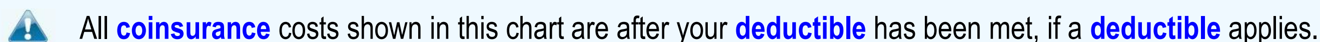
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to **myhealth.jpmorganchase.com** or call **1-877-JPMChase (1-877-576-2427)**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call **1-877-JPMChase (1-877-576-2427)** to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**In-Network Options:** **$750** Individual **$1,400** Individual + Adult **$1,400** Individual + Child(ren) **$1,800** Family	**Out-of-Network Options:** **$2,750** Individual **$4,125** Individual + Adult **$4,125** Individual + Child(ren) **$5,500** Family	Generally, for many in-network routine services, you will pay a copayment with no deductible. For less routine in-network services, you must pay all the costs from providers up to the deductible amount before this plan begins to pay for the covered services you use. For out-of-network services, you generally must meet an annual deductible before this plan begins to pay for the covered services you use. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. **Note:** You may use your earned (via wellness incentive activities) Medical Reimbursement Account (MRA) funds to reimburse eligible expenses towards meeting the overall deductible. You have the opportunity to earn up to $700 in funds for your MRA.
Are there services covered before you meet your deductible?	Yes, many in-network routine services such as preventive care, primary care office visits, mental health office visits, specialist office visits, basic labs and prescription medications.		This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Medical: **$2,000** Individual **$3,400** Individual + Adult **$3,400** Individual + Child(ren) **$5,100** Family	Out-of-Network Medical: **$8,750** Individual **$12,125** Individual + Adult **$12,125** Individual + Child(ren) **$17,500** Family	The out-of-pocket limit is the most you could pay in a year for covered services including annual deductible, coinsurance and copayments. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. **Note:** Your out-of-pocket costs may end up lower due to the MRA funds available to reimburse eligible expenses.

Important Questions	Answers	Why This Matters:
	In-Network Prescription Drugs: **$1,250** Individual; **$2,000** Individual + Adult **$2,000** Individual + Child(ren); **$2,600** Family	
What is not included in the out-of-pocket limit?	**Medical**: Premiums, balance-billed charges (charges over reasonable and customary related to out-of-network care), and health care services this plan doesn't cover. **Prescription drug**: Prescription drugs this plan doesn't cover.	Even though you may pay these expenses, they don't count toward the out-of-pocket limit. **Note:** You can use your MRA funds to reimburse eligible expenses, including deductibles, copayments, and coinsurance (for medical and prescription drug costs).
Will you pay less if you use a network provider?	Yes. See **www.aetna-jpmc.com** (or call **1-800-468-1266**) or **https://jpmc.cigna.com** (or call **1-800-790-3086**) for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	50% coinsurance	Deductible does not apply for in-network services. Virtual doctor visit: $15 copay in-network, not covered out-of-network. Convenience Care Clinic visit: $15 copay in-network and 50% coinsurance out-of-network.
	Specialist visit	$75 copay	50% coinsurance	Deductible does not apply for in-network services. Limits may apply.
	Preventive care/ screening/immunization	No Charge	50% coinsurance	Subject to age and frequency guidelines. Deductible does not apply for in-network services.
If you have a test	Basic Laboratory Services (blood work)	$20 copay	50% coinsurance	Deductible does not apply for in-network services. Limits may apply.
	Imaging (standard radiology, advanced imaging, e.g. CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Limits may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com/jpmc**.	Generic drugs	**Preventive Generic Drugs:** $0 **Retail:** $5 copay per prescription **Mail:** $10 copay per prescription	**Retail:** Covered at Usual & Customary charges **Mail:** Not Covered	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). Copay waived for preventive generic drugs and generic/single-source brand (without generic) contraceptive drugs. Drugs for family planning covered up to $10,000/lifetime.
	Preferred brand drugs	**Preventive Brand Drugs:** $0 **Retail:** $50 copay per prescription **Mail:** $100 copay per prescription	**Retail:** Covered at Usual & Customary charges **Mail:** Not Covered	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). Copay waived for preventive brand drugs and generic/single-source brand (without generic) contraceptive drugs. Drugs for family planning covered up to $10,000/lifetime. If a generic drug is available, you pay the difference between cost of brand & generic drug + generic copay (copay and OOP max. limits do not apply).
	Non-preferred brand drugs	**Preventive Brand Drugs:** $0 **Retail:** $150 copay per prescription **Mail:** $300 copay per prescription	**Retail:** Covered at Usual & Customary charges **Mail:** Not Covered	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). Copay waived for preventive brand drugs and generic/single-source brand (without generic) contraceptive drugs. Drugs for family planning covered up to $10,000/lifetime. If a generic drug is available, you pay the difference between cost of brand & generic drug + generic copay (copay and OOP max. limits do not apply).
	Specialty drugs	**Retail:** $200 copay per prescription **Mail:** $400 copay per prescription	Not Covered	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). If a generic drug is available, you pay the difference between cost of brand & generic drug + generic copay if brand drug is dispensed (copay and OOP max. limits do not apply)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	$500 copay	$500 copay	Deductible does not apply.
	Emergency medical transportation	$250 copay	$250 copay	Deductible does not apply
	Urgent care	$75 copay	20% coinsurance	Deductible does not apply for in-network services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Limited to the semi-private negotiated rate.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit 20% coinsurance/all other services	50% coinsurance	Deductible does not apply for in-network office visits. In-network behavioral health virtual doctor visit is $15 copay with a psychologist, psychiatrist, therapist or social worker. Deductible may apply for other services with a mental health diagnosis, based on mental health parity requirements. Contact your healthcare company for more information.
	Inpatient services	20% coinsurance	50% coinsurance	——————none——————
If you are pregnant	Office visits	$15 copay/primary care or $75 copay/specialist for office visit, otherwise 20% coinsurance	50% coinsurance	Deductible does not apply to initial in-network primary care office visit to confirm pregnancy.
	Childbirth/delivery professional services	$15 copay/primary care or $75 copay/specialist for office visit, otherwise 20% coinsurance	50% coinsurance	Newborns will have a separate deductible and out-of-pocket maximum applied.
	Childbirth/delivery facility services	$15 copay/primary care or $75 copay/specialist for office visit, otherwise 20% coinsurance	50% coinsurance	Newborns will have a separate deductible and out-of-pocket maximum applied. Family building benefits (infertility, fertility and elective preservation) have a $10,000 medical lifetime limit ($30,000 if a nurse consultation with

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				WINFertility is completed). Combined in- and out-of-network. See https://managed.winfertility.com/jpmc/ or call 1-833-439-1517.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limit 200 visits per year combined in- and out-of-network. Must be noncustodial. Unlimited visits for mental health diagnoses, but cost share may vary based on mental health parity requirements. Contact your healthcare company for more information.
	Rehabilitation services	$25 copay	50% coinsurance	Deductible does not apply for in-network services. Speech, occupational, and physical therapy each limited to 60 visits per year (outpatient), combined in- and out-of-network. Unlimited visits for mental health diagnoses, but cost share may vary based on mental health parity requirements. Contact your healthcare company for more information.
	Habilitation services	$25 copay	50% coinsurance	Deductible does not apply for in-network services. Speech, occupational, and physical therapy each limited to 60 visits per year (outpatient), combined in- and out-of-network. Unlimited visits for mental health diagnoses, but cost share may vary based on mental health parity requirements. Contact your healthcare company for more information.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limit 365 days per lifetime combined in- and out-of-network. Must be prescribed and performed in a noncustodial facility.
	Durable medical equipment	20% coinsurance	50% coinsurance	———————none———————
	Hospice services	20% coinsurance	50% coinsurance	———————none———————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	———————none———————
	Children's glasses	Not Covered	Not Covered	———————none———————
	Children's dental check-up	Not Covered	Not Covered	———————none———————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• COVID-19 antibody tests • Cosmetic surgery • Dental care (Adult and children) • Long-term care	• Inpatient private-duty nursing • Routine eye care (Adult and children) • Routine foot care	• Rx: Non-sedating antihistamines and certain specialty and non-specialty medications • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery (you must first contact your health care company to receive coverage) • Chiropractic care (up to 20 visits per calendar year)	• Employee Assistance Program & Work Life Program • Hearing aids ($3,000 limit every 36 months) • Wellness activities	• Family building benefits ($10,000 medical lifetime limit, $30,000 if a nurse consultation with WINFertility is completed). Combined in- and out-of-network. See https://managed.winfertility.com/jpmc/ or call 1-833-439-1517.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.hhs.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants#statelisting.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-JPMChase (1-877-576-2427).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-JPMChase (1-877-576-2427).

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-JPMChase (1-877-576-2427).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-JPMChase (1-877-576-2427).

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,010**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$1,150
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$1,100
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,860**

The plan would be responsible for the other costs of these EXAMPLE covered services.