BANK OF AMERICA

2022 Bank of America Retiree Health & Insurance Summary of Material Modifications

What's a summary of material modifications?

A summary of material modifications (SMM) is a legally required document that details changes made to a summary plan description (SPD), which is a comprehensive description of the benefits and rules of a plan. We issue an SMM when we make changes to a plan.

What does this document include?

This document includes a summary of certain coverage changes to the Retiree Health & Insurance plan that became effective on Jan. 1, 2022 (unless otherwise noted). This document provides an overview of these changes by topic, as well as clarifications to certain other plan provisions.

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Who is this document for?

This document is for former employees and beneficiaries who are participating in the Bank of America Retiree Health & Insurance plan.

This SMM should be read in conjunction with the *2021 Bank of America Retiree Health & Insurance SPD* (2021 Retiree SPD). Please keep this document with your other Bank of America benefit plan materials so you have up-to-date information on your benefit plans.

You can visit My Benefits Resources (**mybenefitsresources.bankofamerica.com**) to access these documents online. Or you may request a printed copy of these materials at any time by calling the Global HR Service Center at **800.556.6044.** Representatives are available Monday through Friday, 8 a.m. to 8 p.m. Eastern (excluding certain holidays).

Eligibility and enrollment

Clarification: Plans offered to rehired retirees

*The following information relates to benefits available to rehired retirees who retire again, described on pages 5–6 of the online version of the 2021 Retiree SPD under **Rehired retirees**. Clarifications to the previously documented information are highlighted in gray, and deletions to the previously documented information appear as ~~strikethrough~~ text.*

Rehired retirees

If you are a current retiree of Bank of America or one of the bank's legacy companies and are rehired by the bank,[1] and you:

- Are regularly scheduled to work 20 hours or more per week, you will become eligible for plans offered to active, benefits-eligible bank employees (including medical, dental, vision, health care accounts, basic life insurance, supplemental life insurance, supplemental AD&D insurance, long-term disability and short-term disability). When you retire again in the future, your retiree medical, retiree dental, retiree vision, retiree health care accounts and, if applicable, retiree life insurance coverage will be available to you, subject to plan and eligibility rules in effect at that time.
- Are a temporary employee or are regularly scheduled to work fewer than 20 hours per week, you will become eligible for medical plans and health care accounts offered to active, benefits-eligible bank employees. Your retiree dental, retiree vision and, if applicable, retiree life insurance benefits will remain in effect, or if you have elected COBRA dental and vision coverage, you can maintain that coverage. When you retire again in the future, your retiree medical coverage (including retiree health care accounts) will be available to you, subject to plan and eligibility rules in effect at that time.

Note: Rehired retirees in Guam, Puerto Rico and the U.S. Virgin Islands are not eligible to participate in health care accounts. Rehired retirees in Hawaii are not eligible for health care accounts except for the Health Flexible Spending Account or a Limited Purpose Flexible Spending Account. ~~or a Health Reimbursement Account.~~

Your eligibility for certain plans offered to active, benefits-eligible bank employees as described above is effective on your first day as an employee upon being rehired. Contact the Global HR Service Center at **800.556.6044** (TTY: Dial **711**, then **800.556.6044**). Representatives are available Monday through Friday, 8 a.m. to 8 p.m. Eastern (excluding certain holidays).

Your health and insurance benefits when you retire again

If you are regularly scheduled to work 20 hours or more per week, your active employee health and insurance coverage will end on the last day of the month in which you return to retiree status.

- You may elect COBRA continuation coverage, if applicable (only applies to group medical, dental and vision coverage).

[1] Applies if you are working for a participating employer in the U.S. or you are an international assignee whose designated home or host country is the U.S. Note that you are not eligible for U.S. benefits if you are a foreign national regularly employed outside the U.S. or you are a U.S. citizen employed overseas on the payroll of an overseas facility.

- You will have the option to convert the difference between your Associate Basic Life Insurance coverage amount (if greater) and your Retiree Basic Life Insurance coverage amount to an individual policy within 45 days of the date your Associate Basic Life Insurance coverage ends, if eligible.
- Your retiree medical coverage (including retiree health care accounts) will be available to you. If you retire again with active medical, dental or vision coverage, you will need to decide whether to elect retiree health care coverage or to elect COBRA coverage.
- Any reduction schedule that applied to your Retiree Basic Life Insurance amount will resume using the coverage amount of your Retiree Basic Life Insurance in place at the time you were rehired.
- Retiree supplemental life and dependent life insurance may be available if you had grandfathered coverage through a predecessor plan before you were rehired.
- Supplemental AD&D insurance may be available to you.

If you are a temporary employee or regularly scheduled to work fewer than 20 hours per week, your retiree medical coverage (including retiree health care accounts) will be available to you again, and you'll maintain the retiree dental, vision, life insurance and supplemental insurance benefits that remained in effect throughout your re-employment.

You will receive detailed information about your options at the time you retire again.

Note

Retiree benefits (including credits, subsidies and life insurance) available when you retire again may be different since they will be based upon the retiree plan provisions and eligibility rules in effect at the time of your subsequent retirement.

Addition: Enrolling in retiree health and insurance benefits

The following information relates to deadlines for new retirees to enroll and the entire entry is in addition to ***Section III — Enrolling in retiree health and insurance benefits*** *beginning on page 11 of the online version of the 2021 Retiree SPD.*

Enrolling as a new retiree

As a Bank of America benefits-eligible retiree, you can enroll in retiree health and insurance benefits at retirement or defer enrollment to a future date of your choice.

If you're newly eligible for retiree benefits and don't take action during your enrollment period, you'll receive the coverage shown on your *Enrollment Worksheet*, which in most cases is no coverage.

If you don't enroll by the deadline shown on your *Enrollment Worksheet*, you won't be eligible to enroll again until the next Annual Benefits Enrollment or within 31 days of a qualified status change (for example, marriage, divorce or the birth or adoption of a child). At that time, you'll be required to provide proof of other medical coverage (other than Medicare) for the past 12 months to enroll in a Bank of America medical plan. Participants from certain legacy organizations or those enrolled in certain legacy medical

plans may not be able to defer enrollment and enroll in future years or cover a spouse, partner or other dependent. Call the Global HR Service Center at **800.556.6044** for information about re-enrollment rules and restrictions. Representatives are available Monday through Friday, 8 a.m. to 8 p.m. Eastern, excluding certain holidays.

Enrolling after deferring benefits

If you deferred enrolling in retiree benefits and recently notified the Global HR Service Center that you're ready to enroll, you have 31 days from the date of your qualifying event or until the end of the enrollment window to complete your enrollment. Because you previously deferred enrollment in retiree coverage when you were first eligible, you must provide proof of other medical coverage (other than Medicare) for the past 12 months to enroll in a Bank of America medical plan.

Medical plans

Change: Retiree prescription drug coverage

The following information relates to the cost of catastrophic prescription drug coverage for Medicare Advantage plan participants, described on pages 56–58 of the online version of the 2021 Retiree SPD. Changes to the previously documented information are highlighted in gray.

Medicare Part D prescription drug coverage

If you are eligible for Medicare, you can enroll in Medicare's prescription drug coverage, also called Medicare Part D.

- Joining a Medicare prescription drug plan is completely voluntary. You do not need to enroll in both a Bank of America prescription drug plan and Medicare Part D.
- Insurance companies and other private companies work with Medicare to provide these plans.
- Medicare Part D plans may vary in what prescription drugs are covered, how much you have to pay and which pharmacies you can use. Some plans may offer more coverage for a higher monthly contribution.
- All Medicare Part D plans must provide at least the standard level of coverage for the drugs they cover, as set by Medicare (see the following example for 2022).

The following table is provided for informational purposes only. Contact Medicare directly for more information.

2022 Medicare Part D coverage

Annual deductible	Prescription drug cost from $480.01 to $4,430		Prescription drug cost from $4,430.01 to $7,050[1]		Prescription drug cost more than $7,050	
Participant pays	**Participant pays**	**Medicare pays**	**Participant pays**	**Medicare pays**	**Participant pays**	**Medicare pays**
$480	25%	75%	Generic: 25% Brand name: 25%[4]	Generic: 75%[2] Brand name: 5%	5%[3]	95%

[1] Medicare Part D enrollees receive a discount on the total cost of their brand name prescription drugs while in this coverage cost range.

[2] The 75% paid by Medicare Part D doesn't apply toward true out-of-pocket.

[3] Assuming no secondary coverage, the participant pays either the remaining 5% of prescription drug costs after reaching $7,050 in covered expenses each year or copays of $3.95 for generic or preferred multi-source prescription drugs and $9.85 for all other prescription drugs — whichever is greater.

[4] You'll pay 25% for brand name drugs. The manufacturer will give you a 70% discount while in the "Donut Hole," and your Medicare Part D plan will pick up the remaining 5%.

Medicare Part D and the Bank of America retiree medical plans

The Medicare Advantage plans offered by Bank of America include Medicare Part D coverage under an Employer Group Waiver Program. Prescription drug coverage for the national Medicare Advantage plans is administered by SilverScript, a CVS Health company. Prescription drug coverage for local Medicare Advantage plans is administered by the health plan. Please contact your local Medicare Advantage plan for details.

Prescription drug coverage under the national Medicare Advantage plans

The following table shows the Medicare Advantage plans' prescription drug coverage.

National Medicare Advantage plans' prescription drug coverage	

Prescription drug copays only through SilverScript	30-day supply:
	• Generic: $5
	• Preferred brand: $20
	• Non-preferred brand: $30
	• Specialty (30-day supply only)
	  • Applicable brand or generic copay applies
	  • Preauthorization may be required
	90-day supply:
	• 2 times the 30-day copay

No coverage gap	The above copays apply until your yearly out-of-pocket costs reach $7,050.
No maximum out-of-pocket	After your yearly out-of-pocket costs reach $7,050, you will pay the greater of: • Generic: $3.95 or 5% but not more than the plan copay • All other drugs: $9.85 or 5% but not more than the plan copay

Addition: Balance billing defined

*The following definition for "balance billing" has been added to the **Definitions** section starting on page 60 of the online version of the 2021 Retiree SPD.*

Balance billing

Balance billing is the difference between what your plan agreed to pay for a service provided in network (the allowed amount) and the amount charged for the same service when obtained from an out-of-network provider or facility.

Change: Emergency care protections under the No Surprises Act

*The following information relates to protections against out-of-network balance billings when emergency care is provided by an out-of-network facility or provider, described on page 81 of the online version of the 2021 Retiree SPD under **Emergency care**. The change to the previously documented information is highlighted in gray.*

Emergency care

If you or a covered dependent need emergency care, you are covered 24 hours a day, seven days a week, anywhere in the world. Some examples of emergencies are:

- Heart attack or suspected heart attack
- Suspected overdose of medication
- Poisoning
- Severe burns
- Severe shortness of breath
- High fever (especially in infants)
- Uncontrolled or severe bleeding
- Loss of consciousness

Whether you are in or out of the health plan's service area, follow the guidelines below when you believe you may need emergency care:

- Call your preferred provider or primary care physician first, if possible. Your preferred provider or primary care physician is required to provide emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility or dial **911** (if your area has this emergency response service).
- After assessing and stabilizing your condition, the emergency facility should contact your preferred provider or primary care physician so he or she can assist the treating physician by supplying information about your medical history.
- If you are admitted to an inpatient facility, notify your primary care physician (under certain HMO/EPO plans) or the medical plan claims administrator (under the HMO/EPO and PPO plans) within 48 hours. The emergency room copay will be waived if you are admitted to the hospital (this does not apply to the Medicare Supplement plans).

Follow-up care after emergencies**:** All follow-up care should be coordinated by your preferred provider or primary care physician. Contact your claims administrator for any prior authorization requirements.

Protection against balance billing

Under the **No Surprises Act**, if you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copays and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

When you receive services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist (critical care) services. These providers can't balance bill you and they can't ask you to give up your protections not to be balance billed. However, you may provide written consent to allow balance billing.

For more information, refer to The No Surprises Act section of this SMM.

Health Savings Account (HSA)

The following information relates to maximum contribution amounts as described on page 104 of the online version of the 2021 Retiree SPD. Changes to the previously documented information are highlighted in gray.

Change: Contribution limits

Section III — Health Savings Account

A Health Savings Account (HSA) offers you a unique way to save and pay for your current and future eligible health care expenses. An HSA provides tax advantages — contributions are tax free, funds earn tax-free interest and withdrawals are not taxed as long as the money is used to pay for eligible health care items or services.[1] Your HSA funds can be used now or in the future. HSA funds can be used to pay for out-of-pocket expenses, such as:

- Medical, dental, vision and prescription drug copays
- Deductibles and coinsurance
- Laser eye surgery, acupuncture, hearing aids and batteries
- Medicare premiums, once you become eligible for Medicare
- COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) coverage premiums
- Long-term care insurance premiums, subject to certain limits

You can contribute up to $3,650 for individual coverage or up to $7,300 for family coverage in 2022. If you are age 55 or older, you can make catch-up contributions (in addition to the annual IRS limits stated in the previous sentence). In 2022, the IRS limits catch-up contributions to $1,000.

Addition: HSA enrollment

*The following information about how to enroll in an HSA has been added to the 2021 Retiree SPD before the **Current HSA participants** section on page 104 of the online version.*

To enroll in an HSA

Bank of America Health Benefit Solutions is the service provider for our health care accounts. To elect the HSA for Life® HSA, follow the steps below.

Note: If you enroll in the non-Medicare High Deductible plan for the first time in 2022 and are eligible to elect an HSA, these steps also apply to you.

To enroll:

1. Go to **myhealth.bankofamerica.com**.
2. Under **Ready to apply for an Individual HSA?**, click **Get started**.
3. Follow the prompts to complete your HSA application.

To learn more, visit **Health Benefit Solutions** **(myhealth.bankofamerica.com)** or call **866.791.0254**.

[1] These advantages are for federal tax purposes. State tax treatment may vary.

Other important information

Addition: No Surprises Act

*The following information relates to new protections provided under the No Surprises Act and the entire entry is in addition to the **Other important information** section beginning on page 115 of the online version of the 2021 Retiree SPD.*

No Surprises Act

The No Surprises Act provides patients with certain rights and protections against surprise medical bills.

Note

When you receive emergency care and are treated by an out-of-network provider in an in-network facility, you are protected from balance billing (surprise billings).

What is balance billing (sometimes called surprise billing)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copay, coinsurance and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Out-of-network providers and facilities haven't signed a contract with your health plan, and they may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- **Emergency services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copays and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain services at an in-network hospital or ambulatory surgical center:** When you receive services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist (critical care) services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

  If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. **You are never required to give up your protections from balance billing.** You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copays, coinsurance and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization)
  - Cover emergency services by out-of-network providers
  - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit

If you believe you've been incorrectly billed, you may contact your medical plan carrier.

Visit **CMS.gov** for more information about your rights under federal law.

ERISA information

Change: Claiming your benefits

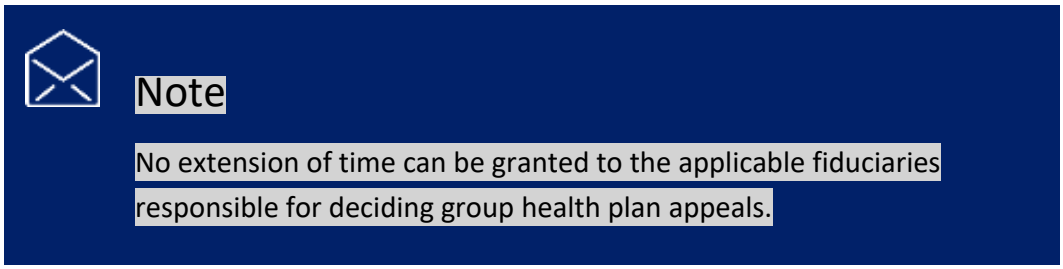
*The following information relates to the time allotted for reviewing and responding to claims described in **Section IX — Claiming your benefits** beginning on page 129 of the online version of the 2021 Retiree SPD. Additions are highlighted in gray.*

The Bank of America Corporation Corporate Benefits Committee, as Plan Administrator, has delegated to the Pay and Benefits Escalation Team, the Benefits Appeals Committee and insurance companies or service providers discretionary authority to determine eligibility for benefits, construe the terms of the applicable retiree component plan and resolve all questions relating to claims for benefits under the retiree component plan. If you think you are eligible for a certain benefit from any retiree component plan but believe you are not receiving that benefit, you must submit a claim to receive that benefit.

Specific instructions about submitting claims are included in each chapter of this handbook. Generally, claims must be submitted in writing. Often, there are time limits for submitting your claims. Make sure you know the time limits of each retiree component plan. If you delay submitting your claim, you could lose benefits. Your claim is not considered submitted until you have provided any additional documentation that is necessary for the claim.

Once your claim has been documented and you have filled out any and all necessary forms, your claim generally is processed within 90 days after it is received. Special circumstances may require an extension for processing the claim. If this happens, you will be notified that additional time, not to exceed another 90 days, is required to process the claim.

Note: Special time frames apply to claims filed and requests for review under the Bank of America health plans. See **Health plans claim and review time limits** (page 130 in the online version of the 2021 Retiree SPD) for more information.



If your claim is denied, you will be notified in writing. This written notice will tell you the reason for the denial. It also will point out what additional information is needed, if any, that could change the decision to deny the claim. Finally, the notice will tell you how you can have the decision reviewed.

Appendix

Change: Vision plan cost share for covered services

The following information relates to cost sharing for covered vision services as described on pages 222–224 of the online version of the 2021 Retiree SPD. Changes to the previously documented information are highlighted in gray.

Covered services

Type of service or supply	In-network	Out-of-network
Exams and other services		
Routine vision exams	**Routine eye exam:** $10 copay, limited to one per calendar year **Standard contact lens exam:** $0 copay; limited to two fit and follow-up visits every calendar year **Premium contact lens exam:** 10% off and $40 allowance; limited to one fit and follow-up visit every calendar year	Up to $40 reimbursement; limited to one exam per calendar year
LASIK surgery	15% off retail price or 5% off promotional price for LASIK surgery through U.S. Laser Network	Not covered
PRK surgery	15% off retail price or 5% off promotional price for PRK surgery through U.S. Laser Network	Not covered
Lenses (in lieu of contact lenses) and frames		
Single vision	100% covered; limited to standard uncoated plastic lenses once per calendar year in lieu of contacts; $130 frame allowance once every other calendar year; 20% discount applies thereafter	Up to $40 lens reimbursement, limited to once per calendar year; $55 frame reimbursement, limited to once every other calendar year
Bifocal	100% covered; limited to standard uncoated plastic lenses once per calendar year in lieu of contacts; $130 frame allowance once every other calendar year; 20% discount applies thereafter	Up to $60 lens reimbursement, limited to once per calendar year; $55 frame reimbursement, limited to once every other calendar year
Trifocal	100% covered; limited to standard uncoated plastic lenses once per calendar year; $130 frame allowance once every other calendar year; 20% discount applies thereafter	Up to $80 lens reimbursement, limited to once per calendar year; $55 frame reimbursement, limited to once every other calendar year

Type of service or supply	In-network	Out-of-network
Progressives	**Standard progressives:** $65 copay **Premium progressives:** **Tier 1: $85 copay** **Tier 2: $95 copay** **Tier 3: $110 copay**	Plan pays a reimbursement, up to $60
Polycarbonate lenses	You pay $30 for children and adults, $130 frame allowance once every other calendar year	Up to $7
Frames	Covered up to $130 once every other calendar year; 20% off balance over $130	$55 allowance for frames, limited to once every other calendar year
Lenticular	Not covered	Not covered
Coatings	**UV:** You pay $15 **Standard scratch coating:** You pay $15 **Anti-reflective coating:** You pay $45	Not covered
Tints	$15 (solid and gradient)	Not covered
Contact lenses		
Standard lens fit and follow-up	0% copay, limited to once every calendar year	Up to $40, limited to once every calendar year
Premium lens fit and follow-up	$40 allowance once per calendar year; 10% discount applies thereafter	Not covered
Medically necessary prescription lenses for specific eye conditions that would prohibit the use of glasses; prior approval is needed	100% covered; limited to once every calendar year	Up to $210 reimbursement; limited to once every calendar year
Elective prescription lenses; one order per calendar year in lieu of lenses	$125 allowance (conventional or disposable); 15% discount thereafter for conventional lenses only	Up to $105 reimbursement

Contact information

For information about retiree medical, dental and vision coverage, contact your carrier directly. If you have questions about your benefits or the information in this SMM, please call the Global HR Service Center at **800.556.6044.** Representatives are available Monday through Friday, 8 a.m. to 8 p.m. Eastern (excluding certain holidays).

This document is a summary of material modifications (SMM) of the *2021 Bank of America Retiree Health & Insurance Summary Plan Description* (2021 Retiree SPD).

The 2021 Retiree SPD describes certain component plans under the Bank of America Retiree Group Benefits Program and describes the Bank of America-sponsored medical plans available to retired individuals as revised and effective on and after Jan. 1, 2022.

This SMM supersedes and replaces any prior communications, policies, rules, practices, standards and guidelines to the contrary, whether written or oral. Receipt of this SMM does not make you eligible for a benefit described in this SMM or the 2021 Retiree SPD. To be eligible for a benefit described in this SMM or the 2021 Retiree SPD, you must meet all requirements for such a benefit. If there is any conflict or inconsistency between the information in this SMM and the terms of the official plan documents or policies, the official plan documents or policies govern.

This document is provided in English. If you have difficulty understanding any part of this document, call the Global HR Service Center for assistance at **800.556.6044.** Representatives are available Monday through Friday, 8 a.m. to 8 p.m. Eastern (excluding certain holidays).

For convenience, the terms “Bank of America,” “bank” and “company” are used in this document to refer to Bank of America Corporation (the plan sponsor), as well as all companies in the Bank of America controlled group of corporations whose former employees participate in the Bank of America Retiree Group Benefits Program. The use of these terms does not mean that you were an employee of Bank of America Corporation.

Bank of America is solely responsible for the content of this document. This communication provides information about certain Bank of America benefits. Receipt of this document does not automatically entitle you to benefits offered by Bank of America.

Every effort has been made to ensure the accuracy of this communication. However, if there are discrepancies between this communication and the official plan documents and policies, the plan documents and policies will always govern. Bank of America retains the discretion to interpret the terms or language used in any of its communications according to the provisions contained in the plan documents and policies. Bank of America also reserves the right to amend or terminate any benefit plan or policy in its sole discretion at any time for any reason.

Notes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