2017 Medical Plan Overview

Effective January 1, 2017

JPMorgan Chase offers a type of Medical Plan known as a "Consumer Driven Health Plan," or CDHP. This plan consists of two Medical Plan options: Option 1 and Option 2, administered by both Cigna and UnitedHealthcare (UHC). Both options cover medically necessary services and supplies, including prescription drugs. The key differences between these options are:

- **Option 1** has higher payroll contributions but lower deductibles and coinsurance maximums.
- **Option 2** has lower payroll contributions but higher deductibles and coinsurance maximums.

This overview provides details of the Medical Plan features and explains how other aspects of your health care benefits work, like the Medical Reimbursement Account (MRA) and associated Wellness Rewards you can earn, and prescription drug coverage. And, it includes detailed information about the many wellness features, tools and resources that can help you get on the road to good health. Our goal is to help you better understand your benefits so you can make good decisions and be an informed consumer of health care in 2017 and beyond.

How the Plan Works

- Plan benefits are offered through a network of participating health care providers (for example, doctors, hospitals, labs, and outpatient facilities).
  - Even though there is an out-of-network benefit available, JPMorgan Chase strongly urges you to stay in-network. An increasing number of employees are selecting out-of-network providers and services, which cost more for all employees and JPMorgan Chase. Selecting in-network providers and services is more cost effective. Additionally, to help make it easier for you to find in-network care, Cigna and UHC continue to increase the size of their network by adding doctors and hospitals.

- You generally must meet an annual deductible – a set amount that you pay out of pocket – before the plan shares in the costs for care. (Note that there are separate deductibles for in-network and out-of-network care.)
  - Important: In-network preventive care, including physical exams and recommended preventive screenings, is covered at 100% with no deductible, coinsurance, or copayments; and in-network primary care office visits are covered at 90% with no deductible.
    - Primary care includes family practitioners, internists, pediatricians, OB/GYNs, and Convenience Care Clinics. Internists must be contracted with Cigna or UHC as a Primary Care Physician (PCP). Go to Cigna or UHC's websites through **My Health** to search for PCPs/primary care physicians.
  - For other services, the plan pays a percentage (generally 80% in-network and 50% out-of-network) of the cost once you meet the annual deductible. Your share—called coinsurance, which is the amount you and the plan share for certain expenses—after the deductible, is typically 20% of the cost of in-network care and 50% of the cost for out-of-network care.
    - The plan's coinsurance maximum (out-of-pocket maximum)—your financial "safety net"—limits the amount you are required to pay in coinsurance each year. Note that there are separate coinsurance maximums for in-network and out-of-network charges.

Complete a Wellness Screening and Wellness Assessment for 2017 MRA Funds:

Employees who complete **both** a biometric Wellness Screening and online Wellness Assessment between Jan. 1-Dec. 31, 2016, will **earn $200** in their 2017 MRA, and **save $500** in 2017 medical payroll contributions.

When an employee's covered spouse/ domestic partner completes **both** Initial Wellness Activities (i.e., Wellness Screening and Wellness Assessment) during 2016, the employee will earn another $100 in their 2017 MRA and save an additional $500 in their 2017 medical payroll contributions. **See page 7 for what happens if you don't complete the activities within the required timeframe.**

Coverage effective after October 1, 2016?
Employees and/or their covered spouse/domestic partner who become eligible for benefits coverage after October 1, 2016, have from their coverage effective date until December 31, 2017 to complete a Wellness Screening and Wellness Assessment to earn 2017 Initial Wellness Rewards. If newly eligible for coverage after October 1, 2016, employees will automatically pay the reduced medical payroll contributions for 2017.

For details, go to **My Health** > Completing a Wellness Screening and Assessment.

On a leave of absence? See more detail on page 7.

- In-network charges do not apply toward the out-of-network deductible or coinsurance maximum – and vice versa.

- Out-of-network information:
  - Benefits for out-of-network care are limited to reasonable and customary (R&C) charges after you meet the out-of-network deductible. These 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.
  - Out-of-network charges are typically higher than the pre-negotiated fees that are covered for in-network care. You are responsible for any amount above the R&C charges.
  - More information can be found on the *What You Need to Know and Do for Out-Of-Network Care* Tip Sheet available on **My Health** > 2017 Benefits Resources and Tip Sheets.

- Prescription drug coverage has a completely different plan design than the Medical Plan features, and is not subject to the same deductibles. (See page 5 for details.)

- Option 1 and Option 2 come with a Medical Reimbursement Account (MRA) you can use to help pay for eligible out-of-pocket medical and prescription drug expenses like deductibles and coinsurance. The MRA is funded by JPMorgan Chase when you take action and complete designated wellness activities. You cannot contribute funds to your MRA. (See page 7 for more details about the MRA and what you can do to maximize funding for 2017.)

Your MRA is here to help!

You can use your Medical Reimbursement Account (MRA) to help pay for eligible out-of-pocket medical and prescription drug expenses. More information about your MRA is on page 7.

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 (Cigna or UHC) to ensure that the treatment, service or procedure meets your health care company's and the Medical Plan's requirements and guidelines. If your in-network provider doesn't check with Cigna/UHC, you are held harmless financially.

- It's important to understand if you are using 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.

Our Health Care Companies-Cigna and UnitedHealthcare (UHC)

JPMorgan Chase partners with Cigna and UHC to administer Option 1 and Option 2 of our Medical Plan. You pay the same for Medical Plan benefits regardless of which company you choose. Both are large, established companies that offer broad nationwide provider networks. They also offer clinical programs, coaching and provide tools and resources to help you research and understand your health treatment alternatives. You choose your health care company and your Medical Plan Option 1 or Option 2) during Annual Benefits Enrollment.

Dependent Coverage

If you're adding a dependent to your coverage, beginning January 1, 2017, you'll need to provide that dependent's Social Security Number. (This information is required by the Affordable Care Act.) Just go to the Benefits Web Center and you'll be prompted for the Social Security Number when adding each dependent for coverage.

Virtual Doctor Visits

Virtual doctor visits allow you to connect to a doctor in minutes-anytime, anywhere-using a smartphone, tablet, or computer for $5 or less per virtual visit. Doctors can make diagnoses, provide advice and call in prescriptions to your local pharmacy. Register before you need care, go to **My Health** > Specialty Services > Virtual Doctor Visits.

Overview of Plan Information

The charts below and on page 4 present an overview of plan features for Option 1 and Option 2. For more detailed information, use the Health Plan Comparison Charts on the Benefits Web Center, which you can access through **My Health** or contact your health care company (see page 15 for contact information).

ANNUAL DEDUCTIBLE				
COVERAGE LEVELS	OPTION 1		OPTION 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee (Also serves as "per person"* amount)	$1,750	$2,750	$2,750	$4,750
Employee + Spouse/Domestic Partner *or* Child(ren)	$2,625	$4,125	$4,125	$7,125
Employee + Spouse/Domestic Partner + Child(ren)	$3,500	$5,500	$5,500	$9,500

*For both deductibles and coinsurance 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 coinsurance maximum, after which the deductible or coinsurance maximum is satisfied for the year for that person. Covered individuals who have not met the deductible or coinsurance maximum may combine to meet the remainder of the deductible or coinsurance maximum for that particular coverage level. If no one person has met the individual deductible or coinsurance maximum, the expenses of all covered individuals can combine to meet the deductible or coinsurance maximum for that coverage level. Note: Your deductible can be 'reset' back to the employee "per person" amount if you add or remove dependents, etc. Contact accessHR for more information.

COINSURANCE PERCENTAGES		
MEDICAL BENEFIT PROVISIONS	COVERAGE FOR OPTION 1 AND OPTION 2	
	In-Network	Out-of-Network**
Preventive Care (age- and gender-appropriate exams such as physical, cervical and prostate cancer screenings, mammograms, or colonoscopy)	100% **before** deductible	50% **after** deductible
Primary Care Office Visit (Family Practitioner, Internist***, Pediatrician, OB/GYN, or Convenience Care Clinic)	90% **before** deductible	50% **after** deductible
Virtual Doctor Visit	90% **before** deductible	0% (Not Covered)
Specialist Office Visit	80% **after** deductible	50% **after** deductible
Other Medical Costs (Hospitalizations, Labs, etc.)	80% **after** deductible	50% **after** deductible
Emergency Care (True emergency)	80% **after** in-network deductible is met	80% **after** *in-network* deductible is met
Emergency Care (Not a true emergency****)	50% **after** in-network deductible is met	50% **after** out-of-network deductible is met

**Percentages do not include amounts above Reasonable and Customary (R&C) limits that you may owe. R&C is the amount health care companies have determined is a normal range of payment for a specific health-related service or medical procedure within a given geographic area. Amounts owed above R&C, if any, are fully payable by you.

***Internists must be contracted with Cigna or UHC as a Primary Care Physician (PCP). Go to Cigna's or UHC's websites through **My Health** to search for PCPs/primary care physicians.

****Examples of 'not a true emergency' are a non-life-threatening situations like a sprain, cold, sore throat, and ear infection. These examples can be handled through your primary care physician, convenience care clinic, or urgent care clinic for less expense than the emergency room (ER).

Charts continue on next page.

ANNUAL COINSURANCE MAXIMUM (DOES NOT INCLUDE DEDUCTIBLE)				
COVERAGE LEVELS	**OPTION 1**		**OPTION 2**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Total Annual Cash Compensation: < $60,000				
Employee (Also serves as the "per person*" maximum	$1,000	$6,000	$2,750	$6,000
Employee + Spouse/Domestic Partner (DP) *or* Child(ren)	$1,500	$8,000	$4,125	$8,000
Employee + Spouse/DP + Child(ren)	$2,000	$12,000	$5,500	$12,000
Total Annual Cash Compensation: $60,000 - $149,999				
Employee (Also serves as the "per person*" maximum	$1,500	$6,000	$3,050	$6,000
Employee + Spouse/DP *or* Child(ren)	$2,250	$8,000	$4,575	$8,000
Employee + Spouse/DP + Child(ren)	$3,000	$12,000	$6,100	$12,000
Total Annual Cash Compensation: $150,000+				
Employee (Also serves as the "per person*" maximum	$2,250	$6,000	$3,050	$6,000
Employee + Spouse/DP *or* Child(ren)	$3,375	$8,000	$4,575	$8,000
Employee + Spouse/DP + Child(ren)	$4,500	$12,000	$6,100	$12,000

*For both deductibles and coinsurance 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 coinsurance maximum, after which the deductible or coinsurance maximum is satisfied for the year for that person. Covered individuals who have not met the deductible or coinsurance maximum may combine to meet the remainder of the deductible or coinsurance maximum for that particular coverage level. If no one person has met the individual deductible or coinsurance maximum, the expenses of all covered individuals can combine to meet the deductible or coinsurance maximum for that coverage level.

Total Annual Cash Compensation (TACC)

This is used for purposes of determining your Medical Plan payroll contributions (information below) and in-network coinsurance maximum (chart on page 3). It includes your annual rate of base salary plus applicable job differential pay (e.g., 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. Overtime is not included. Your TACC is recalculated as of each August 1 to take effect the following January 1 and will remain unchanged throughout the year. For most employees, Total Annual Cash Compensation will be equal to base salary plus job differentials in the year of hire. Your Total Annual Cash Compensation is available on the Benefits Web Center via **My Health**.

Medical Payroll Contributions

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 2017 depends on:

- Level of your Total Annual Cash Compensation,
- Medical option you choose,
- Where you live,
- Number and type of eligible dependents you cover,
- If you and/or your covered spouse/domestic partner completed **both** a biometric Wellness Screening and online Wellness Assessment during 2016, and/or
- If you and/or your covered spouse/domestic partner use tobacco.

The amount you pay in payroll contributions **does not** differ whether you choose Cigna or UHC.

Free Preventive Generic Drugs

To encourage preventive care and the use of generic drugs, eligible preventive generic drugs are covered at 100% with no deductibles or copayments. 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.

Examples of preventive generic drugs include Simvastatin, a generic for Zocor®, to help lower cholesterol, and alendronate, a generic for Fosamax®, to help prevent osteoporosis. A complete list of drugs covered at 100%, as determined by CVS Caremark, can be found on CVS Caremark's website through **My Health**.

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. Be sure to consider carefully how the costs of taking a long-term brand-name drug could add up.

Prescription Drug Coverage

Your prescription drug coverage is part of the Medical Plan and is administered by CVS Caremark. Though it is part of the Medical Plan, it has a different plan design, with separate deductibles and a separate safety net for covered prescriptions in the form of per-prescription maximums and annual out-of-pocket maximums.

The plan offers free preventive generic drugs, a flat copayment for all other generic drugs ($10 at retail/$20 via mail-order), and coinsurance for brand-name drugs (lower coinsurance for preferred brand-name drugs). You also have the option of having long-term prescriptions filled through a convenient mail-order program or at an in-network retail pharmacy.

The plan contains a **mandatory generic drug program**, in which generic drugs are substituted for all brand-name prescription drugs with a direct generic equivalent. If you choose to 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. N**ote:** These cost differences will not be limited by per prescription maximums or annual out-of-pocket maximum limits.

Your prescription drug plan uses CVS Caremark's standard drug lists (Specialty and Non-specialty) of covered and excluded drugs. These lists are subject to change by CVS Caremark and can be viewed at any time on the Caremark website. An independent committee made up of pharmacists, physicians, and medical ethicists review and approve these drug lists (also known as Formulary). In addition, non-sedating antihistamines, such as Clarinex and Allegra, are not on the excluded list but are also not covered under the plan. **Note**: Your physician can contact CVS Caremark to seek medical exception approval for specific clinical reasons.

Specialty Medications

Specialty drugs are typically biologics (medicines derived from living cells) that are complex to manufacture and used to treat complex conditions (e.g., Rheumatoid Arthritis). If you are taking a Specialty Drug that is not on the covered drug list, please be aware that excluded drugs have covered alternatives which are clinically effective.

What is a Preferred Brand-Name?

If there is no generic option available, there may be a different brand-name prescription drug alternative. CVS Caremark has reviewed these alternatives and determined which are clinically appropriate and cost-effective. These are called "preferred brand-name prescription drugs," and are covered at a higher level than non-preferred drugs.

Pharmacy Advisor

This is a voluntary counseling program offered through CVS Caremark to help employees (and covered dependents) with certain conditions, such as diabetes and heart disease, adhere to their prescription regimen, manage their medications and make sure their medications don't conflict with each other. When you pick up your prescription at a CVS pharmacy, the pharmacist will automatically offer to provide onsite counseling.

Go to the Caremark website for information

Find the information you need on Caremark's website, available through My Health > Prescription Drugs, such as:

- An in-network retail pharmacy near you,
- "Important Messages" on the website for instructions on how to learn more about your 2017 Prescription Drug plan design and costs, including Specialty (Advanced Control Specialty Formulary) and Non-specialty (Standard Formulary) drug lists,
- Cost differences between generic and brand-name drugs, and
- List of preferred brand-name drugs.

The chart on the following page presents an overview of the Prescription Drug Plan.

PRESCRIPTION DRUG BENEFIT PROVISIONS	COVERAGE FOR OPTION 1 AND OPTION 2
Retail Prescription Brand-Name Drug Deductible (Waived for generic) (Employee*/Employee + Spouse/Domestic Partner (DP) *or* Child(ren)/Employee + Spouse/DP + Child(ren))	$100/$200/$300
Out-of-Pocket Maximum (Does not include deductible) (Employee**/Employee + Spouse/DP *or* Child(ren)/Employee + Spouse/DP + Child(ren))	$950/$1,400/$1,800
Preventive Drug Coverage	100% for generics only
Retail Pharmacy (Up to a 30-day supply)	Employee copayment/coinsurance: • $10 generics • 30% ($100 max) preferred brand-name*** • 45% ($150 max) non-preferred brand-name***
Mail-Order Pharmacy or CVS Retail Pharmacy (Up to a 90-day supply)	Employee copayment/coinsurance: • $20 generics • 30% ($250 max) preferred brand-name*** • 45% ($375 max) non-preferred brand-name***
CVS Caremark excluded drugs (Specialty and Non-Specialty)	Not covered, you will pay the full cost for these drugs
Non-Sedating Antihistamines (also known as NSA's)	Not covered, you will pay the full cost for these drugs

** Also serves as a "per person" deductible under other coverage levels.*
*** Also serves as a "per person" maximum under other coverage levels.*
**** If a generic is available for a brand-name drug, and participant selects the brand-name drug, they will pay entire cost difference between brand-name and generic as well as the generic co-pay*

Fill Long-Term Prescription Drugs Through CVS Caremark's Mail-Order Program to Save Money

One of the features of the plan is the discount available for long-term maintenance prescriptions (for conditions like high blood pressure and high cholesterol) purchased in bulk by CVS Caremark and fulfilled through the mail-order prescription service. This program saves both you and JPMorgan Chase money.

If you are taking a long-term medication, you may receive your 90-day supply by mail through CVS Caremark's mail-order prescription service or by picking up your 90-day supply at a CVS retail pharmacy, via the Maintenance Choice® program, where the same discounts are available. You may also opt out of Maintenance Choice and obtain a 90-day supply (or a 30-day supply) at any participating network pharmacy. Please keep in mind that it may be more cost-effective for you to use CVS Caremark mail-order prescription service or a CVS retail pharmacy.

You can use your Medical Reimbursement Account (MRA) to help pay for eligible prescription drug expenses (deductible, copayments, and coinsurance). Included as reimbursable are costs for non-covered prescription drugs, such as non-sedating antihistamines (e.g., Clarinex; Allegra).

Wellness Rewards: Medical Reimbursement Account (MRA) and Medical Payroll Contribution Savings

A key part of our Medical Plan and wellness strategy is to engage employees in specific wellness activities by providing Medical Reimbursement Account (MRA) funds. JPMorgan Chase contributes money to your MRA to help you pay for eligible out-of-pocket medical **and** prescription drug expenses (deductibles, coinsurance, and copayments).

How You Can Earn Funds for Your 2017 MRA

STEP ONE: INITIAL WELLNESS ACTIVITIES (BIOMETRIC WELLNESS SCREENING AND ONLINE WELLNESS ASSESSMENT)

When you, the employee, complete **both** a biometric Wellness Screening and online Wellness Assessment between January 1 and December 31, 2016, will **earn $200** in your 2017 MRA, and **save $500** in 2017 medical payroll contributions. If your covered spouse/ domestic partner completes both Initial Wellness Activities (i.e., Wellness Screening and Wellness Assessment) in the required timeframe, you will earn another $100 in your 2017 MRA and save an additional $500 on your 2017 medical payroll contributions. The medical payroll contributions shown when you enroll on the Benefits Web Center assume you and your covered spouse/domestic partner have completed both Initial Wellness Activities during 2016.

Important: Starting in January 2017, your 2017 medical payroll contributions will initially reflect these savings. If you or your covered spouse/domestic partner chooses **not** to complete both activities during 2016, your medical payroll contributions will increase in spring 2017 for both you and your covered spouse/domestic partner. The full $500 (or $1,000) increase will be applied in equal installments to each pay from the first effective pay in spring 2017 through December 2017.

- If the Wellness Screening was completed at your doctor's office, make sure the *Wellness Screening Results Form* (found on **My Health**) is submitted as soon as possible, but no later than January 31, 2017 to ensure timely processing of any applicable wellness incentives.
- If you believe you are entitled to the 2017 medical payroll contributions savings but those are not reflected in your pay, you must contact your health care company and open a case no later than October 31, 2017.

Employees and/or their covered spouse/domestic partner who become eligible for coverage after October 1, 2016, have from their coverage effective date until December 31, 2017 to complete a Wellness Screening and Wellness Assessment to earn Initial Wellness Rewards for 2017. If newly eligible for coverage after October 1, 2016, employees will automatically pay the reduced medical payroll contributions for 2017.

We encourage all employees and their covered spouses/domestic partners to participate in our Wellness Rewards program. However, if an employee is on an approved Leave of Absence for at least 70 consecutive days between September 1 and December 31, 2016, and does not complete their biometric Wellness Screening and online Wellness Assessment during that period, then they will not lose the $500 2017 medical payroll contribution savings ($1,000 if covering a spouse/domestic partner). Other provisions of the Medical Plan and Wellness Program will continue to apply, including the opportunity to earn MRA funds by completing Wellness activities.

What are a biometric Wellness Screening and an online Wellness Assessment?

A biometric Wellness Screening provides overall key indicators of your health. Screenings measure your blood pressure, blood sugar, cholesterol, triglycerides, and body mass index (BMI). There are four ways to get a Wellness Screening, including during your annual physical (three ways for your covered spouse/domestic partner).

The Wellness Assessment is a15-minute online survey that asks you questions about your biometric wellness screening results, diet, lifestyle, sleep patterns and health goals.

For details, go to **My Health** > Learning About Wellness Screenings and Assessments. 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 12 for more details.

STEP TWO: ADDITIONAL WELLNESS ACTIVITIES

Complete up to four Additional Wellness Activities between January 1 and December 31, 2017, and earn $200 for each (maximum $800) in your 2017 MRA

- Your covered spouse/domestic partner can complete up to three Additional Wellness Activities during 2017 and you will receive $100 for each completed activity (maximum $300) in your 2017 MRA.

The chart on page 9 presents an overview of the 2017 Wellness Activities for your 2017 Medical Reimbursement Account.

Remember: To earn funds for completing Additional Wellness Activities, you must complete **both** a Wellness Screening and Wellness Assessment first. Your covered spouse/domestic partner must also complete **both** Initial Wellness Activities before you can earn when they complete Additional Wellness Activities.

YOUR MRA ADDS UP

When you complete Initial and Additional Wellness Activities during the appropriate timeframes, you can earn up to $1,000 in your 2017 MRA. If applicable, your covered spouse/domestic partner can also complete wellness activities during the appropriate timeframes, and you can earn an additional $400 in your 2017 MRA for a total of $1,400.

You can use MRA funds to pay for eligible medical and prescription drug expenses you'll have in 2017 or in future years.

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 (deductibles, coinsurance, and copayments). 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. More information on the HCSA is available on page 10. Unused MRA funds are forfeited upon termination unless you are eligible to retire or elect COBRA. More information can be found in the *As You Leave/As You Retire* guides on **me@jpmc**.

The chart on the following page presents an overview of the 2017 Wellness Activities for your 2017 Medical Reimbursement Account.

If You Don't Enroll in a JPMorgan Chase Medical Plan for 2017

You (the employee) will still be able to earn up to $600 in 2017. Wellness Rewards payable (and taxable) through payroll. You must complete **both** a biometric Wellness Screening and an online Wellness Assessment during the required timeframe (Jan. 1 – Dec. 31, 2016) to earn $200 in 2017. After completing your Wellness Screening and Wellness Assessment, earn an additional $400 by completing two Additional Wellness Activities during 2017.

Wellness Rewards are not available to spouse/domestic partners of employees who do not enroll in the JPMorgan Chase Medical Plan.

You can find more information on your Wellness Rewards program on **My Health** > Not Enrolled in the JPMorgan Chase Medical Plan.

How Your 2017 MRA Activities Add Up

MRA Activity	Who is Eligible to Complete & Amount Earned for Employee's 2017 MRA		Timing and Details
	You	**Covered Spouse /Domestic Partner**	
Initial Wellness Activities	Must complete **both** a biometric Wellness Screening and an online Wellness Assessment		**January 1 – December 31, 2016** Go to **My Health** > Learn About Wellness Screenings and Assessments for details
Get a biometric Wellness Screening If you had a screening at your doctor's office, make sure a *Wellness Screening Results Form* is submitted as soon as possible, but no later than January 31, 2017 for screening completed in 2016. **AND**	$200 for completing **both** activities and save $500 in medical payroll contributions	$100 for completing **both** activities and save $500 in medical payroll contributions	There are four ways to get a free screening: 1. Employees can sign up for an onsite Wellness Screening, available at larger JPMorgan Chase locations 2. Schedule a screening at a participating local lab 3. Visit your in-network health care provider 4. Visit in-store retail clinic such as CVS Minute Clinic, Duane Reade "DR Walk-In Medical Care" Clinics, and Walgreens Healthcare Clinics.
Complete an online Wellness Assessment			Complete on your health care company's website (Cigna or UnitedHealthcare/Rally) accessible via **My Health**
Those eligible for benefits coverage after October 1, 2016, have from their coverage effective date until December 31, 2017, to complete Wellness Screening + Wellness Assessment, earn 2017 MRA funds, and automatically pay reduced medical payroll contributions for 2017.			
Additional Wellness Activities	Choose which activities to complete		**January 1, 2017 – December 31, 2017** Employees and/or their covered spouse/ domestic partner **must** complete Initial Wellness Activities before earning MRA funds for any Additional Wellness Activities.
	Complete up to four activities – maximum of $800	Complete up to three activities – maximum of $300	
Preventive Care. Get a physical, cervical or prostate cancer screening, mammogram, or colonoscopy	$200	$100	Take advantage of all the age- and gender-appropriate screenings that apply to you (each are covered at 100% in-network), but you can only receive funds once a year for this activity.
Biometric Outcomes: • **Body Mass Index (BMI)** under 25* or progress toward it as defined by your health care company • **Blood Pressure** 120/80* or less, or progress toward it as defined by your health care company	$200	$100	Receive funds only once a year for **each** outcome based on results from a Wellness Screening
Personal Action Call with your health care company to discuss Wellness Screening & Assessment results, understand tools & resources available.	$200	$100	Receive funds once a year for this activity
Participate in **Health Coaching Program**, such as stress and weight management, nutrition, maternity support, condition management, and/or treatment decision support	$200	$100	**Telephonic:** Participate in as many programs as you want, but employees can only earn for completing up to four telephonic Health Coaching Programs; spouse/domestic partners up to three. **Online:** Participate in as many online programs as you want, but receive funds only once a year for online programs.
Online Learning Programs: • **Choosing Care Wisely**-become a good health care purchaser using tools and resources available on your health care company's web site • **Planning Your Finances Wisely**-learn more about how to be financially well by using tools and resources that JPMorgan Chase provides.	$200	$100	Receive funds once a year for completing one of these activities. **Note:** You can complete one of these activities and earn Wellness Rewards, but you can't receive Wellness Rewards for completing both modules.
Participate in a **Local Community Physical Activity** event through Good Works, or participate in a JPMorgan Corporate Challenge*	$200	Not Applicable	You can participate in as many local events as you want, but you can only receive funds once a year for this activity.
TOTAL MAXIMUM 2017 MRA funds employee can earn	**$1,000**	**$400**	**$1,400 if employee and covered spouse/domestic partner complete Initial + Additional Wellness Activities within required timeframes**

** If it is unreasonably difficult due to a medical condition for you and/or your covered spouse/domestic partner to achieve the standards for the reward under this program, contact your health care company to work with you (and, if you wish, with your doctor) on an alternative. If you did not enroll in JPMorgan Chase medical coverage, Cigna has been designated as your health care company to administer your Wellness Rewards. For details, go to My Health > Not Enrolled in a JPMorgan Chase Medical Plan.*

Health Care Spending Account (HCSA)

During Annual Benefits Enrollment, you can elect to contribute to a Health Care Spending Account (HCSA) up to an annual maximum of $2,550 in 2017 on a before-tax basis to pay for eligible out-of-pocket health care expenses. Your MRA funds are used first, and only for eligible medical and prescription drug expenses.

You may use your HCSA for these eligible expenses after your MRA funds are used:

- Medical and prescription drug deductibles, coinsurance and copayments; **and**
- Costs for non-sedating antihistamines (e.g., Clarinex; Allegra).

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

- Drugs taken that are excluded from the CVS Caremark covered drug lists;
- Costs for over-the-counter medications for which you have a prescription and all forms of insulin (even if you do not 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.

Note: Certain expenses, such as those for cosmetic surgery or health care premiums, are not reimbursable under the HCSA.

What is a HCSA?

Also known as a Flexible Spending Account, a 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 MRA), dental, or vision plans.

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 $500 remaining in your Health Care Spending Account (HCSA) at the end of 2016, will be automatically carried over to your 2017 HCSA to use toward 2017 expenses. Any amount over $500 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 2017 MRA funds and any MRA funds that carry over from 2016 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 2017 HCSA election.

The claim filing deadline for 2016 expenses is March 31, 2017. Be sure to file your claims before this deadline.

Who Administers Your HCSA?

Your health care company (Cigna or UHC) will be the administrator of your HCSA. If you waive medical coverage through JPMorgan Chase, ADP will administer your HCSA.

Want to know more about what are eligible HCSA expenses? Go to http://www.irs.gov/publications/p502/index.html

Comparing Your MRA and HCSA

MRA (a feature of your Medical Plan)	HCSA (an account you elect separately)
Your MRA is funded exclusively by JPMorgan Chase and consists of: • **Initial Wellness Funds:** For completing **both** the Wellness Screening and Wellness Assessment • **Additional Wellness Funds:** For completing from the following list of activities - Preventive Care, Personal Action Call, Body Mass Index*, Blood Pressure*, Health Coaching, and Local Community Physical Activity* Choosing Care Wisely** or Planning Your Finances Wisely** 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. It is a 'use it or lose it' account. Unused amounts up to $500 will automatically carryover to the next year. **Unused amounts over $500 will be forfeited.**
MRA funds are used **first** and can be used to pay eligible out-of-pocket costs for only those medical and prescription drug expenses covered by your Medical Plan. MRA funds cannot be used for other expenses (e.g., dental and vision).	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; **PLUS** Other out-of-pocket health care costs, such as dental and vision, which cannot be paid out of your MRA.

** If it is unreasonably difficult due to a medical condition for you (and/or your covered spouse/domestic partner) to achieve the standards for the reward under this program, contact your health care company to work with you (and, if you wish, with your doctor) on an alternative.*
***You can complete Choosing Care Wisely or Planning Your Finances Wisely to earn Wellness Rewards, but you can't receive Wellness Rewards for completing both modules.*

Payment Methods for your MRA/HCSA

When you enroll in the JPMorgan Chase Medical Plan, you can choose to have expenses paid from your MRA through either Automatic Claim Payment or a Debit Card. The same method will be used to have expenses paid through your HCSA, if you elect to contribute to one. This election is made at enrollment, and cannot be changed during the year. If you do not enroll in the Medical Plan, other payment methods apply. Go to **My Health** for more information on filing claims with ADP and Cigna.

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 then be used to pay the remaining balance. This will happen automatically through your health care company (either Cigna or UHC). 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 eligible 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 then be applied, as described above. The pharmacy will tell you what amount, if any, you will need to pay.

For dental and vision expenses, you'll need to pay out-of-pocket and then submit a claim to your health care company to be reimbursed from your HCSA.

If You See an Out-of-Network Provider

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 your provider agrees to do so, your claim will be processed as explained on this page. 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 reimbursement form to your health care company.

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 eligible 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 an eligible 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 your 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 out-of-pocket, you can later submit a paper reimbursement form, available on **My Health**, to your health care company for reimbursement.

For dental and vision expenses, you can use your Debit Card to access your HCSA funds. (Remember: MRA funds cannot be used to pay for dental and vision expenses.)

For more information on choosing a payment method, review the *Helping You Choose: Automatic Claim Payment vs. Debit Card* Tip Sheet on My Health.

Take Advantage of Onsite Health & Wellness Centers

At the 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 Health and Wellness Centers to provide additional onsite care when you need it. More information is available on **My Health** > JPMC Health & Wellness Centers.

Your Privacy is Important

Sometimes employees ask us about privacy of their health information, so we thought we'd remind you about how we protect your personal health information. Any personally identifiable health information is not shared with JPMorgan Chase. The information is protected and secure, and complies with privacy regulations, like those outlined in the Health Insurance Portability and Accountability Act (HIPAA).

Plus, while the JPMorgan Chase Health & Wellness Centers are staffed with nurses who are employed by the firm, they are medical professionals and cannot disclose your personal information to anyone outside the centers without your permission.

Get Help with Ongoing Health Conditions

With the Medical Plan, your health care company will administer your Wellness Program. That includes helping you manage a health condition, like 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 (Cigna or UHC) 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, a health care company representative (not JPMorgan Chase) will contact you directly. **Please Note:** Cigna and UHC 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 as well as possibly earning Additional Wellness funds for your MRA that can be earned through participation. So take the call!

Don't wait to receive a call to participate; you can call your health care company directly. (Please see contact information on page 15.) Remember: If you call your health care company for a **Personal Action Call** (see page 9), you can earn up to $200 in

Additional Wellness MRA funds after you have completed **both** your biometric Wellness Screening and online Wellness Assessment (and earn an additional $100 in MRA funds if your spouse/domestic partner completes a Personal Action Call and has completed both a Wellness Screening and Assessment).

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

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

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

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 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 other sites from **My Health**.

Accessing My Health

You can use the site from work or through the internet:

- From work: **My Health** via me@jpmc
- From internet: **myhealth.jpmorganchase.com**

Spouse/DP 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.

Wellness Program Resources

Take advantage of these resources and services dedicated to supporting your overall health and well-being.

What You Need	Services Available to You	How You Can Take Action
Want to make a Personal Action Call to earn Wellness Rewards	Call your health care company to discuss the results of your biometric Wellness Screening and online Wellness Assessment with a Health Coach.	For Cigna, call 1-800-790-3086 and say "Personal Action Call". For UHC, call 1-800-272-8970 and say, "Personal Action Call".
Need Help with a Health Condition?	Speak with a Health Coach who can answer questions about your Wellness Screening and/or Assessment as well as help you with setting and achieving your health goals, assessing treatment options, navigating the Wellness Program, and reminding you about prescription refills and preventive tests.	For Cigna, call 1-800-790-3086 and say "Cigna Health Coaching Team". For UHC, call 1-800-272-8970 and say, "Speak with a Nurse."
Dealing with a Health Issue With Multiple Treatment Options (Treatment Decision Support)?	When dealing with one of many conditions, such as breast cancer and prostate cancer, that have different treatment options, reach out to a registered nurse for Treatment Decision Support, which provides detailed information to help you choose the most appropriate treatment option(s) along with names of high quality, cost-effective physicians near you and questions to ask your doctor.	For Cigna, call 1-800-790-3086 and "Cigna Health Coaching Team". For UHC, call 1-800-272-8970 and say, "Speak with a Nurse."
Need support dealing with managing stress or day to day challenges?	Use the Employee Assistance Program (EAP) and Work-Life services for free, confidential, short-term counseling and referrals to help you and your family handle stress, depression, relationship issues, addictions and eating disorders, and other emotional well-being concerns. You can receive up to five free EAP counseling sessions—even before you use your medical benefits.	*Provided by: MHN Services (MHN)* Call 1-877-576-2007. More information is available through **My Health.**
Thinking of Quitting Tobacco Use?	Get the support you need to quit tobacco use 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 2017 tobacco surcharge if you complete the Tobacco Cessation Program by December 2, 2016.	*Provided by: Alere.* Call 1-866-QUIT-4-LIFE (1-866-784-8454). You can also access the program through **My Health >** My Wellness.
Need immediate medical or health support while at work?	Throughout the year, JPMorgan Chase provides onsite support at most large locations including Health & Wellness Centers, Wellness Screenings and seasonal flu shots.	Onsite support, including Health & Wellness Center locations, is available on **My Health.**
Have Personal Questions About Coverage or Claims? Thinking About Seeing a Specialist?	Speak with your health care company directly for a better understanding of coverage, claims, and costs, as well as identifying a quality specialist or health coach.	For Cigna, call 1-800-790-3086. For UHC, call 1-800-272-8970. For Caremark (prescriptions), call 1-866-209-6093.
Need Help Navigating the Complexities of Health care and Insurance Claims?	Speak with a personal advisor who can help resolve health care issues ranging from finding doctors, specialists and eldercare to untangling medical bills, clarifying insurance coverage or navigating the Health Care Exchanges.	*Provided by Health Advocate, Inc.* Call 1-866-611-8298.
Looking for Answers to General Questions about Your Health and Insurance Plans?	Call accessHR Benefits Contact Center for information about enrollment, general questions about the Medical Plan (i.e., non-claim-related issues), and information about your other health care and insurance benefits coverage (e.g., dental, vision, long term disability, etc.).	Call 1-877-JPMChase (1-877-576-2427). Quick Path: Enter your Standard ID or Social Security number; press 1; enter your PIN; press 1.

Questions?

Additional information to help you make informed health care choices at any time can be found on **My Health**. You may also contact:

For questions about the Medical Plan, MRA, or HCSA…	
Cigna	**1-800-790-3086**; 24/7
UHC	**1-800-272-8970**; 8 a.m. to 8 p.m. all time zones, Monday through Friday
For questions about prescription drug coverage…	
CVS Caremark	**1-866-209-6093** or email customerservice@caremark.com; 24/7 (1-800-863-5488 for TDD assistance)
For enrollment and general benefits questions…	
accessHR Benefits Contact Center	**1-877-JPMChase (1-877-576-2427)** or 1-212-552-5100 if calling from outside the United States; 8 a.m. to 7 p.m. Eastern Time, Monday through Friday
For additional help with claims and Health Care Reform…	
Health Advocate	**1-866-611-8298**; 8 a.m. to 9 p.m. Eastern Time, Monday through Friday

The JPMorgan Chase U.S. Benefits Program is 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.
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