2023 U.S. BENEFITS ENROLLMENT GUIDE

COBRA health and insurance benefits guide

Oct. 25 – Nov. 4, 2022

Understand your options

Know your resources

Review your elections and enroll

BANK OF AMERICA

2023 Annual Benefits Enrollment is Oct. 25 – Nov. 4

You can review and make changes to your COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) elections during this time.

When considering which medical, dental and vision plans are right for you, use this guide along with:

- Your *Enrollment Worksheet*, which shows the plans available to you in 2023 and costs for those plans
- The *2021 Bank of America Health & Insurance Summary Plan Description* (2021 H&I SPD) and the *2022 Bank of America Health & Insurance Summary of Material Modifications* (2022 H&I SMM).

If you choose **No Coverage** for 2023, your COBRA coverage will end on Dec. 31, 2022, or when your premiums aren't paid on time, whichever is earlier.

Compare

To compare your medical plan choices, take a look at the Summaries of Benefits and Coverage. To view them during Annual Benefits Enrollment, log in to **mybenefitsresources.bankofamerica.com** and click **Enroll Now** > **Medical View/Change** > **Compare Medical Options**.

✓Tip

If you don't take action during Annual Benefits Enrollment, you'll have the coverage indicated on your *Enrollment Worksheet*, which, in most cases, is the coverage you're currently enrolled in. (If you live in the greater **Jacksonville, FL**, or **Dallas, TX**, region, be sure to see the note on page 3 about new Aetna coverage in your area.)

What's inside

Medical plans

You have two medical choices to make during Annual Benefits Enrollment: your medical carrier and your medical plan

All three national medical carriers — **Aetna**, **Anthem** and **UnitedHealthcare** — offer the same medical plans and are high-quality options with similar services and networks. (**Kaiser Permanente** will continue to be offered as a carrier in select markets. Refer to the Compare Medical Options feature on **mybenefitsresources.bankofamerica.com** for specific Kaiser Permanente plan information, if available in your area.)

You may experience an increase in your annual medical plan premium in 2023, depending on your pay tier prior to becoming eligible for COBRA, the plan you choose, the number of people you cover, the carrier you select and the ZIP code you live in.

Consider different variables when choosing your medical plan. For example, would you prefer to pay less each month and pay more when you receive care — or vice versa? This high-level comparison of our plans can help:

Comprehensive PPO Plan (Only available if your PYCC was under $100,000)	**Consumer Directed Plan**	**Consumer Directed High Deductible Plan**
• Highest premium costs • Lower expenses when you need care • Lowest deductible	• Premium costs lower than PPO • Deductible lower than the High Deductible Plan • You may pay the negotiated rate for most services until you meet the deductible.	• Lowest premium costs • Highest deductible • You will pay the negotiated rate for most services until you meet the deductible.

Your *Enrollment Worksheet* shows the plans that are available to you and your family

Generally, you'll be eligible for the same medical plans that were available to you before you elected COBRA coverage. Your medical plan choices are determined by your Performance Year Cash Compensation (PYCC) at the time you became eligible for COBRA (see page 11).

- If your PYCC was less than $100,000, you can choose from the Comprehensive PPO and the two consumer-directed plans.
- If your PYCC was $100,000 or more, your choices are the two consumer-directed plans.

The medical plan you choose determines:

- The coverage you receive
- The type of health care account available to you
- Your prescription medication coverage
- What you pay for coverage versus care. (For example, in the Comprehensive PPO plan, you'll pay more every month than you would in either of the consumer-directed plans, but less when you receive care. In the consumer-directed plans, your monthly premiums will be lower, but you'll pay more when you receive care. See the chart on page 4 to compare.)

Reduced primary care physician (PCP) copays

Having and maintaining a relationship with a PCP is important. They can provide preventive care and screenings, identify and treat common medical conditions, catch health issues early before they progress into something more serious and help you get more advanced care when you need it.

New for 2023: To make it easier for plan members to consult their PCP for routine care, 2023 PCP copays will be reduced from $15 to $10 for Comprehensive PPO plan participants and from $40 to $20 for Consumer Directed (CD) plan participants. Consumer Directed High Deductible (CDHD) plans do not have copays as part of their plan design. The cost of preventive care — including annual checkups — will continue to be available at no cost for all plan members.

It pays to stay in network!

Out-of-network deductibles, maximums and other costs are significantly higher than those in network. Find out if your providers are in network across the carriers by going to **My Benefits Resources** > **Enroll Now** > **Medical View/Change** > **Find a Doctor or Hospital**.

Medical plans *(continued)*

Here's how deductibles and out-of-pocket maximums for family coverage compare across plans*

	Annual deductible/coinsurance	Out-of-pocket maximum
Comprehensive PPO or Consumer Directed Plan	• For any family member whose eligible out-of-pocket expenses meet their individual annual deductible, coinsurance begins for that person. • Coinsurance begins for everyone on the plan once the eligible out-of-pocket expenses of two people combine to meet the family deductible.	The in-network, out-of-pocket maximum per family is $4,000 for the PPO Plan and $7,000 for the Consumer Directed Plan. In each of these plans, 100% of eligible costs are covered: • For any family member who reaches their individual out-of-pocket maximum (see page 4) • For everyone on the plan once two people combine to reach the family out-of-pocket maximum
Consumer Directed High Deductible Plan	If anyone covered on the plan meets the family annual deductible, or the eligible out-of-pocket expenses of two or more family members combine to reach it, coinsurance begins for everyone on the plan.	• The in-network, out-of-pocket maximum for this plan is $8,000 per family. • If one person covered under the plan reaches the individual out-of-pocket maximum of $7,350, 100% of additional costs for eligible services are covered for that person. • If another family member adds $650 (for a total of $8,000) in eligible out-of-pocket expenses, 100% of additional costs for covered services for everyone on the plan are covered.

Important reminders about eligibility

- During Annual Benefits Enrollment, you can add or remove a spouse, partner or eligible child to or from your coverage. **If you add an adult to your coverage, you'll be required to verify their eligibility**. You'll receive a Dependent Verification letter at your address on file with more information about the deadlines and documents required.
- If you get married, have a baby, get a divorce or experience another event that is considered a qualified status change, **you must notify the Global HR Service Center within 31 calendar days of the date of the change**.
- Your children are eligible to be covered under your medical, dental and vision plans until age 26. **Note: If your child will turn 26 in 2023 and is covered under your plan, their coverage will end on the last day of their birthday month.**

For more information about who's eligible for coverage under the plans, see page 12.

In the greater Dallas, Jacksonville, Phoenix or Tucson areas?

If you enroll in an Aetna medical plan for 2023, you'll receive coverage from a medical network provided by **Texas Health Aetna** if you live in the greater **Dallas, TX**, region; **Aetna's Baptist Health & St. Vincent's HealthCare** if you live in the greater **Jacksonville, FL**, region; or **Banner|Aetna** if you live in the **Phoenix or Tucson, AZ**, regions.*

These Aetna Accountable Care Organizations (ACOs) will only cover health care services received from their in-network providers while you are within their service area — with the exception of emergencies. When traveling outside your ACO's service area, in-network care will be covered through Aetna's national network.

For more information, visit **aetna.com/bankofamerica** and, when prompted to choose a plan for your search, select the Bank of America EPO Plan available in your region. Or call the ACO directly:

- Banner|Aetna: **866.676.7362**
- Texas Health Aetna: **833.383.2659**
- Aetna's Baptist Health & St. Vincent's HealthCare: **833.383.2660**

***** Eligibility in Aetna ACO networks is determined by your home ZIP code.

* Kaiser California plans have a different deductible and out-of-pocket maximum for employees choosing family coverage. Please contact Kaiser for further information.

Medical plans *(continued)*

	Annual deductible	Coinsurance	Out-of-pocket maximum	Preventive services	Office visits	Prescription medication at retail *(30-day supply)*	Health care account(s) *(More details on page 5)*
Comprehensive PPO Plan (only available if your PYCC was less than $100,000)	In network, you pay up to **$500** per individual or **$1,000** per family. Out of network, you pay up to **$1,000** per individual or **$2,000** per family.	In network, you pay **20%**. Out of network, you pay **40%**.	In network, you will pay no more than **$2,000** per individual or **$4,000** per family. Out of network, you will pay no more than **$4,000** per individual or **$8,000** per family.	In network, you pay **$0**, according to government guidelines. Out of network, you pay the full negotiated rate until you meet the deductible, then you pay coinsurance.	In network, you pay a **$10** copayment for primary care and a **$25** copayment for a specialist visit. Out of network, you pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance.	In network, you pay **Preventive: $0** **Nonpreventive:** Generic: **$0** Preferred brand: **$25** copayment Nonpreferred brand: **$50** copayment Out of network, you pay **40%** coinsurance.	Health Reimbursement Arrangement (**HRA**)
Consumer Directed Plan	In network, you pay up to **$1,200** per individual or **$2,400** per family. Out of network, you pay up to **$2,400** per individual or **$4,800** per family.	In network, you pay **20%**. Out of network, you pay **40%**.	In network, you will pay no more than **$3,500** per individual or **$7,000** per family. Out of network, you will pay no more than **$7,000** per individual or **$14,000** per family.	In network, you pay **$0**, according to government guidelines. Out of network, you pay the full negotiated rate until you meet the deductible, then you pay coinsurance.	In network, you pay a **$20** flat copayment for nonpreventive primary care visits. For specialists and out of network, you pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance.	In network, you pay **Preventive: $0** **Nonpreventive:** Generic: **$0** Preferred brand: **30%** coinsurance (**$100** max) Nonpreferred brand: **45%** coinsurance (**$150** max) Out of network, you pay **40%** coinsurance.	Health Reimbursement Arrangement (**HRA**)
Consumer Directed High Deductible Plan	In network, you pay up to **$2,250** employee only or **$4,500** per family. Out of network, you pay up to **$4,500** employee only or **$9,000** per family.	In network, you pay **20%**. Out of network, you pay **40%**.	In network, you will pay no more than **$4,000** for employee only, **$7,350** per individual or up to **$8,000** per family. Out of network, you will pay no more than **$8,000** for employee only or **$16,000** per family.	In network, you pay **$0**, according to government guidelines. Out of network, you pay the full negotiated rate until you meet the deductible, then you pay coinsurance.	You pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance for primary care and specialist visits.	In network, you pay **Preventive: $0** **Nonpreventive:** The full negotiated price until you meet your deductible, then: Generic: **$0** Brand: **20%** coinsurance Out of network, you pay **40%** coinsurance after you meet your deductible.	Health Savings Account (**HSA**)

Filling your prescriptions

If you elect Aetna or Anthem as your medical carrier for 2023, your prescription administrator will be CVS Health (Caremark). If you elect UnitedHealthcare (UHC), your prescription administrator will be UHC/OptumRx. Both provide access to most national pharmacy chains for non-maintenance prescription medications. A few things to note:

- Most in-network preventive prescription medications — both brand-name and generic — are available at no cost.
- Most in-network, generic nonpreventive prescription medications are also available at no cost for those in a PPO or CD plan, and for those in a CDHD plan or Kaiser Permanente plan in CA, CO, GA, Mid-Atlantic, Northwest or WA after they meet their deductible.
- Once enrolled in a medical plan, you can visit your prescription administrator's website, at **caremark.com** or **myuhc.com**, to confirm whether there's a cost before filling prescriptions.
- Any maintenance prescription medications will need to be filled through your prescription administrators' mail order service. Otherwise your prescription may not be covered under the plan.

Compare the health care account options available to you, based on your medical plan

	Comprehensive PPO: Access to an HRA balance Consumer Directed Plan: Access and additional bank contributions if HRA is elected under COBRA	**Consumer Directed High Deductible Plan**
	Health Reimbursement Arrangement (HRA)	**Health Savings Account (HSA)**
Account use	Eligible health care expenses, including dental, vision and prescription medication	To save for future eligible health care expenses, and also to pay for current eligible health care expenses, including dental, vision and prescription medication
Maximum contribution	The IRS does not allow individual contributions to an HRA. The bank contributes a set amount based on your PYCC and coverage (see below).	**$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. You can't contribute to an HSA if you're enrolled in Medicare Part A or Part B.
Bank contribution	If you elect the Consumer Directed Plan with the HRA option and pay a premium, you can receive bank funding: Your PYCC was less than $50K **$500** Employee-only coverage **$750** Employee plus spouse or partner **or** Employee plus child(ren) coverage **$1,000** Family coverage Your PYCC was $50K to less than $100K **$400** Employee-only coverage **$600** Employee plus spouse or partner **or** Employee plus child(ren) coverage **$800** Family coverage Your PYCC was $100K to less than $250K **$300** Employee-only coverage **$450** Employee plus spouse or partner **or** Employee plus child(ren) coverage **$600** Family coverage	The bank doesn't contribute to this account.
Funds availability	The entire bank contribution amount is available at the beginning of the year.	If you have an HSA, you will maintain access to this portable account. Your HSA balance can be used at any time to pay for eligible health care expenses, including COBRA premiums. If you remain eligible, you can contribute money on a post-tax, but deductible, basis to your HSA through Bank of America Health Benefit Solutions. Log in to **myhealth.bankofamerica.com** or call **866.791.0254**.
Unused funds	Unused funds will automatically roll over to the next year, and you generally will have access to any unused balance from previous years if you maintain coverage under an HRA-eligible medical plan, such as the Comprehensive PPO Plan or the Consumer Directed Plan.	Unused funds will roll over to the next year. Also, if you have more than $1,000 in your HSA, you can invest it, and any growth is generally tax-free. You can take HSA funds with you when you leave the company or retire. You must submit claims from your HSA within 15 months from the date the expense was incurred or 180 days after your active medical coverage ends after your termination date.

Dental coverage

MetLife is the carrier for our dental PPO plan. Visit **metlife.com/mybenefits** to see if your dentist is in network for the MetLife Dental PPO Plan.

A dentist who is out of network hasn't agreed to negotiated rates. The MetLife Dental PPO Plan pays benefits based on the usual and customary charge for a particular service. If an out-of-network provider charges more, you'll be responsible for paying the amount that exceeds the usual and customary limit, plus the applicable coinsurance and deductible.

In select markets, the Aetna Dental DMO Plan is available. If you choose this plan, your primary care dentist must be in the Aetna DMO network in order for you to receive any coverage. Visit **aetna.com/bankofamerica** to see if your dentist is in network. If you plan to go to a new dentist in 2023, be sure they are in network and accepting new DMO patients before you elect this dental plan.

	MetLife Dental PPO (in network)	**Aetna DMO** (select markets, in network)
General dental expenses	**Annual deductible: $50** Individual, **$150** Family The deductible is waived for preventive care and applies to basic and major expenses. **Annual maximum coverage per person** (excludes orthodontia and preventive care services): **$2,000** **Lifetime maximum for orthodontia** (children starting treatment before age 20 and covered adults): **$2,000** **Office visit copayment:** None	**Annual deductible:** None **Annual maximum coverage per person** (excludes orthodontia): None **Lifetime maximum for orthodontia** (covered adults and children): 24 months active treatment, plus 24 months retention per lifetime **Office visit copayment: $5** per visit
Preventive care	**Exams:** Plan pays **100%** of covered services; services don't count toward annual maximum. Limited to two routine visits and two problem-focused visits per calendar year. **Cleaning:** Plan pays **100%** of covered services; services don't count toward annual maximum. Limited to two visits per calendar year. **Dental X-rays:** Plan pays **100%** of covered X-rays; services don't count toward annual maximum. Limited to one set of full mouth series every five years, and two sets of bitewing X-rays per calendar year for children and one set per calendar year for adults.	**Exams:** Plan pays **100%** of covered services, limited to four visits per calendar year. **Cleaning:** Plan pays **100%** of covered services, limited to two visits per calendar year. **Dental X-rays:** Plan pays **100%** of covered X-rays; services don't count toward the annual maximum. Limited to one set of full mouth series every five years and two sets of bitewing X-rays per calendar year.
Basic and major services	**Amalgam (silver) fillings:** You pay **20%** of covered services. **Composite fillings:** You pay **20%** of covered services; limitations may apply. **Extractions:** You pay **20%** of covered services. **Oral surgery:** You pay **20%** of covered services. **Crowns, dentures and bridges:** You pay **50%** of covered services; each individual service is limited to one time, per person, every seven years. **Implants:** You pay **50%** of covered services. **Orthodontia** (adults and children): You pay **50%** of covered services.	**Amalgam (silver) fillings:** You pay **20%** of covered services. **Composite fillings:** You pay **20%** of covered services; limitations may apply. **Extractions:** You pay **20%** of covered services; uncomplicated, non-bony impactions. **Oral surgery:** You pay **20%** of covered services for basic surgery; **50%** of covered major surgery. **Crowns, dentures and bridges:** You pay **50%** of covered services; crowns and dentures limited to initial placement and replacements for appliances that are seven years old or more; bridges limited to initial placement only. Replacements for bridge appliances that are seven years old or more are considered. **Implants:** You pay **50%** of covered services. **Orthodontia** (adults and children): You pay **50%** of covered services.

Vision coverage

We offer vision coverage through the Aetna Vision Plan, which is administered by EyeMed. Visit **member.eyemedvisioncare.com/bac** to see if your eye care provider is in network. Once you become a member, use the Aetna Vision Preferred app to search for providers and easily access special offers, along with your benefits, ID card and claims information.

✓ Tip

If Aetna is your medical carrier, you may choose Aetna's Vision Discount Program as an alternative to vision coverage, at no cost to you. This program offers discounts for routine eye exams, eyeglasses, LASIK surgery, contact lenses and other eye care accessories. For more information, call Aetna at **877.444.1012**.

	In network	Out of network
Routine vision exams (once per calendar year)	**$10** copayment	Plan pays a reimbursement, up to **$40**.
Eyeglasses		
Single vision lenses (once per calendar year)	Plan pays **100%** of covered services, limited to standard uncoated plastic lenses.	Plan pays a reimbursement, up to **$40**.
Progressive lenses (once per calendar year)	**$65** copayment for covered services for standard uncoated plastic lenses.	Plan pays a reimbursement, up to **$60**.
Premium progressive lenses (once per calendar year)	Tier 1: **$85** copayment Tier 2: **$95** copayment Tier 3: **$110** copayment Tier 4: **$65** copayment and **80%** of charge, less **$120** allowance	Plan pays a reimbursement, up to **$60**.
Frame allowance (once every other calendar year)	Plan provides a **$130** frame allowance, **20%** discount thereafter.	Plan pays a reimbursement, up to **$50**.
Contact lenses		
Standard lens fit and follow-up (once per calendar year)	**$0** copayment	Plan pays a reimbursement, up to **$40**.
Premium contact fit and follow-up (once per calendar year)	Plan provides up to a **$55** allowance, **10%** discount thereafter.	Not covered
Medically necessary prescription lenses for specific eye conditions that would prohibit the use of glasses (once per calendar year; prior approval is needed)	Plan pays **100%** of covered services.	Plan pays a reimbursement, up to **$210**.
Elective prescription lenses (once per calendar year)	Plan provides a **$125** allowance in lieu of lenses; a **15%** discount is applied to conventional contacts over the **$125** allowance.	Plan provides a **$125** allowance in lieu of lenses.

Medicare

Plans offered to Medicare-eligible individuals and their Medicare-eligible dependents

If you're eligible for COBRA coverage in 2023 under one of the medical plans offered to Medicare-eligible individuals, review your enclosed *Enrollment Worksheet* for information about plans available to you and your eligible dependents.

For additional information about these plans, please contact the plan directly or refer to the *2021 Bank of America Retiree Health & Insurance Summary Plan Description* (2021 Retiree SPD), the *2022 Bank of America Retiree Summary of Material Modifications* (2022 Retiree SMM) or the *2021 Bank of America Medical Plans Available to Medicare-eligible Individuals on Long-term Disability Summary Plan Description* (2021 LTD SPD) and the *2022 Bank of America Medical Plans Available to Medicare-eligible Individuals on Long-term Disability Summary of Material Modifications* (2022 LTD SMM). These documents can be found on **mybenefitsresources.bankofamerica.com** > **Knowledge Center** > **Plan Information** > **Employee Health & Insurance SPDs**.

COBRA and Medicare

If you became eligible for Medicare before enrolling in COBRA, your bank coverage pays after Medicare. This means when you receive a covered service, Medicare pays for the covered service first, and after Medicare has paid its share, your bank coverage will pay according to that plan's applicable provisions. Therefore, you should enroll in both Medicare Part A and Part B and use providers who accept Medicare. If you or your covered dependent(s) are eligible for Medicare and don't enroll in Medicare, or don't use providers who accept Medicare, you'll be responsible for paying the portion of medical expenses Medicare otherwise would have paid.

If you or your covered dependent(s) become eligible for Medicare after enrolling in COBRA, you must notify the Global HR Service Center immediately. Your COBRA coverage will end once you become eligible for Medicare.

Annual Benefits Enrollment is Oct. 25 – Nov. 4

Online

1. Log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**).
2. From the **Home** page, click **Enroll Now**.
3. When you're finished, confirm your choices by clicking **Complete Enrollment**. Your elections won't be saved unless you complete this step. You'll see a **Confirmation Statement**, which you should save for your records.

Note: If you need assistance, use the online chat option, available on the **Contact Us** page.

By phone

Call the Global HR Service Center at **800.556.6044**.

Representatives are available Monday through Friday (excluding certain holidays), 8 a.m. to 8 p.m. Eastern.

When you call, have your enrollment elections ready. Once authenticated, say **Annual Benefits Enrollment** to speak to a Global HR Service Center representative, who will take your benefit elections and validate your dependent information.

Special service phone numbers

Overseas access: Dial your country's toll-free AT&T USADirect® access number, then enter **800.556.6044**. Access numbers are available online at **business.att.com/collateral/access** or from your local operator.

✓ Tip

During Annual Benefits Enrollment, you can enroll at anytime, from anywhere.

✓ Here are a few things you should know about making changes to your elections after Annual Benefits Enrollment:

- Your Annual Benefits Enrollment elections will last for the entire 2023 calendar year (or until your COBRA coverage ends) unless you notify the Global HR Service Center of a qualified status change during the year.
- Any Health Reimbursement Arrangement (HRA) contribution you receive from the bank in 2023 won't change during the year, even if you have a qualified status change during the year that changes the number of people you cover on your plan.
- If you maintain dental or vision COBRA coverage for 2023, but decline medical coverage during Annual Benefits Enrollment, and later need to enroll following a qualified status change, you may be eligible for a prorated health care account contribution.

Review your Confirmation Statement

Whether you enroll online or by phone, you'll receive a Confirmation Statement of your elections. Be sure to review it carefully. You'll receive more information by mail to help you use your benefits, including ID cards, if applicable.

Paying for your coverage

You have two options to pay for your coverage

1. **Direct debit from a checking or savings account:** You may elect to have your monthly benefits payment deducted automatically from your checking, savings or other personal account. To begin direct debit in January, you'll need to make your payment election by Dec. 1, 2022. If you choose this option, your 2023 payments will be deducted from your account on or around the first of each month, beginning in January 2023.
2. **Invoice billing:** If you don't request direct debit from a checking, savings or other personal account, you'll receive a monthly invoice from the Global HR Service Center that reflects the cost of your benefits. In mid-December, you'll receive your first invoice for your January 2023 benefits payment. After that, you'll receive an invoice prior to the first of each month for the upcoming month's coverage.

Note: Your COBRA coverage will be terminated if you fail to pay the required COBRA premiums in accordance with COBRA's requirements and time frames.

✓ Tip

You can choose or change your payment option at any time:

- Log in to **mybenefitsresources.bankofamerica.com**, navigate to the **Review Billing and Payments** section under **Health and Insurance**, and click **Change** next to **Current Ongoing Payment Method**.
- Call the Global HR Service Center at **800.556.6044**.

Changes you make to your payment method will become effective within 30 days of your new election.

Important notes about your benefits

Compensation

Performance Year Cash Compensation (**PYCC**)

For 2023, your medical plan choices are determined by your PYCC that was in effect when you became eligible for COBRA. We also use this amount to determine your pay tier for medical benefits.

Any changes to your base salary after Dec. 31, 2021, won't change the PYCC amount used to determine your pay tier.

Annual Benefits Base Rate (**ABBR**)

For some commission-based employees, we calculate an ABBR, which is used as your PYCC to determine your available medical plans and your medical premium costs.

Health care accounts

Depending on your enrollment choices, you may receive a Visa® debit card for your health care account.

Bank contributions

Your PYCC amount at the time you became eligible for COBRA and the coverage level you elect are used to determine how much the bank will contribute to your HRA, if elected with an HRA-eligible medical plan. If you elect the Consumer Directed plan with the HRA option and pay a premium, the bank will contribute to your HRA. If you elect the Comprehensive PPO plan, the bank cannot contribute, but you'll be able to access any funds you have in an existing HRA.

Eligible dependents

For health care accounts, eligible dependents under the HRA option include your spouse; birth, adopted or placed-for-adoption children, stepchildren and foster children until the last day of the month in which they turn age 26; and dependents that you claim (or could have claimed) on your federal income tax return.

However, per IRS requirements, the definition of an eligible dependent under an HSA only includes your spouse and family members **you can claim as dependents on your federal income tax return**. If you are uncertain if a child or other individual qualifies as your eligible dependent, call the Global HR Service Center at **800.556.6044**.

If you've selected the Consumer Directed medical plan with the HRA, you may only submit claims for reimbursement from your HRA for yourself and those dependents currently covered under your Bank of America medical plan, per IRS rules.

Maintaining access to your HRA balance

If you have an existing HRA, you can maintain access to your balance by enrolling in an HRA-eligible medical plan. If you choose a plan that's not HRA-eligible or choose not to enroll in a plan, your HRA balance will continue to roll over. The balance won't be accessible until you re-enroll in an HRA-eligible plan or retire after meeting the Rule of 60. HRA-eligible plans include the Comprehensive PPO Plan and the Consumer Directed Plan. For more information, refer to the *2021 Bank of America Health & Insurance Summary Plan Description* (2021 H&I SPD) and the *2022 Bank of America Retiree Summary of Material Modifications* (2022 Retiree SMM) at **mybenefitsresources.bankofamerica.com** > **Knowledge Center** > **Plan Information** > **Employee Health & Insurance SPDs**.

Tax considerations

Some circumstances could result in you being taxed on all or part of the contribution to your health care account, including debit card transactions, so be sure to keep receipts and documentation for health care account purchases.

- You may need to verify that your debit card transactions were for eligible health care expenses. If you don't verify them, your debit card may be deactivated and/or you'll be taxed on the value of any transactions that haven't been verified. For the HSA, the IRS may also impose a 20% penalty for ineligible expenses.
- If you receive bank contributions in an HRA for a family member who is not your tax dependent, you must pay taxes on the amount of the contribution. This is included in your imputed income calculation, if applicable.
- If your contribution to an HSA exceeds the IRS limit, you'll pay taxes on the amount of the contribution that exceeds the limit.
- Note that California and New Jersey tax employer and employee contributions to HSAs. This information was accurate as of this guide's release date.

Verifying your information for an HSA

If you enroll in an HSA, the federal government may require you to verify certain information, such as your name or address, before your HSA can be opened. If you don't provide this information, your account won't be opened and the contributions you make will be returned during the year.

Important notes about your benefits *(continued)*

Who is eligible for coverage under our medical, dental and vision plans?

For detailed information about dependent eligibility, refer to the 2021 H&I SPD and 2022 H&I SMM at **mybenefitsresources.bankofamerica.com** > **Knowledge Center** > **Plan Information** > **Employee Health & Insurance SPDs**.

If you already cover a dependent or add a dependent to your coverage for 2023, take time to verify their eligibility and confirm their personal information.

Children

- For participants on COBRA under the group health plans offered to active employees or individuals on LTD: Your children qualify as your dependents if they're under age 26.
- For participants on COBRA under the group health plans offered to retirees: Your children qualify as your dependents if they are unmarried, depend on you for primary financial support, and are under age 19 or under age 24 if incapable of self care or a full-time student enrolled in a high school or accredited college, university or similar educational institution (student verification required annually).
- Your eligible dependent child may be able to continue coverage after these ages if they are enrolled in a fully insured retiree medical, dental and/or vision plan and live in California, Florida, Georgia, Indiana, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, Texas, Utah, Virginia, Washington, Washington, D.C. or West Virginia. In addition, the HMSA Hawaii PPO plan and Triple-S Salud plan extend dependent child eligibility up to age 26, regardless of full-time student status. Please call the Global HR Service Center at **800.556.6044** for more details.

Spouse or partner

Generally, your spouse or partner is eligible to be covered under our plans.

The U.S. Treasury and IRS guidance state that all same-sex couples who are legally married are treated as married for federal tax purposes, where marriage is a factor, including personal and dependent exemptions and deductions, IRA contributions, tax credits and eligibility for coverage under employee benefit plans.

Other adult dependent

For an individual to qualify as your other adult dependent, they must:

- Be under age 65 (or over age 65 and not eligible for Medicare)
- Be a dependent for federal income tax purposes (to qualify for coverage in a given year, the individual must have been your tax dependent for the previous tax year and must continue to be your tax dependent for the current tax year)
- Live with the employee and be considered a member of the employee's family
- Not be eligible for, and not have declined or deferred, coverage through the Bank of America employee or retiree health care program, including an offer of COBRA coverage

Most medical, dental and vision plans will cover either a spouse or partner, or other adult dependent. The HMSA Hawaii PPO plan and Triple-S Salud plan only provide coverage to spouses or partners.

For information regarding health and insurance coverage for adult family members, visit **mybenefitsresources.bankofamerica.com** or call the Global HR Service Center. If you're uncertain whether an adult family member qualifies as your eligible dependent, call the Global HR Service Center.

When a dependent loses eligibility

You have up to 31 calendar days to call the Global HR Service Center and let us know that one of your dependents should be dropped from the plan, for example, upon divorce. If your dependent receives benefits from a plan after the date coverage ends, you're responsible for reimbursing the plan for benefits provided during that period.

Changes to your contribution amounts will take effect on the first day of the month after you notify the Global HR Service Center that your dependent is no longer eligible.

If your child will turn 26 in 2023 and doesn't qualify as an adult dependent (see eligibility), their coverage will end at the close of their birthday month. (Our plans cover your eligible children through age 25.)

Qualified status change

For details on what's considered a qualified status change, refer to the 2021 H&I SPD and 2022 H&I SMM on **mybenefitsresources.bankofamerica.com** > **Knowledge Center** > **Plan Information** > **Employee Health & Insurance SPDs**.

Important notes about your benefits *(continued)*

Summary of Benefits and Coverage — Availability Notice

As a result of the Patient Protection and Affordable Care Act, Bank of America is required to provide standardized Summaries of Benefits and Coverage (SBCs). The SBCs summarize, in a standard format, important information about the bank's health plans. This is another resource to help you compare your plan choices. To take a look at the SBCs during Annual Benefits Enrollment, log in to **mybenefitsresources.bankofamerica.com** and go to **Enroll Now** > **Medical View/Change** > **Compare Medical Options** for the applicable medical option SBC. If you have specific questions about what's covered, call your medical carrier to ask about coverage for specific health conditions.

To request a paper copy, call the Global HR Service Center at **800.556.6044**.

When you enroll or continue participation in the Bank of America plans, you're acknowledging that the benefits you have elected are subject to the provisions of the Bank of America Group Benefits Program or Retiree Group Benefits Program and the terms and conditions of the benefit plans. You acknowledge that if you enroll in a plan that provides for binding arbitration of any controversy between a plan member or beneficiary and a plan, including, as applicable, its agents, associates, providers and staff physicians, then any such controversy is subject to binding arbitration.

While the term "premium" is used in this guide in reference to certain costs associated with plan benefits, it should be noted that "premium" generally refers to fully insured benefit plans, and not all plans discussed are fully insured.

Women's Health and Cancer Rights Act

(This Act doesn't apply to Medicare or the Medicare Advantage plans.)

As required by the Women's Health and Cancer Rights Act of 1998, each medical plan (other than Medicare Advantage plans) provides the following medical and surgical benefits with respect to a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, coinsurance and copayment provisions applicable to other such medical and surgical benefits provided under the plans.

Please refer to your Health Plan Comparison Charts available in the 2021 H&I SPD and 2022 H&I SMM for deductibles and copayment information applicable to the medical plan in which you choose to enroll. These documents are available on **My Benefits Resources** or upon request by calling the Global HR Service Center at **800.556.6044** from 8 a.m. to 8 p.m. Eastern, Monday through Friday (excluding certain holidays).

Availability of Notice of Privacy Practices

The Bank of America Group Benefits Program (the "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information will be used or maintained by the plan.

If you'd like a copy of the Plan's Notice of Privacy Practices, visit **mybenefitsresources.bankofamerica.com** and click **Knowledge Center** > **Plan Information** > **Legal Notices** or call the Global HR Service Center at **800.556.6044**.

Marketplace special enrollment windows related to COBRA

Under the Affordable Care Act, you can enroll in a medical plan through your state's health care exchange during an open enrollment period or designated special enrollment periods. A special enrollment period will be available when you become eligible for COBRA and after you're no longer eligible for COBRA. There's no special enrollment period if you voluntarily end your COBRA coverage, including for non-payment of premiums.

For more information about specific enrollment rules or plans offered through health insurance exchanges, please visit **healthcare.gov** or call **800.318.2596** (TTY: **855.889.4325**).

Fully insured medical plans

Aetna International, Kaiser Permanente, HMSA Hawaii and Triple-S Salud medical plans, as well as Medicare Advantage HMO and other retiree medical plans, may have other changes in coverage for 2023. Please contact these carriers with any questions.

Important notes about your benefits *(continued)*

Lifetime maximum

A lifetime maximum, or the most the plan will pay for benefits, applies to some medical and dental services. Please check with your plan's insurer or claims administrator regarding any benefit limits.

Falsification of information

If you or an enrolled dependent knowingly submit false information when enrolling in, changing or claiming health and insurance benefits, or if you fail to notify the Global HR Service Center that an enrolled dependent is no longer eligible for coverage, participation for you and your dependents may be immediately, retroactively and permanently canceled. In addition, the insurance company may deny coverage. Pending claims may not be paid, and you must reimburse the plan for any previous claims incurred that should not have been paid. In addition, you may be asked to provide proof of dependent eligibility at a future date. The bank reserves the right to audit your dependent enrollment information at any time. See page 12 for more information about dependent eligibility.

Helpful contact information

Medical
Aetna
aetna.com/bankofamerica
877.444.1012
For Aetna ACO phone numbers, see page 3

Anthem
anthem.com/bankofamerica
844.412.2976

Kaiser Permanente*
kp.org
Please refer to the phone number listed on the back of your ID card

UnitedHealthcare
whyuhc.com/findmydoc
877.240.4075

Dental
Aetna*
aetna.com/bankofamerica
877.444.1012

MetLife
metlife.com/mybenefits
800.942.0854

Vision
Aetna
member.eyemedvisioncare.com/bac
877.444.1012

Health care and dependent care accounts
Health Benefit Solutions
myhealth.bankofamerica.com
866.791.0254
TTY: 800.305.5109

Prescription coverage
Aetna and Anthem plans:
CVS Health
caremark.com
800.701.5833
TTY: 800.231.4403

UnitedHealthcare plan:
UHC/OptumRx
whyuhc.com/findmydoc
877.240.4075

Medicare Advantage plans:
SilverScript
caremark.com
844.449.4726

Comprehensive and Core Transition Plans:
If transitioning from an Aetna or Anthem plan: CVS Health (see info above)

If transitioning from a UnitedHealthcare plan: UHC/OptumRx (see info above)

Additional questions?
Benefits Education & Planning Center
866.777.8187

Global HR Service Center
mybenefitsresources.bankofamerica.com
Contact a representative using the chat function or Submit a Request option on the Contact Us page, or call 800.556.6044

Contact information for other programs can be found on:
HR Connect
hrconnect.bankofamerica.com

Employee Resources at Home
bankofamerica.com/employee

* Kaiser Permanente and the Aetna Dental DMO are only available in select markets.