BANK OF AMERICA

2023 Bank of America 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 material changes to a plan.

What does this document include?

This document includes a summary of certain coverage changes that we made to certain health and insurance component plans under the Bank of America Group Benefits Program that became effective on Jan. 1, 2023 (unless otherwise noted). This document provides an overview of these changes by topic, as well as clarifications to certain other plan provisions.

Who is this document for?

This document is for employees and beneficiaries who are participating in the Bank of America Group Benefits Program.

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This SMM should be read in conjunction with the *2021 Bank of America Health & Insurance SPD* (2021 H&I SPD) and the *2022 Bank of America Health & Insurance SMM* (2022 H&I SMM). Please keep this document with your other Bank of America benefit plan materials so you'll have up-to-date information on your benefit plans.

You can also visit My Benefits Resources (**mybenefitsresources.bankofamerica.com**) or go to HR Connect (**hrconnect.bankofamerica.com**) > **Benefits** > **Health** > **Eligibility & enrollment** > **Resources** > **Summary Plan Descriptions and Summaries of Material Modifications** to access these documents online.

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).

Also, please note that all page number references in this SMM are based on the online version of the 2021 H&I SPD.

About this summary plan description

Clarification: International assignee determination

The determination for international assignee status has been clarified under About this summary plan description at the beginning of the 2021 H&I SPD. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.

This document is a summary plan description (SPD) for certain component plans under the Bank of America Group Benefits Program ("Group Benefits Program") and is generally effective Jan. 1, 2021, unless otherwise noted. It applies to current U.S.-based employees who have met the defined eligibility requirements for each component plan. Certain benefits included also apply to international assignees ~~whose designated home or host country is the U.S.~~ (as designated in the HR system of record).

Change: Medical plan names

*The Banner|Aetna medical plan names in the list of plans covered by the 2021 H&I SPD (found at the beginning of the SPD under **About this summary plan description**) have been renamed to be inclusive of other Accountable Care Organization (ACO)/special networks in addition to Banner|Aetna, such as Aetna's Baptist Health & St. Vincent's HealthCare and Texas Health Aetna. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

- ~~Banner|Aetna~~ Accountable Care Organization (ACO)/special network Comprehensive Plan
- ~~Banner|Aetna~~ Accountable Care Organization (ACO)/special network Consumer Directed Plan
- ~~Banner|Aetna~~ Accountable Care Organization (ACO)/special network Consumer Directed High Deductible Plan

Eligibility and enrollment

Clarification: Benefits requiring an election

*The chart at the beginning of the **Eligibility and enrollment** chapter on page 1 of the online version of the 2021 H&I SPD has been updated to reference another benefit that requires an election. The change is highlighted in gray.*

Benefits requiring an election
(These are available when you first become eligible and during Annual Benefits Enrollment. Some can be elected when you experience a qualified status change.)
	• Medical
	• Health care accounts:
	  ◦ Health Savings Account (HSA)
	  Depending on medical plan enrollment and other eligibility requirements (not an ERISA plan)
	  ◦ Health Reimbursement Arrangement (HRA)
	  Depending on medical plan enrollment and other eligibility requirements
	  ◦ Health Flexible Spending Account (Health FSA)
	  ◦ Limited Purpose Flexible Spending Account (Limited Purpose FSA)
	  Depending on medical plan enrollment and enrollment in an HSA
	• Dental
	• Vision
	• Associate supplemental life insurance
	• Dependent life insurance (spouse/partner and dependent child)
	• Accidental death & dismemberment (AD&D) Insurance
	• Basic long-term disability (LTD) (part-time employees only)
	• Supplemental LTD (full-time and part-time employees)
	• Prepaid legal
	• Purchased Time Off (PTO)

Benefits you receive automatically when you become eligible	• Employee Assistance Program (EAP) • Short-term disability (subject to one year of continuous service) • Basic LTD (full-time employees only) • Associate basic life insurance • Business travel accident (BTA) insurance

Clarification: International assignee determination

*The determination for international assignee status has been clarified in the **Employee eligibility** section on page 2 of the online version of the 2021 H&I SPD. Changes are highlighted in gray.*

Employee eligibility

You're eligible for certain benefits depending on your work status. The terms below will be used throughout this SPD to indicate employee benefits eligibility.

- **Full-time:** An employee whose regularly scheduled hours are 37.5 or more per week (entered as weekly scheduled hours in the payroll system).
- **Part-time:** An employee whose regularly scheduled hours are 20 or more per week but fewer than 37.5 per week (entered as weekly scheduled hours in the payroll system). Part-time employees whose regularly scheduled hours are 20 or more per week generally are eligible for benefits.
- **Part-time scheduled for fewer than 20 hours:** An employee whose regularly scheduled hours are fewer than 20 per week (entered as weekly scheduled hours in the payroll system). Part-time employees whose regularly scheduled hours are fewer than 20 per week generally aren't eligible for the benefits in this SPD.
- **Temporary:** A temporary employee who works at Bank of America on an hourly basis. Temporary employees generally aren't eligible for benefits.

Generally, you're eligible for the benefits described in this SPD if you meet all the following requirements:

- You're an active full-time or part-time employee under the company's Global HR policies.
- You've completed one full month of continuous full- or part-time active employment, not including the month you began working. For example, if your first day of employment is in May, you'll be eligible for benefits on July 1. (If you move from part-time scheduled for fewer than 20 hours status to part-time or full-time status in May, you'll also be eligible for benefits on July 1.)
- You're working for an employer who is participating in the benefits described in this SPD, or you're an international assignee (as designated in the HR system of record).

Note: International assignees and Cayman Island employees are eligible for certain benefits related to life and disability insurance. Please refer to your Letter of Understanding for confirmation of your benefits.

Addition: If you're taking additional paid time away through the Bank of America Sabbatical Program

*The following section about benefits while on a sabbatical has been added after the **If you're disabled and qualify for Medicare** section on page 4 of the online version of the 2021 H&I SPD.*

If you're taking additional paid time away through the Bank of America Sabbatical Program

For U.S. employees, your participation in your elected health and insurance plans will continue with all required deductions being withheld through regular payroll. Bank of America will continue to pay the company's portion of your health and insurance benefits. In addition, vacation and occasional illness time will continue to accrue while on sabbatical.

If you're based outside the U.S., compensation and benefits coverage shall continue unless there are specific local regulatory requirements. If you have any questions, please work with your local HR contact center.

Clarification: Proof of disability requirement when covering a disabled child past age 25

*The **Note** at the top of page 6 of the online version at the end of the **Children** section under **Dependent eligibility** in the 2021 H&I SPD is replaced in its entirety by the following.*

Note

You must submit medical proof of disability to cover a disabled child past age 25. For example, proof is required:

- Before the child reaches age 26 if he or she is already covered under the bank's benefits
- Within 31 days of your initial enrollment in the bank's benefits if you have a disabled child age 26 or older and elect coverage for him or her

You may also be requested by the plan's claims administrators to provide proof of continued disability at any time once your disabled child reaches age 26.

Clarifications: When benefit elections may be changed during the year due to a qualified status change

*The following information clarifies when benefit elections may be changed during the plan year as described under the **Qualified status changes** section on pages 13 – 14 of the online version of the 2021 H&I SPD. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

Qualified status changes

After Annual Benefits Enrollment, your benefit elections remain in effect for the next plan year, which is also the calendar year (Jan. 1 through Dec. 31). You may not change your elections until the next Annual Benefits Enrollment period unless you have a qualified status change during the plan year that allows for election changes, and you apply for the change within 31 calendar days of the event (or 60 calendar days, if applicable as noted below) by calling the Global HR Service Center or going to My Benefits Resources. Your requested change must be on account of and correspond with your qualified status change. For example, after the birth of a child, you may add the child to your existing medical plan, but you may not change to a new medical plan.

Note

There is one exception to this rule: If you enroll in an Accountable Care Organization (ACO)/special network plan — such as Banner|Aetna, Aetna's Baptist Health & St. Vincent's HealthCare or Texas Health Aetna — when you first become eligible for benefits or during Annual Benefits Enrollment but would like to move to a different carrier, you may change to a different carrier, but you must do so within three months of the date your enrollment in the ACO/special network plan becomes effective.

If you don't provide notification within 31 calendar days of the qualified status change, you won't be able to make changes until the next Annual Benefits Enrollment. The notification period with respect to qualified status changes associated with HIPAA special enrollment rights involving the loss of eligibility for Medicaid or CHIP coverage, or eligibility for a state premium assistance subsidy from Medicaid or CHIP, is extended to 60 days after the event.

The following are examples of qualified status changes:

- You have a change in legal marital status (such as through marriage, divorce, legal separation or annulment).
- You gain or lose a dependent (such as through marriage, birth, adoption, placement for adoption, death, divorce, legal separation or annulment).

- You have a change in employment status that affects your plan eligibility (such as a change between full-time or part-time status, a reduction in part-time work to be regularly scheduled for fewer than 20 hour per week, beginning or returning from an unpaid leave of absence, or otherwise).
- Your employment ends and you're rehired more than 30 days but fewer than 181 days after your termination date.
- Your dependent is no longer eligible for coverage (such as due to death, aging out of dependent status or otherwise).
- You move to a new location outside of your current medical or dental network service area.
- You incur a significant cost change in the benefit option(s) you currently have in place (not applicable to Health FSA or Limited Purpose FSA coverage).
- You, your covered spouse or partner or your covered dependent(s) experiences a significant curtailment or termination of coverage under the benefit option(s) you currently have in place (not applicable to Health FSA or Limited Purpose FSA coverage).
- You, your spouse or partner or your dependent changes coverage under another employer's plan due to a qualified status change or during that plan's Annual Benefits Enrollment period that doesn't correspond with the bank's Annual Benefits Enrollment period.
- Your spouse, partner or dependent starts or returns from a strike or lockout.
- You gain eligibility for and enroll in health care coverage through another employer while on severance.
- You, your spouse or partner or your dependent becomes entitled to HIPAA special enrollment rights with respect to group health plan coverage (such as upon the loss of eligibility for non-COBRA coverage, the termination of employer contributions toward non-COBRA coverage or the exhaustion of COBRA coverage; upon the acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; upon your or your dependent's loss of eligibility for Medicaid or CHIP coverage; or upon your or your dependent's eligibility for a state premium assistance subsidy from Medicaid or CHIP).
- You or your spouse or partner receives a judgment, decree or court order requiring coverage to be provided for an eligible dependent child (not applicable with respect to coverage for a former spouse or partner).
- You, your spouse or partner or your dependent(s) enrolled in major medical, dental, vision, Health FSA and Limited Purpose FSA coverage becomes entitled to, or loses eligibility for, Medicare or Medicaid (not applicable to Dependent Care FSA).
- You, your spouse or partner or your dependent(s) enrolls in individual coverage through the Health Insurance Marketplace exchange (only applicable to revoking major medical coverage).
- ~~You gain or lose a dependent (through marriage, birth, adoption, placement for adoption, death, divorce, legal separation or annulment)~~
- ~~You have a change between full-time or part-time status, and part-time regularly scheduled for fewer than 20 hours~~
- ~~You begin or return from an unpaid leave of absence~~

- ~~Your employment ends and you're rehired more than 30 days but fewer than 181 days after your termination date~~
- ~~You move to a new location outside your current medical or dental network~~
- ~~You or your spouse or partner receive(s) a judgment, decree or court order requiring coverage to be provided for an eligible dependent child~~
- ~~Your COBRA coverage or your spouse's or partner's COBRA coverage from another employer ends~~
- ~~You lose eligibility under your parent's plan~~
- ~~You, your spouse or partner, or your dependent(s) experience(s) a significant curtailment or termination of medical, dental or vision coverage~~
- ~~You or one of your eligible dependents dies~~
- ~~Your dependent is no longer eligible for coverage~~
- ~~Your spouse, partner or dependent gains or loses coverage through employment or Medicare~~
- ~~Your spouse, partner or dependent experiences a significant increase in coverage cost~~
- ~~Your spouse, partner or dependent starts or returns from a strike or lockout~~
- ~~Your spouse, partner or dependent changes coverage under another employer's plan due to a qualified status change or during that plan's Annual Benefits Enrollment period that doesn't correspond with the bank's Annual Benefits Enrollment period~~
- ~~You gain eligibility for and enroll in health care coverage through another employer while on severance~~

Note

Medical or other insurance carriers aren't able to change your benefit elections after a qualified status change. Initiating a medical or parental leave will also not change your benefit elections.

You must contact the Global HR Service Center or go to My Benefits Resources to process the qualified status change within 31 days of the event.

Medical

Change: Medical plan names

*The Banner|Aetna reference in the **Medical plan availability based on location** section on page 22 of the online version of the 2021 H&I SPD has been updated to be inclusive of all bank ACO/special networks in addition to Banner|Aetna, such as Aetna's Baptist Health & St. Vincent's HealthCare and Texas Health Aetna. Other clarifications have also been made to this section. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

Medical plan availability based on location

These plans have limited availability as determined by where you live.

Plan	Who it's offered to
Out-of-area plans (Comprehensive, Consumer Directed or Consumer Directed High Deductible)	U.S.-based employees whose home ZIP code falls outside the network provider service area
Kaiser Permanente plans (Comprehensive, Consumer Directed or Consumer Directed High Deductible)	Employees in these ZIP code-based service areas: Colorado, Georgia, Mid-Atlantic, Northwest, Northern California, Southern California and Washington State **Note:** Contact your carrier for plan information.
~~**Banner|Aetna**~~ **ACO/special network plans** (Comprehensive, Consumer Directed or Consumer Directed High Deductible)	Available only to employees in these ZIP code-based service areas: Dallas, Texas; Jacksonville, Florida; and Phoenix and Tucson, Arizona regions **Note:** Contact your carrier for plan information.
HMSA Hawaii PPO Plan	Employees who live in Hawaii **Note:** Contact your carrier for plan information.
Triple-S Salud Plan	Employees who live in Puerto Rico **Note:** Contact your carrier for plan information.
Aetna International Health Plan **Note:** This plan is described in a separate SPD that's provided to eligible employees.	International assignees, Cayman Island employees and benefits-eligible employees who live in Guam or the U.S. Virgin Islands

Clarification: Life insurance coverage for international assignees

*The following clarification has been made to the **Life insurance** section on page 25 of the online version of the 2021 H&I SPD. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

Life insurance

Bank of America offers Associate Basic Life Insurance, Associate Supplemental Life Insurance and Dependent Life Insurance to benefits-eligible full-time and part-time employees.

International assignees (as designated in the HR system of record) are eligible for life insurance in certain cases. Refer to your Letter of Understanding or contact the **MyBenefitChoices International helpdesk** at **00800.4772.4772** or **+44.1244.825.444** for additional information.

Clarification: Long-term disability for international assignees

*The following clarification has been made to the **Long-term disability (LTD)** section on page 27 of the online version of the 2021 H&I SPD. Additions are highlighted in gray.*

Long-term disability (LTD)

Full- and part-time U.S. employees with at least one full month of continuous service, not including the month of hire, as of the date of disability may be eligible for LTD benefits. For full LTD eligibility rules, please see the **Long-term disability** chapter (in the 2021 H&I SPD).

International assignees (as designated in the HR system of record) are eligible for LTD benefits in certain cases. Refer to your Letter of Understanding or contact the **MyBenefitChoices International helpdesk** at **00800.4772.4772** or **+44.1244.825.444** for additional information.

Change: Medical plan names

The Banner|Aetna medical plan names at the top of page 28 of the online version of the 2021 H&I SPD have been renamed to be inclusive of all bank ACO/special networks in addition to Banner|Aetna, such as Aetna's Baptist Health & St. Vincent's HealthCare and Texas Health Aetna. In addition, all references to Kaiser have been updated to Kaiser Permanente in all places where "Kaiser" currently appears in the SPD. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.

Bank of America offers the following medical plans:

- Comprehensive PPO Plan — Aetna, Anthem and UHC
- ~~Banner|Aetna~~ ACO/special network Comprehensive PPO Plan[1]
- Kaiser Permanente Comprehensive Plan
- Comprehensive Out-of-Area Plan — Aetna, Anthem or UHC
- Consumer Directed Plan — Aetna, Anthem, UHC and Kaiser Permanente
- ~~Banner|Aetna~~ ACO/special network Consumer Directed Plan[1]
- Consumer Directed Out-of-Area Plan — Aetna, Anthem and UHC
- Consumer Directed High Deductible Plan — Aetna, Anthem, UHC and Kaiser Permanente
- ~~Banner|Aetna~~ ACO/special network Consumer Directed High Deductible Plan[1]
- Consumer Directed High Deductible Out-of-Area Plan — Aetna, Anthem and UHC
- HMSA Hawaii PPO Plan
- Triple-S Salud Plan

[1] If you enroll in ~~Banner | Aetna~~ an ACO/special network plan but would like to move to a different carrier, you may change to a different carrier, but you must do so within three months of the date your initial enrollment in the ~~Banner | Aetna~~ ACO/special network plan becomes effective.

Change: How you pay for care

*The Banner|Aetna network references in the **How you pay for care** section on page 30 of the online version of the 2021 H&I SPD have been renamed to be inclusive of all bank ACO/special networks in addition to Banner|Aetna, such as Aetna's Baptist Health & St. Vincent's HealthCare and Texas Health Aetna. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

How you pay for care

All the plans provide quality health care, a wide array of medical services, preventive care and prescription drug coverage with certain generic and brand name preventive prescriptions at no cost to you when purchased from an in-network pharmacy (based on health care reform guidelines) in the Aetna, Anthem and UHC plans. The plans differ by how you pay for care.

- In the Comprehensive PPO Plan and Kaiser Permanente Comprehensive Plan, you pay a copay for in-network doctor office visits and prescription drugs. You pay 100% for other care until you reach the deductible ~~(~~except for in-network preventive care and preventive prescription drugs). After you reach the deductible, you pay coinsurance until you reach the out-of-pocket maximum. Once you meet the out-of-pocket maximum, the plan will pay 100% of any additional eligible expenses for the rest of the plan year.
- In the Consumer Directed Plan, you pay the full negotiated rate for medical care (except for in-network preventive care, nonpreventive primary care visits and prescription drugs) until you reach the deductible. After you reach the deductible, you pay coinsurance (within allowed amount limits) until you reach the out-of-pocket maximum. Once you meet the out-of-pocket maximum, the plan will pay 100% of any additional eligible expenses for the rest of the plan year.
- In the Consumer Directed High Deductible Plan, you pay the full negotiated rate for medical care (except for in-network preventive care and preventive prescription drugs) until you reach the deductible. After you reach the deductible, you pay coinsurance (within allowed amount limits) until you reach the out-of-pocket maximum. Once you meet the out-of-pocket maximum, the plan will pay 100% of any additional eligible expenses for the rest of the plan year.
- ~~Plans through Banner|Aetna~~ ACO/special network plans will only cover health care services received from in-network providers. With the exception of emergencies (see **Emergency care** in the 2021 H&I SPD), health care services will **not** be covered when received from providers outside the ~~Banner|Aetna~~ ACO/special network (including providers in the traditional Aetna network). When traveling outside the ~~Banner|Aetna~~ ACO/special network service area, in-network care will be covered through Aetna's national network.

There are instances that do not apply to the out-of-pocket maximum and for which you'll continue to pay health care expenses even after you've met the out-of-pocket maximum. For example, you're responsible for paying any amount over the plan's allowed amount. You're also responsible for paying any penalties if you don't receive precertification for care that requires it. View the **Precertification requirements** section of the 2021 H&I SPD to learn more.

Addition: Database of network providers

*The following information relates to the **Participating providers** section on page 32 of the online version of the 2021 H&I SPD. Additions are highlighted in gray.*

Participating providers

If you're enrolled in the Comprehensive PPO Plan, Kaiser Permanente Comprehensive Plan, Consumer Directed Plan or Consumer Directed High Deductible Plan, you receive the highest level of benefits when you use participating providers. A participating provider is a physician, hospital, laboratory or facility that has agreed to participate in the plan's network of providers and accept the negotiated rates and deductible, copays (if applicable) and coinsurance amounts as payment in full for services rendered. Refer to the **Contacts** chapter (in the 2021 H&I SPD) to find a network provider.

Each medical plan maintains a database on its public website that lists the name, address, specialty, telephone number and digital contact information for each provider that directly or indirectly participates in the network. At least every 90 days, the medical plans will verify directory information and update the database. The medical plans will remove providers for whom it cannot verify information and will update the database within two business days of receiving new or revised information from a provider that affects the directory.

If you request information about the network by telephone or other electronic, web-based or internet-based means, your medical plan will respond as soon as practicable, but at least within one business day. A written response will be provided in print or electronically, as you request.

If you are incorrectly informed by a provider office that a specific provider participates in the network, the in-network deductible and out-of-pocket maximum will apply. You will not be required to pay a cost-sharing amount higher than the in-network amount that would have applied.

Addition: Continuity of care

*The following section about continuity of care has been added after the **Participating providers** section on page 32 of the online version of the 2021 H&I SPD.*

Continuity of care

If you are in the middle of a course of treatment (a continuing care patient) and your in-network provider no longer has a contractual relationship with your medical plan, you may continue to receive care for certain services at the in-network benefit level for up to 90 days after your provider became an out-of-network provider.

Clarification: Midyear plan changes

*The following information relates to the **Midyear plan changes** section on pages 36 – 37 of the online version of the 2021 H&I SPD. Additions are highlighted in gray.*

Midyear plan changes

If you switch from one plan to another during the year, the expenses you paid toward the deductible and out-of-pocket maximum under your original plan generally won't be applied to the deductible and out-of-pocket maximum under your new plan. Here are examples of when you might switch medical plans midyear:

- From a medical plan offered to active employees to a medical plan offered to retirees not eligible for Medicare (and vice versa)
- From a medical plan offered to active employees to a medical plan offered to retirees eligible for Medicare (and vice versa)
- From a medical plan offered to participants not eligible for Medicare to a medical plan offered to participants eligible for Medicare (for example, retiree medical or participants on LTD leave)
- From one medical plan carrier to another (for example, if your primary residence changes and you're no longer eligible for your current medical plan carrier's plans)
- U.S.-based employees starting or ending an international assignment

Please note that other situations may apply.

Clarification: Skilled nursing facility care

*The following information clarifies the type of skilled nursing care facilities that qualify for coverage under the medical plans as described in the **Specialty and outpatient care** section on pages 42 – 43 of the online version of the 2021 H&I SPD. Additions are highlighted in gray.*

Specialty and outpatient care

- Skilled nursing facility care:
    - When you're recuperating from an illness or injury, your physician may recommend that you receive treatment in a skilled nursing facility. Your stay must be preapproved by your medical plan carrier, and coverage for skilled nursing care is limited to 100 days per calendar year.
    - A skilled nursing facility qualifies for coverage under the plans when the facility is accepted by Medicare or when the facility:
        - Is licensed to provide inpatient skilled nursing and physical restoration services by an appropriate state licensing board or is accredited by the Joint Commission Accreditation of Healthcare Organizations
        - Is under the supervision of a physician or registered nurse and provides 24-hour patient care by a staff of licensed nurses under the direction of a full-time registered nurse
        - Has an active use-review plan for all patients

- Is not a place for rest, the aged, alcohol/substance abuse patients, custodial or educational care or care of mental health disorders or intellectual disability
- Nursing services and restorative services must be received by the patient, and the care received must be expected to improve the patient's condition and facilitate discharge from the skilled nursing facility.

Change: Inpatient services

*The following information is an update to the **Inpatient services** section on pages 44 – 45 of the online version of the 2021 H&I SPD. Additions are highlighted in gray.*

Inpatient services

In addition to inpatient care pursuant to a treatment plan approved by your medical plan carrier, the plans cover the following inpatient services unless otherwise noted:

- Room and board up to the hospital's charge for a semiprivate room, including all meals and dietary services, general nursing care, drugs and oxygen, blood and plasma, X-rays and laboratory tests
- Hospital special care units
- Operating rooms, anesthetic supplies furnished by the hospital and surgical supplies, dressings and cast materials
- Physician charges
- Hospice facilities
- Special care units
- Rehabilitation services
- Skilled nursing facility care

Enhancement: Family Support program through Maven

*The following information is an update to the **Prenatal care/maternity care** section on page 47 of the online version of the 2021 H&I SPD. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

Prenatal care/maternity care

The Family Support program through Maven® is available to all U.S.-based employees and dependents enrolled in an Aetna, an Anthem or a UHC medical plan. Kaiser Permanente members have access to similar resources through Kaiser Permanente.

This confidential program provides ~~new~~ parents and future parents expert guidance through pregnancy, fertility, egg freezing, adoption, surrogacy, infancy, postpartum, ~~and~~ the transition back to work and early parenthood. You will have access to Family Support from preconception for fertility and surrogacy and conception in all other instances through the first ~~12 months~~ five years after a child is born or adopted.

You and your covered dependents can use the Maven app or website to access this program. To learn more about the Family Support program, visit HR Connect > **Benefits** > **Pregnancy, adoption, fertility & infancy support**.

Enhancement: Elimination of medical diagnosis of infertility requirement

A medical diagnosis of infertility is no longer required for the plan to pay benefits for certain covered fertility and preservation services. Therefore, footnote 1 under ***Covered expenses*** *in the* ***Fertility reimbursement*** *section on pages 50 – 51 of the online version of the 2021 H&I SPD no longer applies. Deletions to the previously documented information appear as ~~strikethrough~~ text.*

Covered expenses

To receive reimbursement for eligible fertility and preservation:

- The expenses must have been incurred while you (and/or your spouse or partner) were an eligible Bank of America employee enrolled in a U.S. bank medical plan.
- You must request reimbursement within 180 calendar days of the date of service.
- You can't receive reimbursement for the submitted expenses through financial assistance from other sources, such as your spouse's or partner's employer.

Unless otherwise noted, the following expenses are eligible for fertility reimbursement:

- Artificial insemination, including intrauterine insemination (IUI)
- In vitro fertilization (IVF), including:
  - Intracytoplasmic sperm injection (ICSI) and assisted hatching
  - Preimplantation genetic screening (PGS)
  - All medical tests and associated procedures to improve the likelihood of pregnancy success, including treatment by acupuncture or acupressure if it is performed by a physician and used as anesthesia for covered surgery
- Gamete intrafallopian tube transfer (GIFT), including:
  - Removal of egg and then mixing with sperm
  - Transfer of mixture into fallopian tubes
- Zygote intrafallopian tube transfer (ZIFT), including the transfer of a fertilized egg into the fallopian tubes
- Required medication (such as hormone medication)
- Egg or sperm extraction and freezing
- Thawing of the embryos, eggs or sperm
- Fertilization
- Embryo freezing, transfers or implantation
- Embryo/egg/sperm bank fees, including ongoing storage cost fees

- Gestational carriers[1]
- Reversal of sterilization[1]
- Purchase of donor sperm and any charges associated with the storage of the sperm[1]
- Egg or sperm donor screening costs[1]
- Purchase of donor eggs and any charges associated with the care of the donor as required for donor egg retrievals or transfers for gestational carriers. Prescription or medical-related costs for individuals who are not enrolled in a Bank of America medical plan aren't reimbursable.[1]
- Legal fees for donor eggs[1]

Addition: Menopause support through Maven

*The following section about menopause support has been added after the **Fertility reimbursement** section on pages 49 – 52 of the online version of the 2021 H&I SPD.*

Menopause support

The Menopause & Ongoing Care program through Maven® is available to all U.S.-based employees and dependents enrolled in an Aetna, an Anthem or a UHC medical plan.

This program offers members who are going through perimenopause or menopause with 24/7 access to dedicated Care Advocates, virtual access to providers who specialize in menopause and clinically sound education resources. Support areas include symptom detection and navigation; guidance on the best steps for treatment; referrals for in-person care; management of the physical and emotional impacts of menopause and more.

You and your covered dependents can use the Maven Clinic app or website to access this program. To learn more about the Family Support program, visit HR Connect > **Benefits** > **Menopause support**.

Change: Organ transplants travel and lodging benefit

*The **Travel and lodging benefit** section under **Organ transplants** on page 55 of the online version of the 2021 H&I SPD has been removed in its entirety and replaced by a more comprehensive travel and lodging benefit summary. (See the next section that follows in this SMM for the new content.)*

[1] ~~Eligible reimbursement expenses for employees and/or their spouse or partner who have a medical diagnosis of infertility.~~

Addition: Travel and lodging benefit

*The following section has been added to the **Covered medical services** section of the SPD after **Organ transplants** on page 54 of the online version of the 2021 H&I SPD.*

Travel and lodging benefit

You and your covered dependents are eligible for travel and lodging benefits for care received within the U.S. as follows (subject to appropriate legal guidelines):

- Covered organ transplant at an in-network Center of Excellence/Institute of Excellence/Center of Medical Excellence ("COE/IOE/CME")
- Covered cancer treatment at an in-network facility or provider
- Covered admission to an in-network behavioral health hospital or facility for treatment of mental illness or substance use disorder
- Certain covered reproductive health services (abortion, fibroid embolization/ablation and selective reduction)

Note

The plans pay up to a combined lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the benefit recipient and companion(s) for care related to organ transplants, cancer and certain women's reproductive services.

Transplant services include evaluation, candidacy, transplant event and post-transplant care. Your medical plan carrier may require preapproval for inpatient services.

Travel expenses for the person receiving care include charges for:

- Transportation to and from the treatment site or other medical facility where covered services are being provided (must be greater than 100 miles from your home) for the patient and one companion who is traveling on the same day(s)
- Lodging while at, or while traveling to and from, the treatment site where covered services are being provided for the patient (while not confined) and one companion, limited to a maximum of $50 per day for one person or $100 per day for two people

Travel expenses don't include charges for:

- Transportation, lodging and food associated with an organ transplant performed at a facility other than the approved organ transplant COE/IOE/CME, or to any other treatment site or medical facility that does not provide covered services

- Travel within 100 miles of your home
- Food while at, or traveling to and from, the treatment site
- Air ambulance travel
- Laundry bills
- Telephone bills
- Alcohol or tobacco products
- Transportation charges that exceed coach-class rates
- Child care expenses

Travel benefits may be considered taxable income by the IRS. Please consult with a tax advisor for more information.

Addition: Definition of a continuing care patient

*The following definition of a continuing care patient has been added after the **Clinical Policy Bulletins** definition on page 69 of the online version of the 2021 H&I SPD.*

Continuing care patient

A continuing care patient is someone who is:

- Undergoing a course of treatment for a serious and complex condition (as defined in the Consolidated Appropriations Act, 2021) from a provider or facility
- Undergoing a course of institutional or inpatient care from a provider or facility
- Scheduled to undergo nonelective surgery from a provider or facility, including receipt of postoperative care from such provider or facility with respect to such surgery
- Pregnant and undergoing a course of treatment for pregnancy from a provider or facility; or
- Determined to be terminally ill (as determined under the section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from a provider or facility

Health care accounts

Change: Contribution limits

The following information relates to maximum employee and employer contribution amounts as described on page 78 of the online version of the 2021 H&I SPD. Changes to the previously documented information are highlighted in gray.

The contribution maximums for the Health Flexible Spending Account (FSA), Health Savings Account (HSA) and Limited Purpose FSA increased as of Jan. 1, 2023. See the chart that follows for a summary of the changes.

	Health Flexible Spending Account (Health FSA)[1]	Health Reimbursement Arrangement (HRA)	Health Savings Account (HSA)[1]	Limited Purpose Flexible Spending Account (Limited Purpose FSA)[1]
What is the maximum amount that the bank and I combined can put in this account?[1,2]	**$3,050** — The IRS pretax contribution limit (employee contributions only)	The IRS does not allow employee contributions to an HRA and does not impose a legally required maximum on bank contributions.	**$3,850** —Employee-only coverage **$7,750** — Family coverage If you'll be at least 55 years old in 2023, you can make an additional **$1,000** catch-up contribution.	**$3,050** — The IRS pretax contribution limit (employee contributions only)

[1] California and New Jersey tax employer and employee contributions to HSAs. New Jersey taxes employee contributions to Health and Limited Purpose FSAs.

[2] Contribution limits are for 2023 and may change in future years.

Wellness

Change: Eligible wellness activities

*The following information replaces the **Wellness activities** subsection under **Wellness** on pages 103 – 104 of the online version of the 2021 H&I SPD and pages 13 – 16 of the online version of the 2022 H&I SMM.*

Wellness activities

The health screening, health questionnaire and attestation that you have a primary care physician and have had an annual physical examination within the last 12 months are voluntary activities you may complete to maintain your 2023 wellness credit. You must complete and submit the health screening and health questionnaire by the wellness activities deadline for you to maintain at least a portion of your wellness credit. To maintain the remaining portion of the credit, you must attest that you have a primary care physician and have had an annual physical examination within the last 12 months. A spouse, partner or other adult dependent who is enrolled as a dependent in a wellness-eligible medical plan can also complete and submit the health screening and health questionnaire by the wellness activities deadline to maintain at least a portion of their credit. To maintain the remaining portion of their credit, they must attest that they have a primary care physician and have had an annual physical examination within the last 12 months by the wellness activities deadline.

Health screening

The health screening measures your height, weight, blood pressure, waist and total cholesterol, which requires a blood test. If waist measurement isn't available, the health screening will be considered complete as long as your height, weight, blood pressure and total cholesterol are included. Regardless of the medical plan in which you're enrolled, you may choose to complete your health screening before the wellness activities deadline in several ways. You and your covered

spouse, partner or other adult dependent can log on to My Wellness > **Programs** to access the available options. You must complete the health screening by the date of your wellness activities deadline to be eligible to maintain the full credit for completion of all the wellness activities.

Health screening results from a visit with your health care provider

If you're enrolled in a wellness-eligible medical plan and re-enroll in a wellness-eligible plan as part of Annual Benefits Enrollment for coverage that starts on Jan. 1, you and your covered spouse, partner or other adult dependent may use results from a health care provider visit that occurred between March 1 of the year you enrolled and the end of February of the new plan year. These results will be used to automatically satisfy the health screening portion of your wellness activities.

If you're newly enrolled in a wellness-eligible medical plan (for example, you're a new hire or have a qualified status change), you can submit results from a previous health screening that occurred on or after March 1 of the previous year by completing a physician form to satisfy the health screening portion of your wellness activities.

If your medical plan carrier is Kaiser Permanente

If you're enrolled in a Kaiser Permanente medical plan and have height, weight, blood pressure and total cholesterol results captured in your Kaiser Permanente Electronic Medical Record from a provider visit that occurred within the last 24 months (60 months for cholesterol), those results may be used to automatically satisfy the health screening portion of your wellness activities.

Health questionnaire

The health questionnaire is an online survey of your overall health and lifestyle risks. You and your covered spouse, partner or other adult dependent can log on to My Wellness > **Programs** to access and complete the questionnaire. If you don't have internet access, you may call My Wellness Member Services for Bank of America at **833.525.5788** or send an email to boa.support@virginpulse.com and ask to complete the questionnaire telephonically. Representatives are available Monday through Friday, 8 a.m. to 9 p.m. Eastern (excluding certain holidays).

You must complete the health questionnaire in full — online by 11:59 p.m. local time or telephonically before the My Wellness Member Services call center closes — on or before the date of your wellness activities deadline to be eligible to receive the full credit for completion of all the wellness activities required to maintain the full credit to your medical plan premium.

Primary care physician and annual physical examination attestation

An annual physical is an exam with your primary care physician (or someone working under their supervision) either in a provider office or virtually. An exam would typically include a review of medical history, checking of vital signs and examination of the heart, lungs, head, neck, abdomen and extremities. It may also include screenings, such as a skin exam or depression screening.

You must attest that you have a primary care physician and have had an annual physical examination within the last 12 months by the wellness activities deadline to satisfy this portion of the 2023 wellness activities.

Your covered spouse, partner or other adult dependent must also attest that they have a primary care physician and have had an annual physical examination within the last 12 months by the wellness activities deadline to satisfy this portion of the 2023 wellness activities. To do so, log on to My Wellness > **Programs**.

If you don't have internet access, you may call My Wellness Member Services for Bank of America at **833.525.5788** or send an email to boa.support@virginpulse.com to discuss options for satisfying the activity. Representatives are available Monday through Friday, 8 a.m. to 9 p.m. Eastern (excluding certain holidays).

Note

If you're enrolled in a wellness-eligible Kaiser Permanente medical plan, you and/or your spouse or partner must register on the Kaiser Permanente engagement site and accept the wellness program agreement in order to be eligible for rewards. The agreement gives Kaiser Permanente permission to disclose information with your wellness program administrator related to your completion of the health screening in order to retain your credit toward your medical plan contribution. If you do not accept this agreement, Kaiser Permanente will not be able to send your health screening completion details to your wellness administrator.

To access the authorization page, log on to kp.org/engage.

Employee Assistance Program

Change: Availability of onsite Employee Assistance Program (EAP) services

*The following information relates to the **Services** section on page 108 of the online version of the 2021 H&I SPD. Additions to the previously documented information are highlighted in gray. Also, as noted in the 2022 H&I SMM, the number of face-to-face counseling sessions was increased to 12 sessions (from six visits as documented in the 2021 H&I SPD).*

EAP services are available 24 hours a day, seven days a week, and offer:

- Unlimited confidential telephone consultations
- Up to 12 face-to-face counseling sessions per issue at no cost

Counseling sessions must be provided by a participating EAP counselor and arranged by calling **866.327.2725** (TTY: Dial 711, then 866.327.2725) 24 hours a day, seven days a week. In-person EAP visits may be available in certain locations. If additional counseling beyond 12 visits is required and you're enrolled in a Bank of America medical plan, the EAP will assist you in obtaining continuation of

therapy with the same counselor (whenever possible) using the behavioral health portion of your medical benefit. The EAP counselor will assist you in identifying an appropriate behavioral health provider under your medical benefit plan. For all continuation of therapy sessions, you may be responsible for any out-of-pocket expenses. Information on your behavioral health benefit under a bank medical plan may be accessed by calling the main customer care number on your medical plan ID card.

EAP resources are available on HR Connect (**hrconnect.bankofamerica.com**) **Benefits** > **Health** > **Emotional wellness** > **Confidential counseling**. From your personal computer or device, go to member.lifecare.com. If you're on international assignment, contact Aetna customer service at **800.231.7729** for specific information regarding access to the EAP.

Deletion: Note with EAP contact information

*The **Note** on page 110 of the online version of the 2021 H&I SPD has been deleted in its entirety.*

Life insurance

Clarification: Life insurance coverage for international assignees

*The following clarification has been made to the Note in the **Associate Basic Life Insurance** section on pages 112 – 113 of the online version of the 2021 H&I SPD. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

Associate Basic Life Insurance

Bank of America provides Associate Basic Life Insurance equal to one times your annual base pay (rounded up to the next $1,000), up to a maximum of $2 million at no cost to you.

For some employees, this coverage amount is calculated based on their Annual Benefits Base Rate (ABBR) as determined by Bank of America. ABBR is based on benefits-eligible compensation earned in the performance year prior to the Annual Benefits Enrollment period (for example, performance year ~~2019~~ 2021 for ~~2021~~ 2023 benefits). If this affects you, you'll get information about ABBR each year in early October. See Annual Benefits Base Rate in the **Eligibility and enrollment** chapter (of the 2021 H&I SPD) for more information on how ABBR is determined.

If your annual base pay rate changes during the year, your Associate Basic Life Insurance coverage amount will be adjusted accordingly.

Non-U.S.-based employees on ~~a short-term~~ international assignment are eligible for Associate Basic Life Insurance.

Imputed income

You're required to pay imputed income tax on the cost of any company-paid life insurance in excess of $50,000. See **Imputed income** in the **Eligibility and enrollment** chapter (of the 2021 H&I SPD) for more information. If your annual base pay exceeds $50,000, you'll have the option to limit your Associate

Basic Life Insurance coverage to $50,000. (Please note that the imputed income is a much lower amount than your actual coverage — it's based on the cost, not the value, of bank-provided coverage over $50,000.)

Note

International assignees (as designated in the HR system of record) are eligible for life insurance in certain cases. Refer to your Letter of Understanding or contact the **MyBenefitChoices International helpdesk** at **00800.4772.4772** or **+44.1244.825.444.**

Short-term disability

Clarification: Definition of behavioral health provider

*The following information relates to eligible behavioral health providers as defined in the **Eligibility for benefits** section on page 136 of the online version of the 2021 H&I SPD. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

Eligibility for benefits

A full- or part-time U.S. employee regularly scheduled to work at least 20 hours per week with a minimum of one year of continuous service as of the date of disability may be eligible for short-term disability. Continuous service for purposes of eligibility for short-term disability benefits generally is measured from your most recent hire date (including if you're rehired after more than 180 days).

An employee on international assignment should contact the **MyBenefitChoices International helpdesk** at **00800.4772.4772**, Option 2, or **+44.1244.825.444**, Option 2, for specific information regarding leave of absence and time off from work provisions while on assignment.

You must be actively at work or on a paid leave of absence (with the exception of Paid Job Search and Paid Suspension) as of the date of your disability to be eligible for short-term disability benefits. Occasional illness days, vacation and PTO are considered actively at work for purposes of short-term disability.

If you're on personal leave or medical leave due to your own pregnancy, you may be eligible to switch to short-term disability leave upon the birth of the child.

You must receive appropriate care and treatment on a continuing basis from an eligible treating health care provider while you're on short-term disability leave.

A treating health care provider is defined as a licensed medical doctor (MD), advanced practice registered nurse (APRN), nurse practitioner (NP), physician assistant (PA) and/or chiropractor who is

treating you for a medical condition. A treating health care provider for behavioral health or substance abuse conditions is defined as a psychiatrist, clinical psychologist or psychiatric nurse practitioner.

Appropriate care and treatment must meet all of the following conditions and be:

- Received from an eligible treating health care provider (as defined above) whose medical training and clinical experience are suitable for treating the disability
- Necessary to meet basic health needs and of demonstrable value
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and government agencies
- Consistent with the diagnosis of the condition
- Intended to maximize medical improvement

~~Non-psychiatrist health care providers~~ A health care provider other than a health care provider for behavioral health or substance abuse conditions (as designated above) may provide treatment for up to 45 days for behavioral health or substance abuse conditions.

Bank of America reserves the right to request a second opinion as a condition of benefit continuation. If you don't qualify for short-term disability benefits, you may qualify for unpaid medical leave as determined by the short-term disability claims administrator.

Clarification: Previously denied short-term disability claims

*The following information relates to the **Applying for short-term disability** section on page 137 of the online version of the 2021 H&I SPD. Additions are highlighted in gray.*

Applying for short-term disability

These are the three actions you must take to apply for short-term disability:

Step 1: Contact your manager to make him or her aware you'll be taking a leave and continue to follow the specific requirements of your line of business for reporting a leave of absence.

Step 2: Contact Sedgwick, the short-term disability claims administrator, at **855.837.5999** or access the mySedgwick portal to initiate a claim within 15 calendar days of the date your leave began. You can also request leave up to 30 days before your leave is scheduled to begin.

When you contact the short-term disability claims administrator, you should be ready to provide:

- The date of the last day worked
- The first date of disability
- The date you were or will be first treated for the condition
- The nature of the disability and expected return-to-work date
- The name, address and telephone number of the treating health care provider

If you don't report a claim within 15 calendar days after the date of disability, your claim for short-term disability benefits will be denied unless claim initiation isn't practical because of circumstances, such as a loss or impairment of cognitive function. **It's ultimately your responsibility to meet the 15-day deadline (reporting requirement).**

Step 3: Submit any required supporting medical documentation to the short-term disability claims administrator within 15 calendar days of initiating your claim with the short-term disability claims administrator (see Step 2). You or your treating health care provider may complete this step. Although the short-term disability claims administrator will contact the treating health care provider, it's still your responsibility to ensure your provider gets this information to the short-term disability claims administrator **by this 15-day deadline. Missing this 15-day deadline (document requirement) to submit supporting medical documentation may result in a denial of the claim, a lapse in any benefits already in payment or an overpayment of benefits that must be repaid.**

Note

Any previously denied short-term disability claims will not be retroactively approved if you later receive approval for LTD benefit payments.

Clarification: Relapse after unpaid medical leave

*The following information relates to the **Multiple disability claims/relapse** section on pages 142 – 143 of the online version of the 2021 H&I SPD. Additions are highlighted in gray.*

Multiple disability claims/relapse

If you return to work from a short-term disability leave and become disabled again for the same medical condition within 30 calendar days of the return to work (referred to as a **"relapse"**):

- The disability will be considered a continuation of the previous short-term disability claim, regardless of whether such claim was previously approved or denied.
- A new seven consecutive calendar day waiting period will not be required.
- The period of active work will not count toward the maximum short-term disability benefit period of 26 weeks, and your short-term disability benefits will continue to be based on the earnings that were used to calculate the benefits for your original short-term disability leave (known as your predisability earnings).
- Disability benefits will not be paid for the period of active work; however, you will receive your regular pay for that time.

If you become disabled again with the same medical condition more than 30 calendar days after you return to work, or you submit a claim for short-term disability benefits for an unrelated medical

condition, it will be considered a new disability, and the seven consecutive calendar day unpaid waiting period must be satisfied again.

Clarification: Definition of behavioral health provider

*The following information relates to the **When short-term disability benefits end** section on page 144 – 145 of the online version of the 2021 H&I SPD. Additions are highlighted in gray.*

When short-term disability benefits end

Short-term disability benefits automatically end on the earliest of the following:

- When you return to work
- At the end of the maximum benefit period of 26 weeks
- When you're no longer considered disabled by your treating health care provider and/or the short-term disability claims administrator
- When you fail to receive appropriate care and treatment on a continuing basis from a licensed, eligible treating health care provider as defined in the **Eligibility for benefits** section (in the 2021 H&I SPD) whose medical training and clinical experience are suitable for treating the disability
- When you fail to receive treatment as required by a psychiatrist or behavioral health provider, as defined above, within 45 days for behavioral health or substance abuse conditions
- When you're capable of performing the essential functions of your occupation
- When you fail to have a physical examination and/or provide satisfactory objective medical documentation of continuing disability when requested by the short-term disability claims administrator
- When you refuse to cooperate or to participate in a program of medical treatment as prescribed by your treating health care provider and approved and recommended by the short-term disability claims administrator
- When your employment ends
- When you die
- When a non-U.S.-based employee's international assignment ends

Long-term disability

Clarification: Long-term disability for international assignees

*The following information relates to the long-term disability **Coverage options** section beginning on page 150 of the online version of the 2021 H&I SPD. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.*

Coverage options

Bank of America provides full-time employees and non-U.S.-based employees on ~~short-term~~ medium- and long-term international assignments with basic LTD coverage equal to 50% of their monthly predisability earnings (defined in the section that follows on page 151 of the 2021 H&I SPD) at no cost to the employee. Coverage for part-time employees and additional "buy-up" coverage for full-time employees and non-U.S.-based employees on ~~short-term~~ medium- and long-term international assignments ~~is~~ are also available on a post-tax basis, as shown in this table:

Level of coverage	Amount of coverage	Is bonus included in determining coverage?	How is the option paid for?	
			Full-time employees	Part-time employees
Core	50% of monthly predisability earnings	No	The bank pays.	You make post-tax contributions.
Buy-up option 1	60% of monthly predisability earnings	No	You make post-tax contributions.	You make post-tax contributions.
Buy-up option 2[1]	60% of monthly predisability earnings	Yes	You make post-tax contributions.	You make post-tax contributions.

You can buy up any additional coverage on a post-tax basis when you're first eligible, during Annual Benefits Enrollment or through a qualified status change. Your premiums for LTD coverage depend on:

- Your age
- The level of coverage you elect
- Whether you're a full- or part-time employee

The amount of LTD benefit payments will be taxed in accordance with the requirements of the Internal Revenue Code and applicable regulations.

[1] This option is available only if you have an eligible bonus amount for the plan year based on the performance year that most recently ended prior to Annual Benefits Enrollment (for example, an eligible bonus amount for the ~~2022~~ 2023 plan year is based on the ~~2020~~ 2021 performance year). Employees with an ABBR aren't eligible for Buy-up option 2.

The maximum monthly benefit under the LTD Plan, together with all other income benefits, is $30,000. The minimum monthly benefit is 10% of the monthly benefit before reductions for other income benefits or $100, whichever is greater, subject to the Overpayment and Rehabilitation Incentives subsections of the MetLife Long-term Disability Booklet and Summary of Coverage.

Individual Disability Insurance

Addition: Coverage overview

*The following chapter is being added after the **Long-term disability** chapter, which begins on page 146 of the 2021 H&I SPD.*

Individual Disability Insurance

Individual Disability Insurance (IDI), administered by Unum, offers eligible employees the opportunity to elect additional disability insurance to help replace income that exceeds the long-term disability (LTD) coverage limits. This coverage also continues to pay benefits if an employee returns to work part time following a disability.

Eligibility

In general, IDI is available to U.S.-based full-time employees in Job Bands 0 – 4.

Coverage

IDI covers up to an **additional 15%** of your total compensation (base pay plus bonus or ABBR), further enhancing your total disability coverage. It will replace up to 75% of your eligible compensation, less Group LTD, up to an additional $15,000.00 per month.

Coverage	Amount of coverage	Is bonus included in determining coverage amount?	How you pay for this coverage
IDI	15% of monthly predisability earnings	Yes	You make post-tax contributions.

Employees who are eligible for this coverage will receive an invitation email from Unum with instructions on how to enroll. They enroll in this coverage separately from the benefits they elect during Annual Benefits Enrollment (ABE).

Prepaid legal

Addition: Coverage overview

*The following chapter is being added before the **Purchased Time Off** chapter, which begins on page 168 of the 2021 H&I SPD.*

Prepaid legal

Prepaid legal, administered by MetLife Legal Plans, offers employees access to a network of attorneys to assist with personal legal services, including unlimited advice and consultation on real estate matters, traffic and criminal matters, family law and documentation preparation. When a network attorney is used, all eligible attorney fees are covered by the legal plan.

Eligibility

In general, the program is available to all U.S.-based part-time and full-time employees. New hires and newly benefits-eligible employees may enroll in the program when enrolling in their benefits.

How the program works

Employees have access to attorneys for a wide variety of personal legal services. These services include consumer protection, real estate matters, immigration and document preparation. Employees have access to two legal plan options:

- **Prepaid Legal Essential Coverage:** Provides access to some of the most frequently used legal services, such as will preparation, document review, powers of attorney, traffic ticket defense and more
- **Prepaid Legal Full Coverage:** A complete and comprehensive package of fully covered legal services, including wills and estate planning, real estate matters, family law, consumer protection, debt matters, immigration assistance, traffic and criminal matters, document preparation and civil lawsuit defense. You can purchase this service on an annual basis during Annual Benefits Enrollment, and your payments are made through post-tax deductions from each paycheck. Once enrolled, you must remain in the plan for the calendar year.

Other important information

Clarification: No Surprises Act

*The entry below relates to protections provided under the No Surprises Act and was added to the **Other important information** section beginning on page 171 of the 2021 H&I SPD, as described in the 2022 H&I SMM on pages 17 – 18. Clarifications to this section are highlighted in gray.*

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 or receive out-of-network air ambulance services, you are protected from balance billing (surprise billing).

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 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 there 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 services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.
- **Out-of-network air ambulance services:** When you receive air ambulance services, most providers will be an out-of-network provider. In such cases, the most that such providers may bill you is subject to rules similar to those applicable to emergency services and certain services at an in-network hospital or ambulatory surgical center described in this section so as to eliminate the ability of out-of-network air ambulance providers to balance bill you.

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 wrongly billed, you may contact your medical plan carrier.

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

ERISA and claim information

Change and additions: ERISA-covered component plans

*The **ERISA-covered component plans** table beginning on page 205 of the online version of the 2021 H&I SPD has been updated to provide a new address for the Corporate Severance Program claims*

administrator. In addition, two component plans were added to the table. Changes and additions to the previously documented information in the table are highlighted in gray.

ERISA-covered component plans

Plan name	Plan type	Contributions and funding	Payment of benefits	Insurer or claims administrator
Bank of America Group Benefits Program	**Health and welfare benefit plans**			
Bank of America Corporate Severance Program	Severance pay	Company pays cost	Paid directly by company	Bank of America Corporate Severance Program Administrator NC1-021-08-03 401 N. Tryon St. Charlotte, NC 28255-0001
Bank of America Individual Disability Insurance	Disability income	Employees pay cost on a post-tax basis	Insurer	Unum Attn: Customer Services 4-WN 1 Fountain Square Chattanooga, TN 37402
Bank of America Prepaid legal	Legal	Employees pay cost on a post-tax basis	Claims administrator	MetLife Legal Plans 1111 Superior Avenue E Suite 800 Cleveland, OH 44114

Additions: Claims for benefits from insured plan

*The **Claims for benefits from insured plans** table beginning on page 216 of the online version of the 2021 H&I SPD has been updated to include information about Individual Disability Insurance and prepaid legal, two component plans of the Group Benefits Program. Changes to previously documented information are highlighted in gray.*

Claims for benefits from insured plans

Claims for benefits from the insured medical, dental, vision, long-term disability, Individual Disability Insurance, Associate Basic Life Insurance, Associate Supplemental Life Insurance, Dependent Life Insurance, Accidental Death & Dismemberment Insurance, Business Travel Accident Insurance and prepaid legal must be submitted by the deadlines in the following table. Please contact the insurer of each plan listed in the table for information about each plan's claims and appeals procedures.

Insurance	Carrier/claims administrator	Deadline to submit a claim	Address for claims submission	For more information, call
Individual Disability Insurance	Unum	Within 90 days after the end of the 180 day elimination period	Unum Attn: Customer Services 4-WN 1 Fountain Square Chattanooga, TN 37402	**800.895.3398**

Insurance	Carrier/claims administrator	Deadline to submit a claim	Address for claims submission	For more information, call
Prepaid legal	MetLife Legal Plans	Within 12 months of date of service	MetLife Legal Plans 1111 Superior Avenue E Suite 800 Cleveland, OH 44114	**800.821.6400**

Clarification: Appealing a denied disability claim for benefits

The following information relates to appealing a denied claim for benefits on page 223 of the online version of the H&I SPD under the ***Appeal of denied claim for benefits from the short-term disability and long-term disability plans*** *subsection. Additions to the previously documented information are highlighted in gray.*

Appeal of denied claim for benefits from the short-term disability and long-term disability plans

If you disagree with the claims administrator's decision, you may file an appeal with the claims administrator at the address indicated in your denial notice. You must file your appeal with the claims administrator within 180 days of receipt of the denial notice. You should submit all information described in the denial notice as necessary for you to perfect your claim. In addition, you should submit any other information that you believe would support your claim. Note that you may request to see any of the documents pertinent to the denial.

If your appeal is denied in whole or in part, you'll receive written notice that your claim is denied as soon as possible but no later than 45 days after receipt of your appeal. The plans' claims administrator may take a 45-day extension of time in which to review your claim, but only if the extension is necessary due to reasons beyond the control of the claims administrator.

You can bring a civil action against the component short-term disability or long-term disability plan, but only after you've exhausted your administrative review rights under that respective plan. You must bring any civil action no later than one year following the final decision on your claim under these claim procedures. If you fail to bring a civil action within the required time period, you're considered to have permanently waived and abandoned your claim, and you may not reassert it.

Clarification: Appealing a denied claim for benefits under Corporate Severance Program

The following information relates to appealing a denied claim for benefits on pages 223 – 224 of the online version of the H&I SPD under the ***Appeal of denied claim for benefits from the Corporate Severance Program*** *subsection. Additions to the previously documented information are highlighted in gray.*

Appeal of denied claim for benefits from the Corporate Severance Program

If you disagree with the decision of the Severance Support Team, review your denial notice carefully and file an appeal with the Bank of America Benefits Appeals Committee at the address indicated in your denial notice. You must file your appeal with the committee within 90 days of receipt of the denial notice from the Severance Support Team. You should submit all information described in the denial notice as necessary for you to perfect your claim. In addition, you should submit any other information that you believe would support your claim.

If your appeal is denied in whole or in part, you'll receive written notice that your claim is denied as soon as possible but no later than 60 days from receipt of your claim. The committee may take a 60-day extension of time in which to review your claim, but only if the extension is necessary due to reasons beyond the control of the committee.

If your claim is denied in whole or in part, you'll receive a written notice that includes:

- The reasons for the denial and references to the provisions of the plan document upon which the denial is based
- Your right to request, free of charge, all documents that are relevant to your claim
- A statement of your right to bring a civil action following a denial of the claim by the Bank of America Benefits Appeals Committee

You can bring a civil action against the component Corporate Severance Program, but only after you've exhausted your administrative review rights under that respective plan. You must bring any civil action no later than one year following the final decision on your claim under these claim procedures. If you fail to bring a civil action within the required time period, you're considered to have permanently waived and abandoned your claim, and you may not reassert it.

Contacts

Addition: Contact information for ACO/special network medical carriers

*The following contact information has been added to the **Medical contacts** chart beginning on page 229 of the online version of the 2021 H&I SPD.*

Medical

Carrier	Website and phone	Mailing address
Aetna's Baptist Health & St. Vincent's HealthCare	aetna.com **833.383.2660**	P.O. Box 14079 Lexington, KY 40512-4079
Texas Health Aetna	aetna.com **833.383.2659**	P.O. Box 14079 Lexington, KY 40512-4079

Change: Teladoc Health

*Teladoc is now known as Teladoc Health and the following contact information has been added to the **Telemedicine contacts** chart on page 230 of the online version of the H&I SPD. Changes to the previously documented information are highlighted in gray.*

Telemedicine

Telemedicine, available through Teladoc Health, provides access to board-certified doctors, including mental health specialists, by phone or online video. General medical consultations are available on demand, 24/7. Appointments with psychiatrists, licensed psychologists and therapists must be scheduled online in advance. Virtual visits from a primary care physician you select and establish a relationship with are also available to most members through Teladoc Health's Primary360 network. (Teladoc Health virtual visits are not available to ACO/special network plan members.)

Carrier	Website and phone	Mailing address
Teladoc Health (if you're enrolled in an Aetna, an Anthem or a UHC medical plan)[1]	teladoc.com/bankofamerica **855.835.2362**	Teladoc Health, Inc. 1945 Lakepointe Drive Lewisville, TX 75057

Note: Teladoc Health is available only in the U.S. The state of Idaho allows video visits only, and Arkansas and Delaware require the first visit be completed by video.

Addition: Individual Disability Insurance and prepaid legal contact information

*Contact information for Individual Disability Insurance and prepaid legal is being added at the end of the **Contacts** chapter on page 233 of the online version of the H&I SPD.*

Individual Disability Insurance

Carrier	Phone	Mailing address
Unum	**800.895.3398**	Unum Attn: Customer Services 4-WN 1 Fountain Square Chattanooga, TN 37402

Prepaid legal

Carrier	Website and phone	Mailing address
MetLife Legal Plans	info.legalplans.com/bofa **800.821.6400**	MetLife Legal Plans 1111 Superior Avenue E Suite 800 Cleveland, OH 44114

Coronavirus (COVID-19) changes

Clarification: Telehealth cost sharing

*The following information relates to Teladoc Health cost-sharing provisions in the **Telehealth** section on page 235 of the online version of the 2021 H&I SPD. Changes to the previously documented information are highlighted in gray.*

Telehealth

- Teladoc Health provides medical and mental health benefits to employees enrolled in a bank medical plan with Aetna, Anthem or UnitedHealthcare at no cost (not including the ACO/special network options). This benefit will continue to be available at no cost to all Aetna, Anthem and UnitedHealthcare plan participants through Dec. 31, 2024. (Note: Telehealth visits under the Consumer Directed High Deductible Plan were not available at no cost from Jan. 1, 2022, to March 31, 2022.)
- Kaiser Permanente medical plan members have access to a similar program at no cost through Dec. 31, 2024. Contact Kaiser Permanente for details.

Appendix

Change: PCP office visit copay for Comprehensive PPO Plan — Aetna, Anthem or UHC

*The following information relates to the copay for an in-network PCP office visit, shown in the **Comprehensive PPO Plan — Aetna, Anthem or UHC** section of the **Appendix** on page 237 of the online version of the 2021 H&I SPD. Changes to the previously documented information are highlighted in gray.*

Comprehensive PPO Plan — Aetna, Anthem or UHC

Type of service or supply	In network	Out of network
Primary and preventive care		
Note: Some of the preventive care items listed below, including certain breastfeeding support services, oral contraceptive prescription drugs and types of counseling, are covered at 100% in network, subject to guidelines published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration. A full list can be found by visiting healthcare.gov. Please also see **Preventive care** in the **Medical** chapter of the 2021 H&I SPD for more information.		
Office visits — PCP	Plan pays 100% of covered services after $10 copay per visit[1]	Plan pays 60% of covered services after deductible
Office visits — Specialist	Plan pays 100% of covered services after $25 copay per visit	Plan pays 60% of covered services after deductible
Teladoc Health	You pay $0; Plan pays 100%	N/A
Office surgery	Plan pays 100% of covered services after the following copays: • $10 copay — PCP • $25 copay — Specialist	Plan pays 60% of covered services after deductible

Change: Banner|Aetna Comprehensive Plan medical plan chart name

The Banner|Aetna Comprehensive Plan medical plan chart on page 244 of the online version of the 2021 H&I SPD has been renamed to include all bank ACO/special network plans, such as Banner|Aetna, Aetna's Baptist Health & St. Vincent's HealthCare and Texas Health Aetna. Changes to the previously documented information are highlighted in gray.

[1] The PCP copay does not apply to the deductible; however, it does apply to the out-of-pocket maximum.

Accountable Care Organization (ACO)/special network Comprehensive Plan

Type of service or supply	In network	Out of network
All services	Same as services provided under the national Aetna Comprehensive PPO Plan network	No coverage except in the event of an emergency[1]

Change: PCP office visit copay for Consumer Directed Plan — Aetna, Anthem or UHC

*The following information relates to the copay for an in-network PCP office visit, shown in the **Consumer Directed Plan — Aetna, Anthem or UHC** section of the **Appendix** on page 246 of the online version of the 2021 H&I SPD. Changes to the previously documented information are highlighted in gray.*

Consumer Directed Plan — Aetna, Anthem or UHC

Type of service or supply	In network	Out of network
Primary and preventive care		
Note: Some of the preventive care items listed below, including certain breastfeeding support services, oral contraceptive prescription drugs and types of counseling, are covered at 100% in network, subject to guidelines published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration. A full list can be found by visiting healthcare.gov. Please also see **Preventive care** in the **Medical** chapter of the 2021 H&I SPD for more information.		
Office visits — PCP	Plan pays 100% of covered services after $20 copay per visit[2]	Plan pays 60% of covered services after deductible
Office visits — Specialist	Plan pays 80% of covered services after deductible	Plan pays 60% of covered services after deductible
Teladoc Health	You pay $0; Plan pays 100%	N/A

Change: Banner|Aetna Consumer Directed Plan medical plan chart name

The Banner|Aetna Consumer Directed Plan medical plan chart on page 253 of the online version of the 2021 H&I SPD has been renamed to include all bank ACO/special network plans, such as Banner|Aetna, Aetna's Baptist Health & St. Vincent's HealthCare and Texas Health Aetna. Changes to the previously documented information are highlighted in gray.

[1] See Emergency care in the 2021 H&I SPD.

[2] The PCP copay does not apply to the deductible; however, it does apply to the out-of-pocket maximum.

ACO/special network Consumer Directed Plan

Type of service or supply	In network	Out of network
All services	Same as services provided under the national Aetna Consumer Directed Plan network	No coverage except in the event of an emergency[1]

Change: In-network Teladoc Health coverage for Consumer Directed High Deductible Plan — Aetna, Anthem or UHC

*The following information relates to in-network Teladoc Health coverage, shown in the **Consumer Directed High Deductible Plan — Aetna, Anthem or UHC** section of the **Appendix** on page 255 of the online version of the 2021 H&I SPD. Changes to the previously documented information are highlighted in gray.*

Consumer Directed High Deductible Plan — Aetna, Anthem or UHC

Type of service or supply	In network	Out of network
Primary and preventive care		
Note: Some of the preventive care items listed below, including certain breastfeeding support services, oral contraceptive prescription drugs and types of counseling, are covered at 100% in network, subject to guidelines published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration. A full list can be found by visiting healthcare.gov. Please also see **Preventive care** in the **Medical** chapter of the 2021 H&I SPD for more information.		
Teladoc Health	Until Dec. 31, 2024: You pay $0; Plan pays 100%	N/A

Change: Banner|Aetna Consumer Directed High Deductible Plan medical plan chart name

The Banner|Aetna Consumer Directed High Deductible Plan medical plan chart on page 262 of the online version of the 2021 H&I SPD has been renamed to include all bank ACO/special network plans, such as Banner|Aetna, Aetna's Baptist Health & St. Vincent's HealthCare and Texas Health Aetna. Changes to the previously documented information are highlighted in gray.

[1] See Emergency care in the 2021 H&I SPD.

ACO/special network Consumer Directed High Deductible Plan

Type of service or supply	In network	Out of network
All services	Same as services provided under the national Aetna Consumer Directed High Deductible Plan network	No coverage except in the event of an emergency[1]

Change: In-network Teladoc Health coverage for Consumer Directed High Deductible Out-of-Area Plan — Aetna, Anthem or UHC

*The following information relates to in-network Teladoc Health coverage, shown in the **Consumer Directed High Deductible Out-of-Area Plan — Aetna, Anthem or UHC** section of the **Appendix** on page 278 of the online version of the 2021 H&I SPD. Changes to the previously documented information are highlighted in gray.*

Consumer Directed High Deductible Out-of-Area Plan — Aetna, Anthem or UHC

Type of service or supply	In network	Out of network
Primary and preventive care		
Note: Some of the preventive care items listed below, including certain breastfeeding support services, oral contraceptive prescription drugs and types of counseling, are covered at 100% in network, subject to guidelines published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration. A full list can be found by visiting healthcare.gov.		
Please also see **Preventive care** in the **Medical** chapter of the 2021 H&I SPD for more information.		
Teladoc Health	Until Dec. 31, 2024: You pay $0; Plan pays 100%	N/A

[1] See Emergency care in the 2021 H&I SPD.

Change: Prescription drug coverage chart name and 90-day Refill program clarifications

The prescription drug coverage chart on page 284 of the online version of the 2021 H&I SPD has been renamed to include all bank ACO/special networks, such as Banner|Aetna, Aetna's Baptist Health & St. Vincent's HealthCare and Texas Health Aetna. Clarifying content was also added to the 90-day Refill program section of the chart. Deletions to the previously documented information appear as ~~strikethrough~~ text; additions are highlighted in gray.

For Aetna, Anthem, ~~Banner|Aetna and~~ UHC and ACO/special network plans

Comprehensive PPO & Comprehensive Out-of-Area plans		Consumer Directed & Consumer Directed Out-of-Area plans		Consumer Directed High Deductible & Consumer Directed High Deductible Out-of-Area plans	
In network	**Out of network**	**In network**	**Out of network**	**In network**	**Out of network**
Retail (up to a 30-day supply)					
Preventive[1] You pay $0 **Nonpreventive Generic:** $5 copay **Preferred brand name:** $25 copay **Nonpreferred brand name:** $50 copay	40% coinsurance based on your prescription administrator's negotiated cost	**Preventive**[1] You pay $0 **Nonpreventive Generic:** $5 copay **Preferred brand name:** 30% coinsurance ($100 max) **Nonpreferred brand name:** 45% coinsurance ($150 max)	40% coinsurance based on your prescription administrator's negotiated cost	**Preventive**[1] You pay $0 **Nonpreventive** You pay the full negotiated price until deductible is met; 20% coinsurance after deductible	40% coinsurance after deductible based on your prescription administrator's negotiated cost
90-day Refill program (up to a 90-day supply)					
Preventive[1] You pay $0 **Nonpreventive Generic:** $10 copay **Preferred brand name:** $50 copay	Not covered (preventive, nonpreventive generic and preferred brand name)	**Preventive**[1] You pay $0 **Nonpreventive Generic:** $10 copay **Preferred brand name:** 30% coinsurance ($200 max) **Nonpreferred brand name:**	Not covered (preventive, nonpreventive generic and preferred brand name)	**Preventive**[1] You pay $0 **Nonpreventive** Full negotiated price until deductible is met; 20% coinsurance after deductible	Not covered (preventive, nonpreventive generic and preferred brand name)

[1] Most generic and brand name preventive prescription medications are available at no cost. Visit your prescription administrator's website, at caremark.com or myuhc.com, to confirm whether there's a cost before filling prescriptions.

Comprehensive PPO & Comprehensive Out-of-Area plans		Consumer Directed & Consumer Directed Out-of-Area plans		Consumer Directed High Deductible & Consumer Directed High Deductible Out-of-Area plans	
In network	**Out of network**	**In network**	**Out of network**	**In network**	**Out of network**
Nonpreferred brand name: $100 copay		45% coinsurance ($300 max)			

Contact information

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 of the *2021 Bank of America Health & Insurance Summary Plan Description* (2021 H&I SPD).

The 2021 H&I SPD describes certain component plans under the Bank of America Group Benefits Program. Except as modified or clarified by this SMM and the *2022 Bank of America Health & Insurance Summary of Material Modifications* (2022 H&I SMM), the 2021 H&I SPD remains in effect. This 2023 H&I SMM, the 2022 H&I SMM and the 2021 H&I SPD together describe the Group Benefits Program as revised and effective on and after Jan. 1, 2023.

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, the 2022 H&I SMM or the 2021 H&I 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 and 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 employees participate in the Group Benefits Program. The use of these terms does not mean that you are an employee of Bank of America Corporation. You remain solely an employee of the company that directly pays your wages.

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