JPMorgan Chase & Co.

The JPMorgan Chase Medical Plan

The JPMC Medical Plan (AZ & OH)

Highlights

- JPMorgan Chase offers two medical plans (options 1 and 2) paired with a Medical Reimbursement Account (MRA). (For MRA details, see the tip sheet, **MRA, HCSA and Payment Options**.) You will choose your medical option at the time you enroll.
- Your MRA is funded by JPMorgan Chase when you and your covered spouse/domestic partner complete Initial and Additional Wellness Activities. You cannot contribute your own dollars.
- The Medical Plan has two health care companies (Aetna and Cigna). You will choose your health care company at the time you enroll.
- The Medical Plan gives you the freedom to go in- or out-of-network for care, allowing you to choose the provider that best meets your needs. However, you'll generally pay more for out-of-network care.
- The Medical Plan is designed to help you and your family get and stay healthy. In-network eligible preventive care is fully covered, but out-of-network preventive care copay is $60 after you satisfy the deductible.
- The Prescription Drug Plan is part of the Medical Plan and is administered by CVS Caremark. You won't need to make a separate election for prescription drug coverage.

Two medical plan options

Option 1 has higher payroll contributions but lower annual out-of-pocket maximums and generally lower medical and prescription drug copays. Option 2 has lower payroll contributions but higher annual out-of-pocket maximums and generally higher medical and prescription drug copays. Otherwise, both options provide the same coverage.

As a general rule of thumb:

- If you typically use health care services often (other than primary care), you might want to consider enrolling in Option 1. Even though payroll costs are higher for this option, your annual out-of-pocket costs may be lower than if you choose Option 2.
- If you don't usually visit the doctor often except for preventive and primary care, and are generally healthy, you might want to consider enrolling in Option 2. It will cost you less in payroll contributions and still provides you with coverage in case of an unexpected illness or injury.

My Health is your centralized online resource for benefits information. Type "**go/myhealth**" into your intranet browser.

Two health care companies from which to choose

You can choose between two health care companies — either Aetna or Cigna. Both companies offer the same medical plan options at the same cost. And both companies offer extensive nationwide provider networks, Virtual Doctor Visits, well-established clinical programs, and comprehensive tools and resources to help you research and understand your treatment options, including Treatment Decision Support.

Receiving care in-network or out-of-network

The Medical Plan gives you the freedom to go in- or out-of-network for care, allowing you to choose the provider that best meets your needs. However, you'll generally pay more for out-of-network care, and the process of paying for your care will be different than if you choose to stay in-network. Here are some other important differences in cost:

- If you choose to go **in-network**:
  - There is no deductible to meet
  - Preventive care, including physical exams and recommended preventive screenings, is fully covered in-network. Check with your health care company for services covered at 100%.
  - In-network primary care[1] office visits and Virtual Doctor Visits are subject to a $15 copay per visit.
  - In-network specialist office visits are subject to a $75–$110 copay per visit.
  - Mental health therapy office visits with in-network psychologists, social workers or licensed therapists are subject to a $15 copay per visit. Visits with in-network psychiatrist are subject to a $75–$110 copay per visit.
- If you choose to go **out-of-network**:
  - Out-of-network charges are subject to a deductible and to higher copays than in-network care. In-network charges do not apply toward the out-of-network deductible or out-of-pocket maximum.
- For other services, various copays apply. See the JPMC Benefits Guide (SPD).
- The plan's out-of-pocket maximum (your financial "safety net") limits the amount you are required to pay for medical and prescription drugs each year. There are separate out-of-pocket maximums for in-network and out-of-network charges.[2]
- Your prescription drug coverage is managed by CVS Caremark.

For details, visit Your JPMC Benefits Guide (https://jpmcbenefitsguide.com) — the Summary Plan Descriptions — and go to How Your Medical Plan Works.

[1]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 PCPs/primary care.

[2] Children newly added to the plan (including newborns) will have a separate out of pocket maximum applied.

What if I'm currently enrolled in the Medical Plan and don't make elections during Annual Benefits Enrollment?

If you are enrolled in the Medical Plan as of Dec. 31, 2022 and do not take any action during Annual Benefits Enrollment, your 2022 medical elections will automatically map to 2023 so that you and any covered family members have medical coverage on Jan. 1, 2023 as follows:

- You will remain enrolled with your current health care company (Aetna or Cigna) for 2023.
- Your medical plan option (option 1 or option 2) will **not** change.
- Your election of debit card versus automatic claim payment for your Medical Reimbursement Account (MRA) / Health Care Spending Account (HCSA) will also carry over.

Reminder: Any elections to participate in the Health Care and Dependent Care Spending Accounts will **not** map over; you are required by IRS regulations to re-elect this benefit each year.

Prescription drug coverage

JPMC's Prescription Drug Plan is part of the JPMC Medical Plan and is administered by CVS Caremark. You won't need to make a separate election for prescription drug coverage; it's covered by the Medical Plan election you make.

Your prescription drug coverage depends on the type of drug your doctor prescribes and where you fill your prescription. Prescription drugs are split into two main categories:

- **Traditional drugs**, also known as non-specialty drugs, are usually the ones which most people are familiar with and represent the majority of prescription drugs used. This includes medicines used to treat common conditions like high blood pressure, diabetes and asthma, and most short-term medicines used to treat acute conditions like coughs, flu and infections. Traditional drugs generally don't have special handling or shipping requirements, are available at most pharmacies, and are lower cost.
- **Specialty drugs** are generally used to treat complex medical conditions such as rheumatoid arthritis, multiple sclerosis and psoriasis. These drugs 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.

Within the traditional and specialty categories, there are three types of prescription drugs:

- **Generic drugs** have equivalent ingredients to brand-name drugs, but generally cost less.
- **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 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.

  Note: Eligible generic and brand **preventive drugs are covered at 100%** — which means you pay nothing for these prescription drugs at network pharmacies. Mandatory Generic Drug Program applies.

Covered and excluded drug lists

The JPMC Prescription Drug Plan uses CVS Caremark's lists of covered and excluded drugs (also known as Formularies), reviewed and approved by an independent committee of pharmacists, physicians and medical ethicists. Go to My Health > Medical, Rx, MRA & Spending Accounts > My Prescription Drugs to access CVS Caremark's website. From the Plan & Benefits tab, select **Covered Drug List (Formulary)**.

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 direct generic equivalent is available, you pay the entire cost difference between the generic and brand name drugs, plus the generic drug copay. **Please Note:** These cost differences will not be limited by prescription copayments 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.

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.

- **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.
- **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 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 CVS Caremark mail service or by picking them up at a CVS retail pharmacy 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.

For complete prescription drug coverage details, visit Your JPMC Benefits Guide (https://jpmcbenefitsguide.com) — the Summary Plan Descriptions — and go to The Simplified Medical Plan.

Contacts

Additional information to help you choose your benefits during Annual Benefits 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**.

*For plan details, use the 2023 Annual Enrollment Bulletin and Summary Plan Descriptions (SPDs) found on **My Health** > Benefits Enrollment > 2023 Benefits Resources.*

The JPMorgan Chase U.S. Benefits Program is generally 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. 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.