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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	This plan covers eligible items and services without a deductible, but in some cases a copayment may apply.
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: **$1,000** Individual; **$2,000** Individual + Adult **$2,000** Individual + Child(ren); **$2,800** Family In-Network Prescription Drugs: **$1,250** Individual; **$2,000** Individual + Adult **$2,000** Individual + Child(ren); **$2,600** Family	The out-of-pocket limit is the most you could pay in a year for covered services, including 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:** You may use your earned (via wellness incentive activities) Medical Reimbursement Account (MRA) funds to reimburse eligible expenses towards meeting cost sharing expenses. In this plan, you have the opportunity to earn up to $200 in funds each year for your MRA.
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), penalty charges for not getting a PCP referral for specialist visits and surgery 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 copayments for medical and prescription drug costs.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **https://jpmc.centivo.com** (or call **1-833-543-4676**) for a list of in-network providers.	This plan uses a provider network and generally does not offer out-of-network coverage. If you use an out-of-network provider that has not been authorized by the plan, your services will not be covered and you will receive a bill from the provider. Exceptions include urgent care when traveling outside the Centivo service area and emergency room visits.
Do you need a referral to see a specialist?	Yes.	In this plan, you will need a referral from your Primary Care Provider before you see most specialists. If you do not have a referral, a $30 penalty charge will apply. This plan requires every member to choose a Primary Care Provider to be eligible for the lowest out-of-pocket costs.

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	$0 copay	Not covered	Must visit your designated PCP or $30 penalty. Virtual visit $0 copay.
	Specialist visit	$30 copay	Not covered	Must have referral or $30 penalty (in addition to copay). Includes virtual visits.
	Preventive care/ screening/immunization	$0 copay	Not covered	Subject to age and frequency guidelines.
If you have a test	Basic Laboratory Services (blood work)	$10 copay	Not covered	$10 copay applies only at freestanding lab sites. If blood draw occurs at a provider's office, this would be included in the office visit copay (no separate copay).
	Imaging (standard radiology, advanced imaging, e.g. CT/PET scans, MRIs)	$50 copay	Not covered	$150 copay for advanced imaging.
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 $15,000/lifetime.
	Preferred brand drugs	**Preventive Brand Drugs:** $0	**Retail:** Covered at Usual & Customary charges	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).

* For more information about limitations and exceptions, see the plan or policy document at **myhealth.jpmorganchase.com**.

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)	
		Retail: $50 copay per prescription **Mail:** $100 copay per prescription	**Mail:** Not Covered	Copay waived for preventive brand drugs and generic/single-source brand (without generic) contraceptive drugs. Drugs for family planning covered up to $15,000/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 $15,000/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 (copay and OOP max. limits do not apply).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay	Not covered	The facility fee and physician/surgeon fees are one copay (not separate).
	Physician/surgeon fees	$300 copay	Not covered	The facility fee and physician/surgeon fees are one copay (not separate). Primary surgeon services without a PCP referral will have an additional $300 penalty charge (in addition to the copay).
If you need immediate medical attention	Emergency room care	$300 copay	$300 copay	——————none——————
	Emergency medical transportation	$250 copay	Not covered	——————none——————
	Urgent care	$50 copay	$50 copay	Out-of-network covered only if outside Centivo

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)	
				service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day up to a maximum of $1,000	Not covered	The facility fee and physician/surgeon fees are one copay (not separate).
	Physician/surgeon fees	$500 copay per day up to a maximum of $1,000	Not covered	The facility fee and physician/surgeon fees are one copay (not separate). Primary surgeon services without a PCP referral will have an additional $500 penalty charge (in additional to the copay).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/office visit $30 copay/all other services	Not covered	——————none——————
	Inpatient services	$500 copay per day up to a maximum of $1,000	Not covered	——————none——————
If you are pregnant	Office visits	$0 copay/OBGYN care or $30 copay/specialist	Not covered	——————none——————
	Childbirth/delivery professional services	$500 copay per day up to a maximum of $1,000	Not covered	Facility services and professional services delivered in the facility are one copay (not separate). Newborns may also separately incur $500 copay per day and have a separate out-of-pocket maximum applied
	Childbirth/delivery facility services	$500 copay per day up to a maximum of $1,000	Not covered	Facility services and professional services delivered in the facility are one copay (not separate). Newborns may also separately incur $500 copay per day and have a separate out-of-pocket maximum applied. Family building benefits (infertility, fertility and elective preservation) have a $10,000 medical lifetime limit ($35,000 if a nurse consultation with WINFertility is completed). To get started call WINFertility at 1-833-439-1517. Monday – Friday 9:00 am. – 9:00 p.m. EST.
If you need help recovering or have other special health needs	Home health care	$30 copay	Not covered	Limit 200 visits per year.
	Rehabilitation services	$20 copay	Not covered	Speech, occupational, and physical therapy each limited to 60 visits per year (outpatient). Unlimited visits for mental health diagnoses.
	Habilitation services	$20 copay	Not covered	Speech, occupational, and physical therapy each limited to 60 visits per year (outpatient). Unlimited

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)	
				visits for mental health diagnoses.
	Skilled nursing care	$500 copay per day up to a maximum of $1,000	Not covered	Limit 365 days per lifetime. Must be prescribed and performed in a noncustodial facility.
	Durable medical equipment	$100 copay	Not covered	If the cost is less than the copay, you pay the lower cost.
	Hospice services	No charge	Not covered	——————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 (up to 20 visits per calendar year) • 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, $35,000 if a nurse consultation with WINFertility is completed). To get started, call WINFertility at 833-439-1517. Monday – Friday 9:00 a.m. – 9:00 p.m. EST.

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** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500 per day**
- **Other copayment** **Varies**

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	$0
Copayments	$2,250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,310**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500 per day**
- **Other copayment** **Varies**

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	$0
Copayments	$2,250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,305**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$500 per day**
- **Other copayment** **Varies**

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	$0
Copayments	$2,020
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,020**

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