for possible approval for specific clinical reasons.

[12] *If you fill your prescription with a brand-name drug when a direct generic equivalent is available, you will pay the entire cost difference (a medical exceptions process is available). Some medications require prior authorization, have associated quantity limits or are excluded from coverage on CVS Caremark's standard drug list. Criteria must be met for coverage. An independent committee made up of pharmacists, physicians and medical ethicists reviews and approves the drug lists (also known as formularies). For more information, please visit www.caremark.com.*

[13] *CVS Caremark creates and maintains the standard preventive drug list. Drugs may qualify as preventive care based on guidance from sources including but not limited to the U.S. Preventive Services Task Force, Internal Revenue Service and U.S. Department of the Treasury.*

Three Ways to Fill Your Prescription Drugs

There are three ways to fill your prescription drugs, depending on whether you are purchasing short-term or long-term medications:

Short-Term Drugs

- **At an in-network retail pharmacy:** Short-term (acute) medications, such as antibiotics, generally have a limited number of refills. Always present your CVS Caremark ID card at the pharmacy. Network pharmacies are easy to find, with more than 66,000 nationwide.

Long-Term Drugs

- **Through the Maintenance Choice® Program:** This is best for long-term medications, such as those taken for chronic conditions like diabetes and high cholesterol, because you can get up to a 90-day supply. The cost through Maintenance Choice® is often lower than if you were to refill the prescription each month at a retail pharmacy. You can obtain your prescription drugs through either mail order or by picking them up at a CVS retail store at the same low price.
- **Through opting out of the Maintenance Choice® Program:** If you would prefer to obtain long-term medications in either a 30- or 90-day supply through any network pharmacy, you must first call CVS Caremark to opt out of the Maintenance Choice® Program. Please Note: Your costs for these medications may be greater than if you utilize the Maintenance Choice® Program.

Free Preventive Drugs

To encourage preventive care, covered preventive generic and brand drugs are covered at 100% with no copays. Preventive drugs are medications that can help prevent the onset of a condition if you are at risk or help you manage your health if you have a condition.

The CVS Caremark Brand and Generic Preventive Drug List is a list of preventive drugs covered at 100%, as determined by CVS Caremark. The list can be found on CVS Caremark's website, on the Covered Drug List (Formulary) section of the Plan & Benefits tab, through **My Health. Please note:** certain drugs, products, or categories may not be covered regardless of their appearance on this list. Step therapy, prior authorization, or quantity limits may apply. Mandatory Generic Drug Program applies.

If You Take a Non-Covered Drug

If you choose to take a non-covered drug, you will pay the **full cost** of the drug. This could be a costly option.

Traditional (Non-Specialty) and Specialty Lists of Covered and Excluded Drugs

JPMorgan Chase uses CVS Caremark's lists of covered and excluded drugs. An independent committee made up of pharmacists, physicians and medical ethicists reviews and approves the drug lists (also known as Formularies). These lists are subject to change quarterly by CVS Caremark. The following drug lists are available on CVS Caremark's website, on the Covered Drug List (Formulary) section of the Plan & Benefits tab, available through **My Health** > Medical, Rx, MRA & Spending Accounts > My Prescription Drugs:

- CVS Caremark® Standard drug list: a guide that includes covered generic and preferred brand name traditional drugs.
- CVS Caremark® Specialty drug list: a guide that includes covered generic and preferred brand name specialty drugs.

The CVS Caremark Standard and Specialty drug lists are not all-inclusive lists of covered drugs. Both drug lists include covered drugs grouped by drug category, alphabetically for quick reference, and also include a complete list of excluded/not covered drugs along with their preferred alternatives.

Please Note: CVS Caremark excluded drugs (Traditional and Specialty) are not covered. Additionally, non-sedating antihistamines (NSAs) like Clarinex® and Allegra®, are not covered under the Prescription Drug plan. If you take a non-covered drug, you will pay the full cost of the drug.

Go to the CVS Caremark website for information

Find the information you need on CVS Caremark's website, available through **My Health** > Medical, Rx, MRA & Spending Accounts > My Prescriptions Drugs, such as:

- An in-network retail pharmacy near you,
- A digital copy of your prescription drug coverage ID card
- Cost differences between generic and brand name drugs, and
- Lists of covered and preferred drugs.

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The 2024 Wellness Incentive Program

Wellness is about much more than going to the doctor when you're sick. That's why the firm continues to promote a culture of well-being and invest in a comprehensive wellness program that covers everything from free flu shots and health screenings to a wide array of programs that help you manage your weight, quit smoking, reduce stress and manage your overall well-being.

In 2024, we will continue to offer popular programs while also introducing new streamlined features based on employee feedback. Here's a summary of what to expect:

- **Continuing employee favorites:** Through prior surveys, you told us that wellness programs that provide the most value to you are related to evaluating your health, identifying risks, physical activity, and rewarding biometric outcomes. With this in mind, the 2024 Wellness Incentive Program will provide an opportunity to earn in three key areas: healthy outcomes, preventive care and completing well-being activities, including the opportunity to earn for staying physically active and tracking your activity.
- **Ways to save and earn:** You also told us that while earning dollars toward your Medical Reimbursement Account (MRA) is important, you also want to save money on your medical payroll contributions. We are continuing to offer ways to save and earn money toward your medical expenses by participating in certain Wellness Programs:
    - **Save $500-$1,000 on your medical payroll contributions.** By completing the biometric Wellness Screening and online Wellness Assessment by the Nov 17, 2023 deadline, you can save $500 on your medical payroll contributions – and double that if your covered spouse/domestic partner does the same. These actions will no longer earn MRA rewards in 2024.
    - **Earn up to $700 in wellness dollars in 2024.** Earn dollars in your MRA by completing certain activities, such as meeting healthy outcomes (e.g. blood pressure target), getting preventive care (e.g. annual physical) or completing physical, emotional or financial wellness activities. Covered spouses / domestic partners will no longer be eligible to participate in the Wellness Incentive Program or earn MRA rewards, with those funds reallocated to Medical Plan enhancements.

What's a biometric Wellness Screening and online Wellness Assessment?

- A biometric Wellness Screening provides overall key indicators of your health. Screenings measure your blood pressure, blood sugar, A1C, cholesterol, triglycerides, body mass index (BMI) and waist circumference. There are five ways to get a Wellness Screening, including during your annual physical (three ways for your covered spouse/domestic partner).
- The Wellness Assessment is an online survey that asks you questions about your biometric wellness screening results, diet, lifestyle, sleep patterns and health goals.
- For details, see **My Health** > Wellness Activites & Services > Well Screening and Assessment. Together, your Wellness Screening and Wellness Assessment results provide you with helpful information about what you're doing well, recommendations for improving your health, and potential issues to discuss with your doctor.
- JPMorgan Chase does not receive the data from your Wellness Screening and Wellness Assessment. That information goes directly to your health care company. See Privacy information on page 22 for more details.

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Wellness Rewards through the MRA – *Only for those covered by Aetna or Cigna*

When you enroll in Medical Plan Option 1 or Option 2, you are eligible to receive funding in an MRA, which you can use to pay for eligible out-of-pocket medical and prescription drug expenses not covered by your plan. You do not contribute to your MRA; rather, it is funded by JPMorgan Chase when you participate in certain Wellness Incentive activities. In 2024, these activities can earn you up to a maximum of $700 annually as follows:

Healthy Outcomes ($200 max)	Preventive Care ($300 max)	Well-being Activities ($600 max)
Reaching these outcomes*: • Body Mass Index (BMI) or waist circumference target ($100) • Blood pressure target ($100)	**Completing:** • Annual physical or GYN visit ($200) • Mammogram, prostate screening, colonoscopy or cervical screening ($100)	**Completing any of the following:** • Financial well-being activity with Financial Finesse ($100) • Emotional well-being activities through meQuilibrium ($200) • Wellness activity tracking through Virgin Pulse** ($300)

* If you are unable to meet the goal's objectives, you may still be able to earn the incentive by completing an alternative activity.
** You will receive more information about Virgin Pulse in late 2023.

Important Notes:

- **MRA rewards do not apply to the Kaiser HMO Option in CA.** The Kaiser HMO Option does not offer incentives for completing Wellness Activities, as do Options 1 and 2 of the 2024 JPMC Medical Plan. The Kaiser model is an integrated coordinated care model where activities like coaching and treatment decision support are part of the care you receive from your providers — and not carved out as separate activities to be completed and incented. The savings generated from this more limited wellness incentive program have been reinvested back into the Kaiser HMO Option.
- **Leaves of absence:** Employees who are on an approved leave of absence for 45 consecutive days between September 1 and November 17, 2023, and do not complete their biometric Wellness Screening and online Wellness Assessment during that time will automatically save $500 in 2024 on their medical payroll contributions (or $1,000 if they cover a spouse/domestic partner). Employees can also earn MRA funds for completing Additional Wellness Activities.
- **Timing:** Please note that it takes time to process paperwork on whether or not each covered employee and their covered spouse/domestic partner completed both the wellness screening and the wellness assessment before the deadline. Because of this, *all* employees will see the savings reflected in their payroll contributions at the beginning of the year -- $500 savings for individuals or $1,000 savings for couples. By March 2024, we will know whether or not you completed both the wellness activities before the deadline. At that time, if you are determined not to have completed both actions, you will lose these savings and your payroll contributions will increase in March. The $500 or $1,000 increase will be applied in equal installments to each paycheck from the first effective paycheck in March 2024 through December 2024. You have until June 30, 2024, to open a case with Cigna if you believe your wellness screening and wellness assessment were completed by the deadline.
- **MRA Balance transfers. All unused MRA funds at the end of 2023 will be rolled over into your 2024 account.** If you change health care companies (Aetna/Cigna/Kaiser) for 2024, your 2023 MRA balance will automatically transfer to your new health care company in April 2024.
- **New hires:** Employees who become eligible for benefits coverage — and/or add a spouse/domestic partner to medical coverage — after September 1, 2023, will automatically save $500 (individuals) or $1,000 (couples) on both 2023 and 2024 medical payroll contributions without completing the wellness screening and wellness assessment in 2023.

Wellness Rewards if You Don't Enroll in a JPMorgan Chase Medical Plan for 2024

If you are not enrolled in the medical plan, you (the employee) can earn Wellness Rewards up to $400 annually in 2024, in taxable pay, for completing Wellness Incentive Activities for healthy outcomes, preventive care, emotional well-being and financial well-being. ***If you did not enroll in JPMorgan Chase medical coverage, Cigna has been designated as your health care company to administer your Wellness Rewards.*** You can find more information on your Wellness Rewards program on **My Health** > **Not Enrolled in JPMC Medical?**

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Health Care Spending Account (HCSA)

During Annual Benefits Enrollment, you can elect to contribute to a Health Care Spending Account (HCSA) up to the annual maximum for 2024 on a before-tax basis to pay for eligible out-of-pocket health care expenses. With respect to eligible medical and prescription drug expenses, your MRA pays first for medical and prescription drug costs, such as deductibles, coinsurance and co-payments. After your MRA funds are depleted, your HCSA pays for eligible out-of-pocket medical and prescription drug expenses. For eligible out-of-pocket dental and vision expenses, your HCSA funds can be used even if you have not depleted your MRA funds since these expenses cannot be paid from MRA funds.

You may use your HCSA for these eligible out-of-pocket medical and prescription drug expenses after your MRA funds are used:

- Medical and prescription drug costs, such as deductibles, coinsurance and co-payments; **and**
- Costs for non-covered prescription drugs, such as non-sedating antihistamines (e.g., Clarinex, Allegra) with a prescription from your doctor.

You may use your HCSA for these eligible expenses immediately as MRA funds cannot be used:

- Prescription drugs that are excluded from the CVS Caremark covered drug lists;
- Costs for over-the-counter medications for which you have a prescription
- Dental deductibles and coinsurance **not** covered under any Dental Plan you may be enrolled in; **and**
- Eyeglasses and contact lenses for amounts **not** covered under any Vision Plan you may be enrolled in.

What is an HCSA?
Also known as a Flexible Spending Account, an HCSA is a tax-free way for you to pay for eligible out-of-pocket health care expenses. It means you'll save money on certain expenses that are not reimbursed by your medical (including your

The HCSA is generally subject to the "use it or lose it" rule. This means you lose funds that are left in your account at year end. However, any balance of up to $610 remaining in your Health Care Spending Account (HCSA) at the end of 2023 will be automatically carried over to your 2024 HCSA to use toward 2024 expenses. Any amount over $610 in your HCSA, after processing claims for the year, **will be forfeited**. Keep in mind that this rule will apply each year going forward. Your 2024 MRA funds and any MRA funds that carry over from 2023 must be used **first** to pay for eligible out-of-pocket medical and prescription drug expenses before you can use your HCSA funds. It's important to take this into consideration when planning your 2024 HCSA election.

Carry Over MRA Funds From Year to Year

Any unused MRA funds at year-end will automatically carry over to the next year to pay for eligible out-of-pocket medical and prescription drug expenses (copays and out-of-network deductibles). Be sure to factor in any unused MRA funds from the prior year when considering any Health Care Spending Account (HCSA) elections during Annual Enrollment each year as MRA funds are used first for eligible medical and prescription drug expenses. Unused MRA funds are forfeited upon termination unless you are eligible to enroll in retiree medical coverage or elect COBRA. More information can be found in the *As You Leave Guide* found on My Health > 2024 Benefits Resources.

HCSA Claim Filing Deadline

The claim filing deadline for 2024 expenses is March 31, 2025. Be sure to file your claims with your 2024 health care company before the deadline.

If you were previously enrolled in the HCSA and decide not to participate in 2024, any unused amounts under $25 will be forfeited. Even if you do not participate in 2024, amounts of $25 or more up to IRS limit will remain available for eligible health care expenses.

Who Administers Your HCSA?

Your health care company (Aetna or Cigna) will be the administrator of your HCSA.

If you are enrolled with Kaiser or do not have medical coverage through JPMorgan Chase, Cigna will administer your HCSA.

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Comparing Your MRA and HCSA

	Medical Reimbursement Account (MRA) (a feature of the JPMC Medical Plan)	**Health Care Spending Account (HCSA)** (an account you elect separately)
Enrollment	There is no enrollment required for the MRA. It is included when you enroll in the JPMC Medical Plan.	You must make an active election to participate each year; prior year elections do not automatically carry over.
Funding	Your MRA is funded by JPMorgan Chase when you and/or your covered spouse/domestic partner complete certain Wellness Activities. See the chart on page 16. You cannot contribute your own dollars. Unused MRA funds carryover from year to year.	Your HCSA is funded by you via payroll deductions, on a before-tax basis, based on the election you make during enrollment. You decide how much to set aside up to an annual maximum of $3,050 for 2023. It is a 'use it or lose it' account. Unused amounts up to $610 will automatically carryover to the next year. **Unused amounts over $610 will be forfeited.**
Eligible expenses	The MRA can be used only for eligible out-of-pocket medical and prescription drug expenses, including medical and prescription drug copayments and out-of-network deductibles and coinsurance. MRA funds cannot be used for other expenses (e.g., dental and vision). See the tip sheet, **MRA, HCSA and Payment Options**, found on My Health > Benefits Enrollment > 2024 Benefits Resources.	Your HCSA can be used to pay for the same out-of-pocket costs paid by your MRA, ***after*** you have used up your MRA funds; **AND** Dental and vision out-of-pocket expenses, which cannot be paid out of your MRA. See the tip sheet, **MRA, HCSA and Payment Options**, found on My Health > Benefits Enrollment > 2024 Benefits Resources.

Payment Method for your MRA/HCSA

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

If You See an In-Network Provider

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

Using the Automatic Claim Payment Method

When you use the automatic claim payment method, your health care company will automatically use your MRA funds first, then HCSA funds, to pay for your portion of eligible medical and prescription drug expenses. You generally will not be asked to pay anything during a visit to an in-network provider. Your health care company will pay the provider first from the Plan, then for your share of the cost using your MRA funds.

Once your MRA funds are depleted, your HCSA funds (if applicable) will be used to pay the remaining balance. This will happen automatically through your health care company (either Aetna or Cigna). Any bill you receive from your provider will be after your MRA funds and any available HCSA funds are applied. You should pay the bill after comparing it to the statement you receive from your health care company.

For covered prescription drug expenses, the Plan will pay for its portion of the cost at the time of purchase, and your MRA funds will automatically be applied to your portion of the cost. Once your MRA funds are depleted, your HCSA funds (if applicable) will be applied, as described above. The pharmacy will tell you what amount, if any, you will need to pay.

Using the Debit Card Payment Method

With the debit card payment method, you have the option of using your debit card or paying out-of-pocket for covered expenses. Keep in mind that you will need to keep your receipts and be prepared to substantiate any debit card claims, as required by the IRS. The same debit card accesses funds from both your MRA and HCSA, if applicable.

When you have a covered medical expense, your in-network provider will generally not require payment at the time of service.

After your medical claim is processed by your health care company or at the time of a prescription drug purchase, you can either pay with your debit card or pay out-of-pocket. (You will have to pay out-of-pocket if your provider does not accept the debit card as a form of payment.) When you use your debit card, your MRA funds will be used first. Once your MRA funds are depleted, your HCSA (if applicable) will then be applied. If you pay using personal funds and later decide you wish to be reimbursed from your MRA or HCSA, you must submit a paper claim form (via mail or fax) or an online claim form for reimbursement from your MRA or HCSA. The form can be found on your health care company's website (Aetna or Cigna) or on **My Health** > Medical, Rx, MRA & Spending Accounts > Claims and Other Forms.

If Your In-Network Provider Asks You to Pay at the Point of Service

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

If this happens, you should show your provider your ID card and explain that your health care company needs to review the claim first to see what you owe. If you are still required to pay at the time of service, you should do so and get a receipt from your provider.

Out-of-Network Medical Coverage

We encourage you to stay in-network, but if you choose to visit an out-of-network provider, you should present your ID card, and ask if your provider will submit the claim for you. If an out-of-network provider will not file a claim for you, you will need to pay for the service at the time of your visit and submit a paper claim reimbursement form to your health care company. If you use an out-of-network provider, it is your responsibility to obtain preauthorization for treatments, services or procedures that require approval.

Note on Medical Necessity and Preauthorization Guidelines: If you use an **in-network** doctor, facility or other in-network service provider, they are responsible for checking with your health care company (Aetna or Cigna) to ensure that the treatment, service or procedure meets your health care company's and the Medical Plan's requirements and guidelines.

Out-of-Network Medical Costs, Deductibles and Out-of-Pocket Maximums	Plan Option 1		Plan Option 2	
	TACC: <$100k	TACC: $100k+	TACC: <$100k	TACC: $100k+
Medical Deductible				
Employee-Only Coverage	$2,750		$4,750	
Employee + Spouse/Domestic Partner or Employee + Child(ren)	$4,125		$7,125	
Employee + Family (Employee + Spouse/Domestic Partner + Child(ren))	$5,500		$9,500	
Cost Share				
Preventive Care	50% after deductible		50% after deductible	
Primary Care Office Visit (PCP, Pediatrician, OB/GYN)	50% after deductible		50% after deductible	
Telehealth	Not covered		Not covered	
Mental Health Office Visits	50% after deductible		50% after deductible	
Specialist Office Visit	50% after deductible		50% after deductible	
Physical/Occupational/Speech Therapy	50% after deductible		50% after deductible	
Chiropractic Visit	50% after deductible		50% after deductible	
Basic Labs	50% after deductible		50% after deductible	
Urgent Care	50% after deductible		50% after deductible	
Inpatient Hospital Admission	50% after deductible		50% after deductible	
Outpatient Procedure/Surgery	50% after deductible		50% after deductible	
Standard Radiology	50% after deductible		50% after deductible	
Advanced Imaging (MRI, CT)	50% after deductible		50% after deductible	
Durable Medical Equipment (DME)/Prosthetics/Appliances	50% after deductible		50% after deductible	
Ambulance	$250 copay (no deductible)		$250 copay (no deductible)	
Emergency Room	$300 copay (no deductible)	$500 copay (no deductible)	$600 copay (no deductible)	$800 copay (no deductible)
Medical Out-of-Pocket Maximum				
Employee-Only Coverage	$8,750		$10,750	
Employee + Spouse/Domestic Partner or Employee + Child(ren)	$12,125		$15,125	
Employee + Family (Employee + Spouse/Domestic Partner + Child(ren))	$17,500		$21,500	
Prescription Drug Provisions	Not Applicable			

Expert Medical Advice

If enrolled in the JPMC Medical Plan, you and your covered family members have access to Expert Medical Advice through Included Health. It's free and voluntary.

Leading expert physicians are available to review documentation on an initial diagnosis you've received, recommended treatment plan for a condition or diagnosis, complex medical condition, scheduled surgery/major procedure and medications you are taking.

They can also help you find a highly-rated, in-network doctor or specialist, assist you with scheduling office appointments and advise you on how to prepare for the office visit. And if you're in the hospital, a Care Coordinator can help answer your questions and connect with your care team.

For more information, go to **My Health** > Medical Specialty Services > Expert Medical Advice

To access, contact Included Health:

- Online: www.includedhealth.com/jpmc
- Phone: 1-888-868-4693; 8 a.m. to 9 p.m., Eastern Time, Monday through Friday
- Mobile app: download from the iPhone or Android app store (search: Included Health)

Onsite JPMC Health & Wellness Centers and Employee Assistance Program

At the JPMC Health & Wellness Centers, you have access to basic medical services and educational resources - many at no charge to you. The Centers provide medical care, treatment, and resources when you need them at work to supplement the care and direction you get from your own doctor. Onsite nurses are available to act as advisors and help you connect with your health care company's coaching programs. Doctors are also available at most JPMC Health and Wellness Centers to provide additional onsite care when you need it. More information is available on **My Health** > Medical Specialty Services > JPMC Health & Wellness Centers.

Employee Assistance Program

The Employee Assistance Program (EAP) is here to support you — and your family members — to ***prevent*** small issues from becoming bigger ones, to ***support*** you through life's challenges, and to help you ***thrive*** day to day. Whether it's providing easy and affordable access to therapy/counseling, or helping you find services like eldercare or legal support, EAP can help. It's convenient, completely confidential, and it's available at no cost to you, 24/7.

EAP services are available to all benefits-eligible employees and their eligible dependents. Crisis services are available to all employees. For crisis support, contact our EAP partner, Spring Health, at 1-877-576-2007 (option 2).

Spring Health Services

JPMC is partnering with Spring Health to enhance our U.S. Employee Assistance Program (EAP). **Our goal: Accessible, affordable, high-quality mental health support when you need it – because life can be hard, and we've got your back.**

Our partnership with Spring Health provides additional mental health support that can help you take a proactive approach to managing your mental health over time. Services are available at no cost to all U.S. benefits-eligible employees and their eligible dependents (age 6+). For additional details, see Dependent Eligibility Requirements. Your care with Spring Health is private and confidential.

Highlights of Spring Health Services:

- A personalized mental health care plan: Take a short assessment to get a personalized care plan and access to a clinical Care Navigator, who can help you act on our plan and stay on track.
- **Coaching:** 6 free sessions a year to help you set and meet your goals for mental strength and conditioning and better manage life's daily challenges.
- **Counseling / therapy:** 8 free sessions a year with a broad and diverse network of qualified mental health professionals; 24/7 access to scheduling, and appointment availability within a few days.
- **Continuation of care:** Continued access to your Spring Health counselor / therapist within your medical plan (if enrolled in the JPMC Aetna or Cigna plan) after your 8th session at an in-network rate.
- **Mental strength exercises:** Access to Moments, a digital library of articles and self-guided exercises to help you improve your mental strength.

For more information

- Learn more about our Spring Health program or get started today at the Spring Health site to leverage these services for you and/or your eligible dependents.
- go/springhealth
- jpmc.springhealth.com
- For questions, please contact Spring Health support or call **1-877-576-2007** (M-F, 8am-11pm ET), Crisis support: 24/7 (option 2). If a life threatening emergency, please call **911**.

Your care with Spring Health is private and confidential.

Get Help with Ongoing Health Conditions

With the Medical Plan, your health care company will help you manage a health condition, including high blood pressure, high cholesterol, or diabetes, as well as providing health coaching programs to help you improve your health.

If your health care company (Aetna or Cigna) feels you could benefit by working with a health coach based on their review of your biometric Wellness Screening results, online Wellness Assessment responses, and/or claims data, your health care company (not JPMorgan Chase) will contact you directly. **Please Note:** Aetna and Cigna have access to your medical, prescription drug, and lab claims. So even if you do not get a biometric Wellness Screening or complete an online Wellness Assessment, you may still be contacted by your health care company. Keep in mind that you do not have to participate in these programs, but if you don't, you'll miss out on programs that can improve your health. So take the call!

Don't wait to receive a call to participate; you can call your health care company directly.

Here is a look at the most common health topics addressed by the health coaches at Aetna and Cigna. But, you should feel free to contact them on any health topic.

✓ Asthma	✓ High Blood Pressure
✓ Congestive Heart Failure	✓ High Cholesterol
✓ COPD, Emphysema, or Chronic Bronchitis	✓ Maternity Support
✓ Coronary Artery Disease	✓ Physical Activity
✓ Depression or Anxiety	✓ Stress Management
✓ Diabetes/Pre-Diabetes	✓ Weight Management
✓ Healthy Eating	

Please refer to the Aetna and Cigna websites available through **My Health** for a more comprehensive list of the topics they address through their telephonic and online programs.

LGBTQ+ Benefits

The Medical Plan covers certain procedures related to gender affirmation services. Employees and their covered dependants enrolled in the U.S. Medical Plan will have access to expanded coverage for gender affirmation services, including tracheal shave, facial feminization/masculinization, voice therapy and voice modification surgery.

LGBTQ+ Health Concierge Service

LGBTQ+ Health Concierge Service — delivered by Included Health — is an advocate in your corner who shares your needs and concerns.

Available at no cost to all U.S. JPMC employees and their dependents who are enrolled in the JPMC Medical Plan, this new personalized service is tailored to the needs of the LGBTQ+ community to help them:

- Find in-network, LGBTQ+ affirming providers
- Connect with community support and resources
- Navigate gender-affirming care as a transgender or non-binary person
- Understand plan benefits and coverage that may pertain to them, such as PrEP and gender-affirming procedures
- And more

Learn more. For help with any of these topics, call a dedicated LGBTQ+ Health Concierge at 1-877-266-2861, Mon. – Fri., 9 a.m. – 8 p.m. ET. Or go online to the new website: go/IncludedHealth (from work); www.includedhealth.com/jpmc (from home)

You'll need to register the first time you access the website.

My Health

Health and wellness questions can arise at any time. With **My Health**, you have a centralized resource with 24/7 access to information related to your Medical Plan and health care company, your MRA, wellness activities, tip sheets on how the plan works, the Benefits Web Center for enrollment information, and much more for you and your covered spouse/domestic partner.

As an employee, **My Health** provides one-stop access to all of your medical plan, prescription plan, and MRA information on a personalized basis. Simply use your Single Sign-On password to access **My Health**. You can access **My Health** from work or through the internet:

- From work: **My Health** via me@jpmc or type "go/myhealth" into your intranet browser.
- From internet: **myhealth.jpmorganchase.com**

Spouse/domestic partner access to My Health: The internet URL can be used by both employees and spouses/domestic partners anywhere. Spouses/ Domestic Partners can access **My Health** without a password, but their health care company's website will require their own username and password.

Who to call with Benefits Questions

See the tip sheet found on My Health > Benefits Enrollment > 2024 Benefits Resources > Who to call with benefits questions

Your Privacy is Important

Privacy Information. We are committed to protecting your personal health information, and complying with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), as applicable. When you participate in health and benefits related activities, including a Wellness Screening, Wellness Assessment, health coaching activities, benefits-related surveys or treatment at a JPMC or Vera onsite Health & Wellness Centers, your personal health information will be maintained and used in accordance with appropriate notices, privacy policies and applicable law.

For more information, go to My Health > Benefits Enrollment > Benefits Resources > Privacy Notice.

The JPMorgan Chase U.S. Benefits Program is generally available to most employees on a U.S. payroll who are regularly scheduled to work 20 hours or more a week and who are employed by JPMorgan Chase & Co. or one of its subsidiaries to the extent that such subsidiary has adopted the JPMorgan Chase U.S. Benefits Program. This information does not include all of the details contained in the applicable insurance contracts, plan documents, and trust agreements. If there is any discrepancy between this information and the governing documents, the governing documents will control. JPMorgan Chase & Co. expressly reserves the right to amend, modify, reduce, change or terminate its benefits and plans at any time. The JPMorgan Chase U.S. Benefits Program does not create a contract or guarantee of employment between JPMorgan Chase and any individual. JPMorgan Chase or you may terminate the employment relationship at any time.