Understanding Your Out-of-Pocket Medical and Prescription Drug Costs

Core Medical Plan

Effective January 1, 2020

This tip sheet provides information on your out-of-pocket costs. In addition to medical payroll contributions, your out-of-pocket costs are mainly made up of your:

- Deductible,
- Coinsurance, and
- Prescription drug copayments

You can use your Medical Reimbursement Account (MRA) to help pay for your deductible, coinsurance and copayments.

Your Deductible Explained

- The deductible is the amount you need to pay each year before the Medical Plan starts paying for certain services. It is 100% paid by you (with help from your Medical Reimbursement Account, called the MRA), and the amount you pay toward the deductible resets to $0 each January 1.

- The amount of your deductible depends on the plan option you elect, your Total Annual Cash Compensation, whether you go in-network or out-of-network for care, and your coverage level (employee only, employee + spouse/domestic partner or child(ren), or employee + spouse/domestic partner + child(ren)).

Pay Less Coinsurance if You Stay In-Network

Coinsurance is the percentage you pay for certain services (with help from your MRA); the plan pays the rest. Coinsurance varies based on whether you go in-network or out-of-network. It also varies by the type of service you receive (and whether or not you have satisfied the coinsurance maximum):

- First, eligible in-network preventive care is not subject to the deductible or coinsurance, so you pay nothing for those visits.

- Next, for non-preventive care to in-network primary care visits with doctors such as internists*, pediatricians, general and family practitioners, or OB/GYNs, Virtual Doctor Visits or visits to convenience care clinics, are not subject to the deductible, but you pay 10% of the costs. Note that:
  - Virtual Doctor Visits provide on-demand 24/7/365 access to non-urgent care through a national network of doctors, including pediatricians. Virtual Doctor Visits allow you to connect with a doctor using a smartphone, phone, tablet or computer for $5 or less per virtual visit.
  - Convenience care clinics are health care clinics located at certain in-store retail locations such as CVS. They are often open nights and weekends, so they can be a good alternative for things like a sore throat or an ear infection if you can’t see your doctor.

* An internist must be contracted with Aetna or Cigna as a primary care physician (PCP). Go to Aetna’s or Cigna’s website through My Health to search for PCP/primary care doctors.

My Health is your centralized online resource for benefits information. Type "go/myhealth" into your intranet browser (for the best user-experience, use Internet Explorer or Firefox browsers).

The Core Medical Plan is the consumer driven health plan that is offered to all US benefits-eligible employees except for those residing in Arizona and Ohio.
• For most other covered services, such as a specialist visit, you must first pay your deductible. After you’ve met your deductible, your coinsurance is 20% of the cost of service for in-network care.

You Have a Safety Net

To shield you from high costs, there is an annual coinsurance maximum, or the most you’ll pay in a calendar year for covered services. If the amount you’ve paid in coinsurance reaches your coinsurance maximum, the plan pays 100% of covered services for the rest of the year. **Note:** There are separate safety nets for in-network and out-of-network services. The coinsurance maximum does not include the amount you pay toward your deductible; it is in addition to that amount. The out-of-network coinsurance maximum calculation does 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.**

“Per Person” Rule

For both deductibles and coinsurance maximums, the “per person” rule allows any one person within family coverage to reach an individual deductible or coinsurance maximum, after which the deductible or coinsurance is satisfied for the year for that person. Other family members may then combine to meet the remainder of the deductible or coinsurance maximum for the family as a whole. If no one person has met the individual deductible or coinsurance maximum, the expenses of all covered members can combine to meet the deductible or coinsurance maximum for the whole family. **Note:** Your deductible can be ‘reset’ back to the employee “per person” amount if you add or remove dependents during the year. Contact the accessHR Contact Center for more information.

Payment Process and Costs

• When you go to an in-network doctor, you generally will not pay at the time you receive care. Instead, your provider’s office will process the claim with your health care company, and you will be billed after your health care company has processed your claim. Remember, you’ll pay in full until you meet your deductible (with help from your MRA). The exceptions are in-network preventive care services, as these are covered at 100% with no deductible, in-network primary care services, which are covered at 90% with no deductible and Virtual Doctor Visits which allow you to connect with a doctor online for $5 or less per visit before the deductible. How you pay for these costs depends on the process in which you are enrolled – Automatic Claim Payment or Debit Card. See the tip sheet, “Spending your MRA and HCSA: Automatic Claim Payment and Debit Card” for more information.

• For out-of-network providers, the payment process may be different. It is recommended that you do NOT pay at the time of service, if possible. However, many out-of-network doctors may require you to pay in full at the time you receive care. Also note that you’ll pay a separate, higher deductible and a higher level of coinsurance for out-of-network care. To learn more about out-of-network coverage, look to the “What You Need to Know and Do for Out-of-Network Care” tip sheet.

For more details about what to expect when you go to an in-network doctor, check out the “What to Do When You Need to Go to the Doctor (In-Network)” tip sheet.

Prescription Drug Coverage

• Your prescription drug coverage is administered by CVS Caremark (not Aetna or Cigna) and works differently than other expenses paid by the Medical Plan. There’s a separate retail annual

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- The JPMorgan Chase Prescription Drug Plan has also adopted **CVS Caremark’s standard and specialty drug lists of covered and excluded drugs**. These lists are subject to change quarterly by CVS Caremark. If you continue to take a non-covered drug, you will pay the full cost of the drug. You can view the lists on the CVS Caremark website through **My Health > Medical, Rx, MRA & Spending Accounts > My Prescription Drugs > Covered Drug List**. **Please Note:** Non-sedating antihistamines, such as Clarinex and Allegra, are not on the excluded list but are excluded from coverage.

- The plan contains a **mandatory generic drug program**, in which generic drugs are substituted for certain brand-name prescription drugs that have a direct equivalent. If you fill your prescription with a brand-name drug when a generic alternative is available, you pay the entire cost difference plus the generic drug copay. **Please Note:** These cost differences will not be limited by per prescription maximums or annual out-of-pocket maximum limits.

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

See the “Understanding Your Prescription Drug Coverage” tip sheet, or go to the CVS Caremark website through **My Health > Medical, Rx, MRA & Spending Accounts > My Prescription Drugs** for more information.

### Contacts

Additional information to help you choose your benefits during annual enrollment and use them throughout the year can be found on **My Health**. If you have additional questions or need more information, see the tip sheet, **Who to Call With Benefits Questions**.

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For plan details, use the 2020 Annual Enrollment Bulletin and Summary Plan Descriptions (SPDs) found on **My Health > Benefits Enrollment**.

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