The U.S. Fertility Benefits Program

Effective 1/1/21

JPMorgan Chase is committed to assisting employees in meeting their diverse family planning needs. Through the Family Building Assistance Policy, financial support is provided to eligible employees to help offset the high cost of adoption, surrogacy, and certain fertility treatments. The U.S. Fertility Benefits Program provides assistance with fertility treatments for individuals who do not have a medical diagnosis of infertility.

This summary will provide you with a better understanding of how the Fertility Benefits Program works, including how and when benefits are paid.

Questions?

For questions or concerns regarding the U.S. Fertility Benefits Program, please contact the Program's service provider:

WINFertility
(833) 439-1517

Representatives are available Monday through Friday, from 9 a.m. to 7:30 p.m. Eastern Time.

About This Summary Plan Description

This section is the summary plan description (SPD) and the plan document for the JPMorgan Chase U.S. Fertility Benefits Program, which is a benefit offered under the JPMorgan Chase U.S. Medical Plan. This summary plan description provides you with important information required by the Employee Retirement Income Security Act of 1974 (ERISA) about the Program.

While ERISA does not require JPMorgan Chase to provide you with benefits, it does mandate that JPMorgan Chase clearly communicate to you how the Program operates and what rights you have under the law regarding Program benefits. The U.S. Department of Labor requires JPMorgan Chase to routinely provide benefits plan summaries to Program participants. Please retain this section for your records.

Be sure to read the “Program Administration” section on page 354 for more important details about the Program and this summary plan description.

Please Note: No person or group (other than the plan administrator for the JPMorgan Chase U.S. Benefits Program) has any authority to interpret the plans (or official plan documents) or to make any promises to you about them. The plan administrator for the JPMorgan Chase U.S. Benefits Program has complete authority in his or her absolute discretion to construe and interpret the terms of the plans and any underlying insurance policies and/or contracts, including the eligibility to participate in the plans, and to make factual determinations.

All decisions of the plan administrator for the JPMorgan Chase U.S. Benefits Program are final and binding upon all affected parties. The plan administrators delegate their discretion to interpret the plans to the claims administrators, and to decide claims and appeals, including making factual determinations, to:

- The claims administrators; and
- The Health Care and Insurance Plans Appeals Committee.

No Assignment of Benefits

The plans are used exclusively to provide benefits to you and, in some cases, your survivors. Neither you nor JPMorgan Chase can assign, transfer, or attach your benefits, or use them as collateral for a loan. You may not assign your right to file actions under ERISA regarding the plans, or use power of attorney or similar arrangements for that purpose.

Please Note: You may assign to a health care service provider the right to payment. Please contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) for more information.

The JPMorgan Chase U.S. Benefits Program is available to most employees on 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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Fertility Benefits Highlights

parents@jpmc	**parents@jpmc** is your central online resource for information about expanding your family, parental leave and support for working parents. From **parents@jpmc** you can learn more about the fertility benefit available.
Eligibility	U.S. benefits-eligible employees who have completed the Introductory Period and their covered spouses/domestic partners are eligible for fertility benefits only if they meet the following requirements: ▪ The person receiving the fertility services is enrolled in the JPMorgan Chase U.S. Medical Plan ▪ The person receiving the fertility services and their partner (if applicable and clinically linked to the fertility treatment) have not received a medical diagnosis of infertility ▪ The person receiving the fertility services has enrolled with WINFertility, the administrator of fertility benefits ▪ The expenses are incurred while the person receiving the fertility services was enrolled in the Medical Plan Note: If a medical diagnosis of infertility is determined, the person receiving the fertility services may qualify for infertility benefits under the JPMorgan Chase U.S. Medical Plan in lieu of this fertility benefit. If, during the course or treatment, it is determined that there is a medical diagnosis of infertility, WINFertility will transfer you to your JPMorgan Chase U.S. Medical Plan health care company to utilize the infertility benefit.
You Must Enroll	To be eligible for benefits from the Program, you must enroll by calling WINFertility and complete a consultation with a WINFertility Nurse Care Manager. If you do not call and complete a consultation, you will not be eligible for benefits and you will not be eligible for reimbursement for fertility services incurred prior to enrollment.
Covered Services	Examples of fertility services that are covered include, but are not limited to, the following if performed on the individual enrolled in the U.S. Medical Plan: ▪ Intrauterine insemination (IUI); ▪ In vitro fertilization (IVF); ▪ Medications associated with an approved IUI or IVF cycle. For more details on the covered services and the exclusions, see “What the Plan Provides” on page 206 and “What’s Not Covered” on page 347.
WINFertility Network	WINFertility has a network of providers that feature credentialed reproductive endocrinologists and associated clinical staff, and has negotiated competitive pricing across this network. If you use an in-network WINFertility provider, you will have the associated costs automatically processed by WINFertility as the services are received, up to the lifetime maximum. This means you won’t have to pay out-of-pocket at the time of service and will not have to submit claims for reimbursement. Ancillary services prescribed by the WINFertility provider to outside labs, facilities, or providers may not be payable directly by WINFertility, but would be eligible for reimbursement. If you use an out-of-network provider, you will pay for those services out-of-pocket and then submit a request for reimbursement to WINFertility. Claims must be submitted within six months of when the expenses are incurred.
Lifetime Maximum Benefit	The Program provides benefits for covered services, up to a per-person lifetime maximum of $30,000 in benefits for medical and prescription drug costs.

Participating in the Program

Who's Eligible?

U.S. benefits-eligible employees who have completed the Introductory Period and their covered spouses/domestic partners are eligible for fertility benefits only if they meet the following requirements:

- The person receiving the fertility services is enrolled in the JPMorgan Chase U.S. Medical Plan,
- The person receiving the fertility services and their partner (if applicable and clinically linked to the fertility treatment) have not received a medical diagnosis of infertility,
- The person receiving the fertility services has enrolled with WINFertility, the administrator of fertility benefits, and
- The expenses are incurred while the person receiving the fertility services was enrolled in the Medical Plan.

Who's Not Eligible

You are not eligible for Fertility Program benefits if you do not meet the criteria under "Who's Eligible" or if there is a medical diagnosis of infertility. If there is a medical diagnosis of infertility, you may quality for infertility benefits under the JPMorgan Chase U.S. Medical Plan in lieu of this fertility benefit.

Your family members other than your spouse/domestic partner, such as your children, are not eligible for benefits under the Fertility Benefits Program, even if they are covered by the JPMorgan Chase U.S. Medical Plan.

The services incurred by egg and sperm donors that may be involved in the fertility treatment are not covered under this benefit.

Enrolling

To be eligible for benefits from the Fertility Benefits Program, you must enroll in the program by calling WINFertility and completing a consultation with a WINFertility Nurse Care Manager.

If you do not call and complete a consultation, you will not be eligible for benefits and you will not be reimbursed for fertility services incurred prior to enrollment.

When Coverage Begins

The Fertility Program's coverage begins immediately after you complete your consultation with a WINFertility Nurse Care Manager.

There is no retroactive coverage. For example, if you receive fertility services and then call WINFertility and have a consultation with a Nurse Care Manager *after* receiving those services, Fertility Benefits Program benefits will not be payable for any services received before your consultation.

Cost of Coverage

There is no additional payroll contribution cost for the Fertility Benefits Program benefits; your payroll contributions for the U.S. Medical Plan also covers the Fertility Benefits Program benefits. The Fertility Benefits Program benefits are in addition to the benefits you receive as a member of the U.S. Medical Plan.

When Coverage Ends

Your eligibility for the Fertility Benefits Program ends when your coverage under the JPMorgan Chase U.S. Medical Plan ends, unless you elect Medical Plan coverage under COBRA. For details, see "Continuing Health Coverage Under COBRA" on page 349.

Our Partner, WINFertility

JPMorgan Chase has partnered with WINFertility as the claims administrator for the Program. WINFertility is a fertility benefit management company that offers integrated fertility management services to participants in the JPMorgan Chase U.S. Medical Plan (e.g., clinical oversight, advocacy, and nurse care managers that provide support throughout the fertility journey).

Fertility-related medical and drug expenses incurred under the Fertility Benefits Program will be managed and processed by WINFertility, and not the carriers responsible for the U.S. Medical Plan (i.e., Aetna, Cigna or CVS Caremark).

WINFertility's Network

WINFertility has a network of providers that feature credentialed reproductive endocrinologists and associated clinical staff, and has negotiated competitive pricing across this network.

If You Have Other Coverage

If your fertility care expenses are covered by another source (such as an insurance company) or under a plan maintained by your spouse/domestic partner's employer or any government provided assistance, then those expenses will not be eligible for reimbursement under the JPMorgan Chase U.S. Fertility Benefits Program.

What's Covered

The following services are covered up to a $30,000 total lifetime benefit maximum*:

- Artificial insemination / intrauterine insemination under medical supervision
- Advanced reproductive technologies:
  - In-Vitro Fertilization
  - Reciprocal IVF is covered if the patient receiving treatment is an eligible member and is enrolled in the program with WINFertility
  - Frozen Embryo Transfer
  - Cryopreservation for the following:
    - Blastocysts(s) and embryo(s) from covered IVF cycles. Covered blastocyst and embryo storage is limited to one year.
      - All frozen embryos stored after a completed cycle with ovarian stimulation must be utilized prior to coverage availability for another ovarian stimulation cycle. Embryo transfer guidelines per the American Society of Reproductive Medicine should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate
- Medically necessary diagnostic workup and radiology services

Confirm Coverage

The services listed here are not a complete list. To confirm that your treatment is covered under the plan, call WINFertility at (833) 439-1517, weekdays from 9 a.m. through 7:30 p.m. Eastern Time.

- Pathology and laboratory services, including:
  - Hormonal assays
  - Swimup semen analysis, as appropriate
  - Ultrasound exams
  - Ova identification
  - Fertilization and embryo culture
  - Embryo, gamete-zygote transfer
  - Preimplantation Genetic Diagnosis* and Preimplantation Genetic Screening
- Medications necessary for the procedures above, including parenteral injection and oral ovulation induction drugs.

* Preimplantation Genetic Diagnosis may be covered under your Medical Plan.

The Lifetime Maximum

Under the Program, the firm may pay for or reimburse qualified, non-duplicative expenses up to a lifetime maximum of $30,000 per eligible person receiving fertility services (i.e., the employee in the U.S. Medical Plan or their enrolled spouse/domestic partner) for fertility treatment.

Note that in cases where both individuals are employees of JPMorgan Chase and both are enrolled in the U.S. Medical Plan, the $30,000 lifetime maximum is for each employee.

The $30,000 lifetime maximum applies to all fertility-related expenses processed through the Fertility Benefits Program, including both in-network and out-of-network services. Expenses related to a person receiving healthcare services once pregnant, including the delivery, would be covered under the JPMorgan Chase U.S. Medical Plan.

If, during the course or treatment, it is determined that there is a medical diagnosis of infertility, WINFertility will assist you with transitioning to your JPMorgan Chase U.S. Medical Plan health care company to utilize the infertility benefit. The infertility benefit as a separate lifetime maximum and the expenses for treatment under the fertility benefit will not count towards the infertility maximum.

What's Not Covered

The following services are not covered:

- Donor expenses for donated oocytes or sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications)
- Surrogacy expenses
- Services requested which are not medically appropriate, as determined by WINFertility in its sole discretion
- Elective egg freezing
- Cryopreservation of sperm or oocytes prior to gender reassignment
- Embryo adoption
- Services not specifically listed as covered in this benefit
- At-home inseminations
- Fertility services for an eligible member who has a diagnosis of medical infertility

Claiming Benefits

The following explains when and how to file claims for fertility services. For more information on your rights with respect to claims, please see "Program Administration" on page 354.

How to File Claims

Rules regarding claims depend on whether you use a WINFertility in-network provider or an out-of-network provider, as shown below:

Provider	Claims Process
WINFertility In-Network Provider	If you use a WINFertility in-network provider, you will have the associated costs automatically processed by WINFertility as the services are received, up to the lifetime maximum. This means you won't have out-of-pocket costs for services provided by the WINFertility provider and will not have to submit claims for reimbursement. Ancillary services prescribed by the WINFertility provider to outside labs, facilities, or providers may not be payable directly by WINFertility, but would be eligible for reimbursement.
Out-of-Network Provider	If you use an out-of-network provider, you will pay for those services out-of-pocket and then submit a request for reimbursement of eligible services to WINFertility, up to the lifetime maximum. Claims must be submitted within six months of when the eligible expenses are incurred. Please see "Where to Submit Claims" on page 211 for your claim administrator's phone and address information.

Your request for reimbursement must include the following:

- A complete WINFertility Out-of-Network Reimbursement Form which can be found on parents@jpmc;
- An itemized statement or claim form indicating the description of services, dates incurred, amounts, and name of the patient/person receiving the fertility services;
- Proof of payment.

Separate claim forms must be submitted for each family member for whom a claim is made.

Where to Submit Claims

WINFertility is the Fertility Benefits Program's claims administrator.

Documentation can be emailed to:

reimbursementclaims@winfertility.com

or mailed to:

WINFertility
Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831
Attn: Claims Department
(833) 439-1517

Representatives can be reached from 9 a.m. to 7:30 p.m., Eastern Time, Monday through Friday.

Appealing a Claim

If a claim for reimbursement under the Fertility Benefits Program is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in “Program Administration” on page 354.

Help Pursuing Claims
You may authorize someone else to pursue claim information on your behalf. If you do so, you must notify the claims administrator in writing of your choice of an authorized representative. Your claims administrator will provide you with a HIPAA (Health Insurance Portability and Accountability Act of 1996) consent form that you must use to specify the extent to which your personal representative is authorized to act on your behalf. This form must be on file with your claims administrator prior to any action by your personal representative. If you would like to designate an authorized representative for claims related to eligibility to participate in a plan, please contact the HR Answers Benefits Contact Center.

What Happens If…

For many of the JPMorgan Chase Health Care and Insurance Plans for Active Employees benefits, certain life changes and events can give you special opportunities to change your decisions to participate or to decline coverage under certain benefits.

Because participation in the U.S. Fertility Benefits Program requires that you be enrolled for coverage in the JPMorgan Chase U.S. Medical Plan, please see the *What Happens If…*section of *Your JPMC Benefits Guide*, available at www.jpmcbenefitsguide.com and in print on request to the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576 2427), for details on when you can adjust your participation in the JPMorgan Chase U.S. Medical Plan. For more information, see the Benefits Status Change Guide on **My Health** > Learn About the JPMC Benefits Program.

Continuing Health Coverage Under COBRA

Health care and wellness program benefits for you, and your covered dependents, end as of the last day of the month in which you leave the firm. If you are currently enrolled in the Medical Plan (including the Fertility Benefits Program and Medical Reimbursement Account [MRA]), Dental Plan, Vision Plan, or Health Care Spending Account, you may elect to continue this coverage for you and your eligible covered dependents for up to 18 months by enrolling in the Consolidated Omnibus Budget Reconciliation Act (COBRA). Also under COBRA, you may elect to continue participating in certain wellness-related programs offered through a single “bundled” election.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents have the right to continue health care coverage at your own expense for a certain period of time if your JPMorgan Chase-provided health care coverage ends because of certain circumstances—called “qualifying events.”

Your covered dependents include your spouse and your eligible dependent children who are covered at the time of a qualifying event (your “qualified beneficiaries,” as defined below). For domestic partners, JPMorgan Chase may provide COBRA-like health coverage if the domestic partner was covered under the JPMorgan Chase Medical Plan, Dental Plan, Vision Plan, and/or Employee Assistance Program at the time coverage ended.

COBRA coverage applies to the Medical Plan as well as certain other health care plans.

If you elect COBRA Medical Plan coverage, the U.S. Fertility Benefits Program is included in that election. This section regarding COBRA may make references to dependent children. As a reminder, dependent children are not eligible for benefits under the Fertility Benefits Program.

More details about coverage under COBRA are available through the HR Answers Benefits Contact Center.

Qualified Beneficiary

Individuals eligible for COBRA continuation coverage are called “qualified beneficiaries.” A qualified beneficiary includes the covered spouse and eligible dependent children of a covered employee, and, in certain cases, the covered employee.

Under current law, to be considered a qualified beneficiary, an individual must generally be covered under a group health plan on the day before a qualifying event occurs that causes a loss in coverage (such as termination of employment or a divorce from or death of the covered employee). In addition, a newborn child or a child who is placed for adoption with the covered employee during the period of COBRA continuation coverage is also considered a qualified beneficiary.

Qualifying Events

You, your spouse, and your dependent children may elect COBRA coverage for varying lengths of time, depending on the circumstances under which your JPMorgan Chase health care coverage ends:

- **If Your Employment Terminates or Your Work Hours Are Reduced.** If you lose coverage because your employment terminates (for any reason other than gross misconduct) or your work hours are reduced, you and/or your covered dependents may purchase COBRA coverage for up to 18 months. Certain events may extend this 18-month COBRA continuation period:
  - If your covered dependents experience any second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
  - If you become eligible for Medicare while employed (even if this is not a qualifying event for your covered dependents because they do not lose coverage) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your covered dependents may elect COBRA continuation for up to 36 months from the date that you become eligible for Medicare.
- **If Your Covered Dependents Lose Coverage.** If your spouse and/or your dependent children lose coverage because of any of the circumstances listed below, they may purchase COBRA coverage for up to 36 months from the date that coverage ends because:
  - You pass away;
  - You divorce your spouse or become legally separated;
  - You become eligible for Medicare; or
  - Your dependent child loses dependent eligibility status under the terms of the plan (for example, the end of the month in which your dependent child reaches age 26).
- **If You or Your Covered Dependents Become Disabled.** If you or one of your covered dependents becomes disabled under the Social Security Administration guidelines within 60 days of a qualifying event, or you are disabled at the time COBRA coverage is initially offered, you and your covered dependents may continue COBRA coverage for an additional 11 months beyond the initial 18 months, to a total of 29 months. You must notify HR Answers, the COBRA Administrator, within 60 days after Social Security issues a determination of disability status and before the initial 18-month COBRA coverage period ends. You also must notify the COBRA Administrator within 30 days after Social Security determines the end of disability status for you or your covered dependent.

If a second qualifying event occurs at any time during this 29-month disability coverage period, your covered dependents (but not you) may continue COBRA coverage for an additional seven months, to a total of 36 months.

Continuation Coverage for a Domestic Partner Dependent

A domestic partner or the children of a domestic partner who are not your tax dependents are not eligible for COBRA continuation coverage under federal law. However, JPMorgan Chase provides COBRA-like coverage if your domestic partner (and his or her eligible children) was covered under the JPMorgan Chase Medical Plan, Dental Plan and Vision Plan, at the time coverage ended. Call HR Answers for more information.

The rate for domestic partner continuation coverage will be the same as the COBRA rate. Contributions will be made on an after-tax basis and will represent the full value of the coverage plus 2%. If you pass away while continuing your own coverage under COBRA, coverage may be continued by your covered domestic partner for a total of 36 months.

If a second qualifying event occurs anytime within the original 18-month period, COBRA continuation coverage may be extended for an additional 18 months, for a total period of 36 months.

Giving Notice of a COBRA Qualifying Event

If your employment terminates, your work hours are reduced, or you pass away, and this results in a loss of benefits under the Medical, Dental, or Vision Plans, the COBRA Administrator automatically will notify you or your covered eligible dependents about your right to elect continued coverage under COBRA. You will receive the necessary election forms to your home address of record within 14 days from the date that the COBRA Administrator is notified of your eligibility for COBRA coverage.

However, if you divorce or your eligible dependent child loses dependent status under the terms of the plan, you or one of your covered dependents must contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) within 60 days of any such event. If notice is not received within that 60-day period, your dependents will not be entitled to elect COBRA continuation coverage. Notice must be provided to the COBRA Administrator and must include the following information: the name of the employee or qualified beneficiaries requesting coverage, the qualifying event and the date of the qualifying event. In addition, you may be asked to provide supporting documentation such as a divorce decree. Otherwise, your covered dependents will not be eligible to elect continued coverage under COBRA.

If a qualified beneficiary experiences a second qualifying event that would entitle him or her to additional months of continuation coverage, he or she must notify the COBRA Administrator. This notice must include the:

- Name of the employee;
- Name of the qualified beneficiary receiving COBRA coverage; and
- Type and date of the second qualifying event.

This notice must be provided within 60 days from the date of the second qualifying event (or, if later, the date coverage would normally be lost because of the second qualifying event). In addition, the qualified beneficiary may be asked to provide a copy of a death certificate or divorce decree.

When the plan is notified that one of these events has happened, the qualified beneficiary will automatically be entitled to the extended period of COBRA continuation coverage. If a qualified beneficiary fails to provide the appropriate notice and requested supporting documentation during this 60-day notice period, the qualified beneficiary will not be entitled to extended continuation coverage.

Updating Your Personal Contact Information

To ensure that you receive information to enroll in COBRA, please contact the HR Answers Benefits Contact Center to update your personal contact information as well as your dependent's contact information.

If you are a former employee and you have a newborn or adopt a child while you are on COBRA continuation coverage and you enroll the new child for coverage, the new child will be considered a qualified beneficiary rather than an after-acquired dependent. This gives the child additional rights, such as the right to continue COBRA benefits even if you pass away during the COBRA period, and the right to an additional 18 months of coverage if a second qualifying event occurs during the initial 18-month COBRA period after your termination or retirement.

Choosing COBRA Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the:

- Date you and/or your covered eligible dependents would lose coverage because of the qualifying event; or
- Date you are notified of your and/or your covered eligible dependents' right to continue coverage because of the qualifying event (that is, the date of your COBRA Enrollment Notice).

If you make no election during the 60-day period, you waive your right to continue coverage. Each qualifying beneficiary has an independent right to elect COBRA coverage. Covered employees may elect coverage on behalf of their spouses, and parents may elect coverage on behalf of their children.

You will receive COBRA materials approximately two weeks after the date they are notified of the qualifying event. These materials will describe the enrollment instructions and time frames for making your elections. You will have a period of 60 days from the date of your qualifying event to elect COBRA coverage. **Important Note:** You must make an election at the time COBRA coverage is offered—it is not automatically provided.

Premium Due Dates

If you elect to continue coverage under COBRA, you must pay the first two premiums (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums are due on the first calendar day of the month for that month's coverage, and must be paid within 30 days of each due date. If you elect to continue your coverage under COBRA but do not make timely payments (even if you do not receive a bill), your coverage will be terminated retroactively to the time frame applicable to your last payment and will not be reinstated. As it relates to the U.S. Fertility Benefits Program, the cost of this coverage is included in your U.S. Medical Plan premiums; there is not a separate premium for this program.

Coverage During the Continuation Period

With respect to Medical Plan and Dental Plan coverage, you and your covered dependents may choose to continue the coverage option that you had as an active employee or you may elect a different option at the time you initially enroll for COBRA coverage. (Because the Vision Plan has only one option, there is no opportunity to change that coverage if you continue it under COBRA.) If coverage is changed for active employees, the same changes will be provided to individuals with COBRA coverage. In addition, you and your covered dependents may change coverage during Annual Benefits Enrollment, if a qualified change in status occurs, or at other times, to the same extent that active employees may do so.

Please Note: Although JPMorgan Chase allows you to elect a different option at the time of your initial COBRA election, not all plans allow a change. Generally, all self-insured options allow a change at this time. It is the responsibility of the employee to contact the health care administrator of his or her Medical and Dental Plan option to verify if coverage is available.

COBRA Coverage Costs

If you choose to continue coverage under COBRA, you will generally pay the full cost for yourself and/or your qualified beneficiaries, plus a 2% administrative fee. If COBRA coverage is extended because of a disability, the rates for coverage during the additional 11 months are 150% of the full cost.

If a second qualifying event occurs during the initial 18-month period of COBRA coverage, the 102% rate applies to you and your qualified beneficiaries for the full 36 months of COBRA coverage, even if you or one of your covered dependents becomes disabled. However, if a second qualifying event occurs during an extended disability coverage period, then the rates of coverage will continue at the higher disability coverage rates explained above.

Company-Subsidized COBRA Coverage

If you are eligible for benefits under the U.S. Severance Pay Plan, you will receive a COBRA subsidy and will pay the active employee rate for medical coverage under COBRA for the lesser of 1) six months; or 2) the number of months of severance benefits you receive. For calculation purposes, four weeks of severance pay equal one month, and fractional months are rounded up to the next higher whole number of months (for example, 11 weeks would be rounded up to three months). This subsidy will apply to medical and dental coverage only (the Vision Plan, Health Care Spending Account Plan, and the Wellness Program are not subsidized by JPMorgan Chase, including under COBRA for individuals receiving severance benefits). Your eligibility for company-subsidized COBRA coverage is conditioned upon JPMorgan Chase's receipt of the executed Release. Regardless of whether you were ever informed that you are eligible for benefits under the U.S. Severance Pay Plan, JPMorgan Chase's discretionary determination that you engaged in misconduct or violated the company's Code of Conduct before or during the COBRA subsidy period or that you could have been terminated for cause will render you ineligible for a COBRA subsidy. Unsubsidized COBRA coverage (102% of the total cost of coverage) will be available after the end of the subsidized portion of the COBRA period for the remainder of the 18-month COBRA continuation period.

Company-subsidized COBRA coverage is also available for your eligible, covered survivors, if you pass away as an active employee. Continuing coverage is available at the active employee costs for up to 36 months.

How Continued Coverage Could End

Under COBRA rules, coverage will end for you and/or your covered dependents when the first of the following occurs:

- Your COBRA coverage period ends;
- You do not make the required premium payments for coverage on a timely basis;
- You obtain coverage under another group plan that does not exclude or limit coverage for pre-existing conditions. However, if the new plan does have pre-existing conditions or limits, you can continue your COBRA coverage for that specific condition up to the end of your original maximum COBRA period (18 or 36 months, depending on your situation);
- You become eligible for Medicare. However, if you become eligible for Medicare, your covered dependents may be eligible to continue coverage through COBRA for up to 36 months from the date of the original qualifying event;
- In the case of an extended disability coverage period, you or your covered dependent is no longer considered disabled under Social Security guidelines;
- For newborns and children adopted by or placed for adoption with you during your COBRA continuation period, the date your COBRA coverage period ends, unless a second qualifying event occurs; or
- JPMorgan Chase terminates the plan.

Additional Questions About COBRA Coverage

If you have additional questions about your COBRA coverage, please call the HR Answers Benefits Contact Center at (877) JPMChase ((877) 576-2427), or (212) 552-5100, if calling from outside the United States. Service Representatives are available Monday through Friday, from 8 a.m. to 7 p.m., Eastern Time, except certain U.S. holidays.

Program Administration

This section provides you with important information as required by the Employee Retirement Income Security Act of 1974 (ERISA) about the U.S. Fertility Benefits Program. While ERISA doesn't require JPMorgan Chase to provide you with benefits, by choosing to do so, ERISA mandates that JPMorgan Chase clearly communicate to you how the plans subject to the provisions of ERISA operate and what rights you have under the law regarding plan benefits.

About This Section

This section summarizes administrative and rights information for the U.S. Fertility Benefits Program. Please retain this section for your records.

For most plans, the summary plan description and the plan document are the same document. For plans where this is not the case, copies of the plan documents are filed with the plan administrator and are available upon request.

Questions?

For questions or concerns regarding the U.S. Fertility Benefits Program, please contact the Program's service provider, WINFertility, at (833) 439-1517. Representatives are available Monday through Friday, from 9 a.m. to 7:30 p.m. Eastern Time.

For questions about eligibility and plan operations, contact the HR Answers Benefits Contact Center, at 877-JPMChase ((877) 576-2427) (or (212) 552-5100, if calling from outside the United States). Service Representatives are available Monday through Friday, from 8 a.m. to 7 p.m. Eastern time, except certain U.S. holidays.

General Information

The following summarizes important administrative information about the U.S. Fertility Benefits Program.

Keep Your Information Current

Update your contact information (home address and phone numbers) on My Personal Profile. To access My Personal Profile while actively employed, go to https://mpp.jpmchase.net

Program Sponsor

JPMorgan Chase Bank, NA
545 Washington Boulevard
12th Floor
Mail Code: NY1-G120
Jersey City, NJ 07310

(Certain participating companies have adopted the U.S. Fertility Benefits Program for their eligible employees. See "Participating Companies" on page 289 for a list of participating companies.)

Program Year

January 1 – December 31

Plan Administrator

JPMorgan Chase U.S. Benefits Executive
c/o JPMorgan Chase Benefits Administration
545 Washington Boulevard
12th Floor
Mail Code: NY1-G120
Jersey City, NJ 07310

Claims Administrator

WINFertility, at (833) 439-1517.

COBRA Administrator

COBRA questions should be directed to JPMorgan Chase HR Answers Benefits Contact Center.

COBRA payments should be directed to:

COBRA Payments JPMorgan Chase
P.O. Box 27524
New York, NY 10087-7524

(877) 576-2427

Benefits Fiduciaries

Please see "About Plan Fiduciaries" on page 357 for information on benefits fiduciaries.

Agent for Service of Legal Process

Legal Papers Served:

JPMorgan Chase & Co.
4 Chase Metrotech Center
FL 18, NY1-C312
Brooklyn, NY 11245

Service of legal process may also be made upon a plan trustee or the Plan Administrator.

Employer Identification Number

13-4994650

Plan Administrative Information

Plan Name/ Number	Insurer	Payment of Benefits	Type of Administration
JPMorgan Chase Medical Plan (U.S. Fertility Benefits Program)/502	Not Applicable (no insurer)	WINFertility, Inc. Greenwich American Center One American Lane Terrace Level Greenwich, CT 06831 (833) 439-1517	Self-Insured/Trustee

Participating Companies

In some cases, affiliates or subsidiaries of JPMorgan Chase have decided to participate in the U.S. Fertility Benefits Program. These affiliates or subsidiaries are referred to here as “participating companies.” The list may change from time to time, and any company may end its participation in a plan at any time.

- Bear Stearns Asset Management, Inc.
- Connexions Loyalty Acquisition, LLC
- eCast Settlement Corp
- FNBC Leasing Corporation
- Highbridge Capital Mgmt, LLC
- InstaMed Communications, LLC
- J.P. Morgan Alternative Asset Management, Inc.
- J.P. Morgan Chase Custody Services, Inc.
- J.P. Morgan Electronic Financial Services, Inc.
- J.P. Morgan Institutional Investments, Inc.
- J.P. Morgan Investment Holdings LLC
- J.P. Morgan Investment Management Inc.
- J.P. Morgan Securities, LLC
- J.P. Morgan Trust Company of Delaware
- JPMorgan Chase Bank, National Association
- JPMorgan Chase Holding LLC
- JPMorgan Distribution Services, Inc.
- Neovest, Inc.
- Paymentech, LLC
- Security Capital Research & Management, Incorporated
- WePay Inc.
- 55i, LLC

Your Rights Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) gives you certain rights and protections while you are a participant in the U.S. Fertility Benefits Program. It is unlikely you will need to exercise these rights, but it is important that you be aware of what they are.

ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the office of the Plan Administrator, all plan documents including insurance contracts and copies of all documents filed by the plans with the U.S. Department of Labor, such as detailed annual reports (Form 5500 Series).
- Obtain, upon written request to the Plan Administrator, copies of all plan documents and other plan information (for example, insurance contracts, Form 5500 Series, and updated summary plan descriptions). The plan administrator may require reasonable charges for the copies.
- Receive a summary of the plans’ annual financial reports. (The plan administrator is required by law to furnish each participant with a copy of such reports.)
- Continue health care coverage for yourself, your spouse, or your eligible dependents if there is a loss of coverage under the plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision free of charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of the plans' documents or the latest annual report from the plan administrator and do not receive it within 30 days, you may file suit in a U.S. federal court. In such a case, the court may require the plan administrator to provide the information and pay up to $110 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a U.S. state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If it should happen that the plans' fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a U.S. federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

Keep Your Contact Information Current

Active participants are required to update their personal contact information, including mailing address, to receive benefits-related information and correspondence. You can make changes online via My Personal Profile at mpp.jpmorganchase.com. You can also call the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427).

About Plan Fiduciaries

The plan "fiduciary" is the individual or organization responsible for plan administration, claims administration, and managing plan assets. The plan fiduciary has a duty to administer the plan prudently and in the best interest of all plan members and beneficiaries.

Prudent Actions by Plan Fiduciaries

In addition to establishing the rights of plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefits plans. Certain individuals who are responsible for the plans are called "fiduciaries," and they have a duty to administer the plans prudently and in the interest of you, other plan members, and beneficiaries. While participation in these plans does not guarantee your right to continued employment, no one — including your employer or any other person — may terminate you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

Health Care and Insurance Plans for Active Employees

For the U.S. Fertility Benefits Program, the Plan Administrators delegate fiduciary responsibility for claims and appeals to the claims administrators, and to the Health Care and Insurance Plans Appeals Committee, where that committee is authorized to decide appeals as described in this summary.

Assistance with Your Questions

If you have any questions about the U.S. Fertility Benefits Program, you should contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427). If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Regional Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by visiting www.dol.gov/ebsa via the Internet.

You should also contact the Department of Labor if you need further assistance or information about your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with respect to health benefits that are offered through a group health plan, as well as the remedies available if a claim is denied in whole or in part.

Privacy Information

The privacy of your health information is important to you and to JPMorgan Chase. We are committed to protecting your personal health information, and complying with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). This means that when you complete a Wellness Screening or a Wellness Assessment, participate in any health coaching activities, or receive health care treatment of any kind, your personal health information is not disclosed to anyone, including JPMorgan Chase, without your authorization and except as permitted by HIPAA. (For detailed information about your HIPAA Privacy Rights, please see the Privacy Notice found on **My Health**.)

If you are enrolled in the U.S. Fertility Benefits Program, WINFertility may have access to your individual health care and prescription claims data related to fertility services. WINFertility maintains the confidentiality of your information in accordance with privacy regulations such as HIPAA.

Privacy Notice

JPMorgan Chase is committed to maintaining the highest level of privacy and discretion about your personal compensation and benefits information.

However, federal legislation under the Health Insurance Portability and Accountability Act (HIPAA) legally requires employers—like JPMorgan Chase—to specifically communicate how certain "protected health information" under employee and retiree health care plans may be used and disclosed, as well as how plan participants can get access to their protected health information.

What Is Protected Health Information?

Protected health information is considered to be individually identifiable health information as it relates to the:

- Past, present, or future health of an individual; or
- Health care services or products provided to an individual; or
- Past, present, or future payment for health care services or products.

The information included in this section is a summary of HIPAA privacy regulations. To comply with the law, JPMorgan Chase will distribute to you once every three years, a "Privacy Notice of Protected Health Information Under the JPMorgan Chase Health Care Plans" that describes in detail how your personal health information may be used and your rights with regard to this information.

You can access the Privacy Notice at **My Health** or by contacting the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427) at any time to request a paper copy. Under HIPAA, protected health information is confidential, personal, identifiable health information about you that is created or received by a claims administrator (like those under the JPMorgan Chase Medical Plan), and is transmitted or maintained in any form. ("Identifiable" means that a person reading the information could reasonably use it to identify an individual.)

Under HIPAA, the Medical Plan, which includes the U.S. Fertility Benefits Program, may only use and disclose participants' protected health information in connection with payment, treatment, and health care operations. In addition, the Medical Plan must restrict access to and use of protected health information by all employees/groups except for those specifically involved in administering the Medical Plan, including payment and health care operations. In compliance with HIPAA, the Medical Plan agrees to:

- Not use or further disclose protected health information other than as permitted or required by law;
- Not use or disclose protected health information that is genetic information for underwriting purposes;
- Ensure that any agents (such as an outside claims administrator) to whom the Medical Plan gives protected health information agree to the same restrictions and conditions that apply to the Medical Plan with respect to this information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of JPMorgan Chase;
- Notify you if a breach of your protected health information is discovered;
- Report to the JPMorgan Chase HIPAA Privacy Officer any use or disclosure of the information that is inconsistent with the designated protected health information uses or disclosures;
- Obtain your authorization for any use or disclosure of protected health information for marketing, or that is a sale of the protected health information as defined under applicable law;
- Make available protected health information in accordance with individuals' rights to review such personal information;
- Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules;
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules;
- Make the Medical Plan's internal practices, books, and records relating to the use and disclosure of protected health information received from the claims administrators available to the Secretary of Health and Human Services for purposes of determining the Medical Plan's compliance with HIPAA;
- Return or destroy all protected health information received in any form from the claims administrators. The Medical Plan will not retain copies of protected health information once it is no longer needed for the purpose of a disclosure. An exception may apply if the return or destruction of protected health information is not feasible. However, the Medical Plan must limit further uses and disclosures of this information to those purposes that make the return or destruction of the information infeasible; and
- Request your authorization to use or disclose psychotherapy notes except as permitted by law, which would include for the purposes of carrying out the following treatment, payment or health care operations:
  - Use by the originator of psychotherapy notes for treatment;
  - Use or disclosure by the Medical Plan for its own training program; or
  - Use or disclosure by the Medical Plan to defend itself in a legal action or other proceeding brought by you.

If you believe that your rights under HIPAA have been violated, you can file a complaint with the JPMorgan Chase HIPAA Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the JPMorgan Chase HIPAA Privacy Officer, please contact the Privacy Officer for the JPMorgan Chase Health Care Plans in writing at this address:

HIPAA Privacy Officer for the JPMorgan Chase Health Care Plans
JPMorgan Chase Corporate Benefits
4041 Ogletown Road, Floor 02
Newark, DE, 19713-3159
Mail Code: DE6-1470

Claims Related to Eligibility to Participate in the Plans and Plan Operations

This section provides information about the claims and appeals process for questions relating to eligibility to participate in the Program, such as whether you meet the requirements of employees/dependents/beneficiaries who are allowed to obtain benefits under the plans. In addition, if you have a type of claim that is not otherwise described in this summary, including claims related to general plan operations, lawfulness of plan provisions, or Section 510 of ERISA, you must file your claim in accordance with this section. For information on filing claims for benefits, please see "Claiming Benefits" beginning on page 361.

Help Pursuing Claims for Eligibility
You may authorize someone else to pursue claim information on your behalf. If you would like to designate an authorized representative for claims related to eligibility to participate in a plan, please contact the HR Answers Benefits Contact Center at 877-JPMChase ((877) 576-2427).

How to File This Type of Claim and What You Can Expect

For questions about eligibility to participate in the Program and to receive benefits or about general plan operations, please contact the HR Answers Benefits Contact Center.

If you are not satisfied with the response, you may file a written claim with the plan administrator at the address provided in "General Information" on page 354. The plan administrator will assign your claim for a determination. You must file your claim within 90 days of the event giving rise to your claim. You will receive a written decision within 90 days of receipt of your claim. Under certain circumstances, this 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your request. In this situation, you will receive written notice of the extension and the reasons for it, as well as the date by which a decision is expected to be made, before the end of the initial 90-day period. If the extension is required because of your failure to submit information necessary to decide the claim, the period for making the determination will begin as of the date you submit the additional information, assuming it is provided in a timely fashion.

If Your Claim Is Denied

If you receive a notice that your claim has been denied, either in full or in part, the notice will explain the reason for the denial, including references to specific plan provisions on which the denial was based. If your claim was denied because you did not furnish complete information or documentation, the notice will state the additional materials needed to support your claim. The notice will also tell you how to request a review of the denied claim and the time limits applicable to those procedures.

To appeal a denial of the type of claims described in this section, you must submit a written request for appeal of your claim to the plan administrator within 60 days after receiving the notice of denial. In connection with your appeal, you may submit written comments, documents, records, or other information relevant to your claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to your claim. The Plan Administrator will decide appeals under the Program.

In most cases, a decision will be made within 60 days after you file your appeal. But if special circumstances require an extension of time for processing, and you are notified that there will be a delay and the reasons for needing more time, there will be an extension of up to 60 days for deciding your appeal. If an extension is necessary because you did not submit enough information to decide your appeal, the timing for making a decision about your appeal is stopped from the date the plan administrator sends you an extension notification until the date that you respond to the request for additional information, assuming your response comes within a reasonable time frame.

Once a decision is reached, you will be notified in writing of the outcome. If an adverse benefit determination is made on review, the notice will include the specific reasons for the decision, with references to specific plan provisions on which it is based.

If you would like to file a court action after your appeal, please see “Filing a Court Action” on page 298, which sets forth the rules that will apply.

Claiming Benefits

This section explains the benefits claims and appeals process for the benefits of the U.S. Fertility Benefits Program. It includes detailed information about what happens at each step in the process and includes important timing requirements. This section also includes information about each plan’s “fiduciary” and contact information. See “About Plan Fiduciaries” on page 357 and “Contacting the Claims Administrator” on page 365. For claims relating to eligibility questions or claims, please see “Claims Related to Eligibility to Participate in the Plans and Plan Operations” on page 360.

Help Pursuing Claims

You may authorize someone else to pursue claim information on your behalf. If you do so, you must notify the claims administrator in writing of your choice of an authorized representative.

Your claims administrator will provide you with a HIPAA (Health Insurance Portability and Accountability Act of 1996) consent form that you must use to specify the extent to which your personal representative is authorized to act on your behalf. This form must be on file with your claims administrator prior to any action by your personal representative.

Steps in the Benefits Claims and Appeals Process

Step 1: Filing Your Initial Claim for Benefits

In general, when you file a claim for benefits, it is paid according to the provisions of the U.S. Fertility Benefits Program. Your initial claims must be filed no later than six months of when the expenses are incurred. Generally, in-network claims filing is performed by the physician or care provider.

Step 2: Receiving Notification from the Claims Administrator/Plan Administrator if an Initial Claim for Benefits Is Denied

If an initial claim for benefits is denied, the claims administrator or plan administrator will notify you within a "reasonable" period, not to exceed:

- As soon as reasonably possible but no more than 72 hours for claims involving urgent care, where the life of a claimant could be jeopardized (may be oral, with written confirmation within three days). **Please Note**: You must be notified if your claim is approved or denied.
- 15 days for pre-service claims, where approval is required before receiving benefits, plus one 15-day extension because of matters beyond the plan's control.
- 30 days for post-service claims, where the claim is made after care is received, plus one 15-day extension because of matters beyond the plan's control.

Under certain circumstances, the claims administrator or Plan Administrator, as applicable, is allowed an extension of time to notify you of a denied benefit.

What Qualifies as a "Denied Benefit"?

A "denied benefit" is any denial, reduction, or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit. In addition, a benefit may be denied if you didn't include enough information with your initial claim.

Please Note: If an extension is necessary because you did not submit necessary information needed to process your claim, the timing for making a decision about your claim is stopped from the date the claims administrator or plan administrator sends you an extension notification until the date that you respond to the request for additional information. You generally have 45 days from the date you receive the extension notice to send the requested information to the claims administrator or Plan Administrator.

Please Note: Concurrent care claims are claims for which the plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments. Concurrent care claims may fall under any of the other steps in the claims appeal process, depending on when the appeal is made. However, the plan must give you sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

The Explanation You'll Receive from the Claims Administrator/Plan Administrator in the Case of a Denied Benefit

If your initial claim is denied, the claims administrator or plan administrator is legally required to provide an explanation for the denial, which will include the following:

- The specific reason(s) for the denial;
- References to the specific plan provisions on which the denial is based;
- A description of any additional material or information needed to process your claim and an explanation of why that material or information is necessary; and
- A description of the plan's appeal procedures and time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA after, and if, your appeal is denied.
- If the benefit was denied based on medical appropriateness, an experimental or unproven treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge upon request.

Step 3: Filing an Appeal to the Claims Administrator/Plan Administrator if an Initial Claim for Benefits Is Denied

If you have filed a claim for benefits and your claim is denied, you have the right to appeal the decision. JPMorgan Chase is not involved in deciding appeals for any denied benefit claim under the U.S. Fertility Benefits Program.

The plan administrators delegate all fiduciary responsibility and decisions about a claim for a denied benefit under the Fertility Benefits Program to WINFertility.

Under certain plans including the U.S. Fertility Benefits Program, final appeals for denied claims will be heard by a review panel that is independent of both the company and the claims administrators.

If your initial claim for benefits is denied, you — or your authorized representative — may file an appeal of the decision with the claims administrator or plan administrator within 180 days after receipt of the claim denial.

In your appeal, you have the right to:

- Submit written comments, documents, records, and other information relating to your claim.
- Request, free of charge, reasonable access to, and copies of, all documents, records, and other information that:
  - Was relied upon in denying the benefit.
  - Was submitted, considered, or generated in the course of denying the benefit, regardless of whether it was relied on in making this decision.
  - Demonstrates compliance with the administrative processes and safeguards required in denying the benefit.
  - For health care: constitutes a policy statement or plan guideline concerning the denied benefit regardless of whether the policy or guideline was relied on in denying the benefit.

You also have the right to receive:

- A review that does not defer to the initial benefit denial and that is conducted by someone other than the person who made the denial or that person's subordinate.
- For a denied benefit based on medical judgment (including whether a particular treatment, drug, or other item is experimental or unproven), a review in which the plan fiduciary/claims administrator consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was not consulted in connection with the initial benefits denial, nor the subordinate of this person.
- The identification of medical or vocational experts whose advice was obtained in connection with denying the benefit, regardless of whether the advice was relied on in making this decision.
- In the case of an urgent care claim where the life of a claimant could be jeopardized, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of a denied benefit.
  - All necessary information, including the decision on your appeal, will be transmitted between the plan fiduciary/claims administrator and you by telephone, facsimile, or other available similarly prompt method.

Step 4: Receiving Notification from the Claims Administrator/Plan Administrator if Your Appeal Is Denied

If your appeal is subsequently denied, the claims administrator or plan administrator is legally required to notify you in writing of this decision within a "reasonable" period of time according:

- As soon as reasonably possible but no more than 72 hours for claims where the life of a claimant could be jeopardized (urgent care)
- 15 days where approval is required before receiving benefits (pre-service claims)
- 30 days where the claim is made after care is received (post-service claims)

The claims administrator or the plan administrator is allowed to take an extension to notify you of a denied appeal under certain circumstances. If an extension is necessary, the claims administrator or plan administrator will notify you before the end of the original notification period. This notification will include the reason(s) for the extension and the date the claims administrator or the plan administrator expects to provide a decision on your appeal for the denied benefit. **Please Note**: If an extension is necessary because you did not submit enough information to decide your appeal, the time frame for decisions is stopped from the date the claims administrator or the plan administrator sends you an extension notification until the date that you respond to the request for additional information.

The Explanation You'll Receive from the Claims Administrator/Plan Administrator in the Case of a Denied Benefit

If an appeal is denied, the claims administrator or plan administrator is legally required to provide an explanation for the denial, which will include the following:

- The specific reason(s) for the denial;
- References to the specific plan provisions on which the denial is based;
- A statement that you're entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement describing any appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring a civil action under ERISA.
- If the benefit was denied based on medical appropriateness, experimental, or unproven treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A description of the expedited review process for urgent care claims in the Medical Plan, where the life of the claimant could be jeopardized.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the benefit denial, or a statement that a copy of this information will be provided free of charge upon request in the Medical Plan.

The U.S. Fertility Benefits Program requires two levels of appeal, which you must complete if you would like to pursue your claim further.

Step 5: Receiving a Final Appeal by an Independent Review Panel

If your appeal of a benefits claim is denied, your final appeal for coverage will be heard by a review panel that is independent of both the company and the claims administrator.

The independent review panel hears only appeals that involve medical judgment or a rescission of coverage; the panel does not hear appeals about eligibility to participate in a plan or legal interpretation of a plan that does not involve medical judgment.

Filing a Court Action

If an appeal is denied (in whole or in part), you may file suit in a U.S. federal court. If you are successful, the court may order the defending person or organization to pay your related legal fees. If you lose, the court may order you to pay these fees (for example, if the court finds your claim frivolous). You may contact the U.S. Department of Labor or your state insurance regulatory agency for information about other available options.

If you bring a civil action under ERISA, you must start the action by the earlier of: (i) one year after the date of the denial of your final appeal; or (ii) three years after the date when your initial claim should have been filed, regardless of any state of federal statutes relating to limitations of actions. If, however, the applicable state or federal law relating to limitations of actions would result in a shorter limitations period within which to start the action, the shorter limitations period will apply. You cannot file a suit unless you have completed two appeals, if required by the claims administrators.

Contacting the Claims Administrator

WINFertility

Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831

(833) 439-1517

If You Are Covered by More Than One Health Care Plan

The JPMorgan Chase U.S. Fertility Benefits Program has provisions to ensure that payments from all of your group health care plans don't exceed the amount the JPMorgan Chase plans would pay if they were your only coverage.

The rules described here apply to JPMorgan Chase Program. The following rules do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

The JPMorgan Chase health care plans do not allow for duplication of benefits. If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. The non-duplication provisions of the JPMorgan Chase health care plans will ensure that, in total, you receive benefits up to what you would have received with the JPMorgan Chase plans as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount.

A summary of coordination rules (that is, how JPMorgan Chase coordinates coverage with another group plan to ensure non-duplication of benefits) follows. If you have questions, please contact your health care company for help.

Here's an example of how the JPMorgan Chase health care plans coordinate benefits with other group health care plans:

- Assume your spouse/domestic partner has a necessary covered procedure with a reasonable and customary (R&C) charge of $100 after meeting any deductible.
- If your spouse/domestic partner's plan (which we'll assume is primary) pays 70% for that procedure, your spouse/domestic partner will receive a $70 benefit (70% of $100).
- Also assume that your JPMorgan Chase health care plan (which we'll assume is your spouse/domestic partner's secondary coverage and that the deductible has already been satisfied)—would pay 80% for this necessary procedure. In this case, your spouse/domestic partner normally would receive an $80 benefit (80% of $100) from the JPMorgan Chase plan.

- Since your spouse/domestic partner already received $70 from his or her primary plan, he or she would receive the balance ($10) from the JPMorgan Chase plan.
- If, however, your JPMorgan Chase plan considered the R&C charge to be $80, no additional benefit would be payable, as the JPMorgan Chase plan would pay 80% of $80, or $64. As that amount would have already been paid by your spouse/domestic partner's plan, no additional benefit would be payable from the JPMorgan Chase plan.

Determining Primary Coverage

To determine which health care plan pays first as the primary plan, here are some general guidelines:

- If you are enrolled in the JPMorgan Chase plan and another plan and your other health care plan doesn't have a coordination of benefits provision, that plan will be considered primary, and it will pay first for you and your covered dependents.
- If your covered dependent has a claim, the plan covering your dependent as an employee or retiree will be considered primary to this plan.
- If your claim is for a covered child who is enrolled in coverage under both parents' plans, the plan covering the parent who has the earlier birthday in a calendar year (based on the month and date of birthday only, not the year) will be considered primary. In the event of divorce or legal separation, and in the absence of a qualified medical child support order, the plan covering the parent with court-decreed financial responsibility will be considered primary for the covered child. If there is no court decree, the plan of the parent who has custody of the covered child will be considered primary for the covered child. (Please see "Qualified Medical Child Support Orders" in the *Health Care Participation* section.)
- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

After it is determined which plan is primary, you'll need to submit your initial claim to that plan.

After the primary plan pays benefits (up to the limits of its coverage), you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You'll need to include a copy of the written Explanation of Benefits from your primary plan.

Coordination with Medicare

Medicare is a national health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). It generally provides coverage for Americans ages 65 and older. It also provides coverage to younger people with a qualifying disability. As long as you remain an active employee with JPMorgan Chase, your JPMorgan Chase coverage will be primary, and any Medicare coverage for you will be secondary. Additionally, any covered dependents who become eligible for Medicare, while you remain an active employee, will also have JPMorgan Chase coverage as primary.

- While you remain an active JPMorgan Chase employee, the JPMorgan Chase health care plans will be primary for you and your covered dependents unless those dependents have primary coverage elsewhere. If your covered dependents have primary coverage elsewhere, those claims will be considered by that primary coverage first, JPMC coverage will be secondary and Medicare will consider claims for those health care expenses tertiary (third) Even if you work past age 65 and you and/or a covered spouse/domestic partner enroll in Medicare, the JPMorgan Chase plans will consider claims for your health care expenses before Medicare while you are an active employee.
- When you are no longer an active JPMC employee or are receiving LTD benefits, Medicare coverage will be primary for the Medicare enrolled individual. JPMC coverage will be terminated upon Medicare eligibility and coverage in Medicare plans is available from Via Benefits.

Right of Recovery

If the JPMorgan Chase plan provides benefits to you or a covered dependent that are later determined to be the legal responsibility of another person or company, the JPMorgan Chase plans have the right to recover these payments from you or from the person or company who is determined to be legally responsible. Assignment of your claim to a third party does not exempt you from your responsibility for repaying the plan. You must notify the JPMorgan Chase plan promptly of any circumstance in which a third party may be responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plan making payments on your behalf.

Subrogation of Benefits

The purpose of the JPMorgan Chase health care plans is to provide benefits for eligible health care expenses that are not the responsibility of any third party. The JPMorgan Chase plans have the right to recover from any third party responsible for compensating you with respect to an illness or injury that results in the JPMorgan Chase plans making payments on your behalf or on behalf of a covered dependent. This is known as subrogation of benefits. The following rules apply to the plan's subrogation of benefits rights:

- The JPMorgan Chase plans have first priority from any amounts recovered from a third party for the full amount of benefits the plans have paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- You agree to help the JPMorgan Chase plans use this right when requested.
- If you fail to help the JPMorgan Chase plans use this right when requested, the plans may deduct the amount the plans paid from any future benefits payable under the plans.
- The JPMorgan Chase plans have the right to take whatever legal action they deem appropriate against any third party to recover the benefits paid under the plans.
- If the amount you receive as a recovery from a third party is insufficient to satisfy the JPMorgan Chase plans' subrogation claim in full, the plans' subrogation claim shall be first satisfied before any part of a recovery is applied to your claim against the third party.
- The JPMorgan Chase plans are not responsible for any attorney fees, attorney liens, or other expenses you may incur without the plans' prior written consent. The "common fund" doctrine does not apply to any amount recovered by any attorney you retain regardless of whether the funds recovered are used to repay benefits paid by the plans.

If you receive a subrogation request and have questions, please contact your health care company.

Right of Reimbursement

In addition to their subrogation rights, the JPMorgan Chase health care plans are entitled to reimbursements from a covered person who receives compensation from any third parties (other than family members) for health care expenses that have been paid by the plans. The following rules apply to the plans' right of reimbursement:

- You must reimburse the JPMorgan Chase plans in first priority from any recovery from a third party for the full amount of the benefits the plan paid on your behalf, regardless of whether you are fully compensated by the third party for your losses.
- Regardless of any allocation or designation of your recovery made in a settlement agreement or court order, the JPMorgan Chase plans shall have a right of full reimbursement, in first priority, from the recovery.

- You must hold in trust for the benefit of the JPMorgan Chase plans the gross proceeds of a recovery, to be paid to the plans immediately upon your receipt of the recovery. You must reimburse the plans, in first priority and without any set-off or reduction for attorney fees or other expenses. The "common fund" doctrine does not apply to any funds recovered by any attorney you retain, regardless of whether the funds recovered are used to repay benefits paid by the plans.
- If you fail to reimburse the JPMorgan Chase plans, the plans may deduct any unsatisfied portion of the amount of benefits the plans have paid or the amount of your recovery from a third party, whichever is less, from future benefits payable under the plans.

If you fail to disclose the amount of your recovery from a third party to the JPMorgan Chase plans, the plans shall be entitled to deduct the full amount of the benefits the plans paid on your behalf from any future benefits payable under the plans.

Special Notice for Employees Who Have Been Rehired by JPMorgan Chase

If your employment has been reinstated with JPMorgan Chase (that is, you have been rehired within 31 days of your employment termination date or your coverage termination date), you and your dependents will be assigned the same U.S. Medical Plan coverage (which includes Fertility Benefits Program coverage) you had before your coverage termination date. **Please Note**: If you are a retired employee when rehired, you must take active employee coverage and discontinue any retiree coverage you may have elected.

Please Note: If you are rehired after 31 days of your termination date, you will need to make new benefits elections for all plans for which you would like to participate.

Defined Terms

As you read this summary of the JPMorgan Chase U.S. Fertility Benefits Program, you'll come across some important terms related to the Program. To help you better understand the Program, many of those important terms are defined here.

Claims Administrator	The claims administrator is the company that provides certain claims administration services for the Program. For the Fertility Benefits Program benefits, the claims administrator is WINFertility.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you and/or your covered dependents to continue certain health plan coverage on an after-tax basis (under certain circumstances) when coverage would otherwise have ended. "Continuing Health Coverage Under COBRA" on page 282 provides details on COBRA coverage. You must elect JPMorgan Chase Medical Plan coverage under COBRA to continue the Fertility Benefit under COBRA. There is no additional charge for the Fertility Benefit under COBRA if Medical Plan coverage is elected.
Covered Services	Covered services are services and procedures that are generally reimbursable by the Program. While the Program provides coverage for numerous services and supplies, there are limitations on what's covered. While a service or supply may be necessary, it may not be covered under the Program. Please see the sections that explain what the Program covers and what is not covered for more details.
Introductory Period	All employees, including re-employed individuals, begin employment with a 90-day introductory period, regardless of the length of the break in employment for re-employed individuals. The introductory period does not apply if an employee transfers or is promoted into a new position or if the employee joins the firm through a merger or acquisition. During the 90-day introductory period of continuous service, employees demonstrate their performance capabilities and assess whether the position is suited to them. The manager also assesses whether the employee is appropriately qualified and suited for the position. The introductory period may also serve as a period of time to complete any training or licensing requirements for the position in which the employee was hired. At JPMorgan Chase's discretion, there may be times when the introductory period will be extended beyond 90 days. During an employee's introductory period (and throughout employment with JPMorgan Chase) an employee's employment may be terminated at any time without prior warning.
In-Network Provider/Out-of-Network Provider	"In-network" and "out-of-network" are terms referring to whether a provider is part of the WINFertility network (in-network provider) or is not part of the WINFertility network (out-of-network provider).