2023 U.S. ANNUAL BENEFITS ENROLLMENT

Health and insurance benefits enrollment guide for individuals on long-term disability (LTD)

Oct. 25 – Nov. 4, 2022

Understand your options

Know your resources

Review your elections and enroll

Get ready for enrollment

This guide includes details about the health and insurance coverage available to you and your eligible family members during 2023 Annual Benefits Enrollment (ABE). When considering which plans are right for you, use the materials enclosed with this guide to help understand your choices.

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Note

If you'd like to keep the coverage shown on your enclosed *Enrollment Worksheet*, there is no need for you to take action. You'll automatically receive the coverage listed for 2023.

Consider this

You can change your elections as many times as you'd like during ABE. In most cases, the choices you make during ABE will remain in effect for the entire calendar year unless you experience a qualified status change (for example, marriage, divorce, or the birth or adoption of a child). **If you think you have a qualified status change, you have 31 days to notify the Global HR Service Center at 800.556.6044**. You can also call the Global HR Service Center if you have questions about your elections after enrollment has closed.

Make sure your personal information is up to date

If you've recently enrolled in Medicare or changed your address or telephone number, call the Global HR Service Center at **800.556.6044** to provide your current:

- Permanent street address (not a PO box)
- Medicare Beneficiary Identifier (MBI)
- Telephone number

2023 ABE dates and details

During ABE from **Oct. 25 – Nov. 4, 2022**, you can change your coverage and add or remove family members. For details about dependent eligibility requirements, see page 17 or log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) > **Knowledge Center** > **Plan Information** > **Employee Health & Insurance SPDs** to view:

- The *2021 Bank of America Health & Insurance Summary Plan Description* (2021 H&I SPD) and *2022 Bank of America Health & Insurance Summary of Material Modifications* (2022 H&I SMM) — for medical, dental, vision and life insurance, and health care account eligibility information **for dependents who are not Medicare-eligible**
- The *2021 Bank of America Medical Plans Available to Medicare-eligible Individuals on Long-term Disability Summary Plan Description* (2021 LTD SPD), *2021 Bank of America Retiree Health & Insurance Summary Plan Description* (2021 Retiree SPD) and *2022 Bank of America Retiree Health & Insurance Summary of Material Modifications* (2022 Retiree SMM) — for medical plan eligibility information **for dependents who are Medicare-eligible**

You may also call the Global HR Service Center at **800.556.6044**.

When choosing your health and insurance coverage for 2023, review your current benefits elections and decide whether you want to make any changes

Here are some important questions to help you consider your needs:

- Do you anticipate any changes in 2023 to the health or medical needs of you or your family?
- Do you want to enroll in or change your dental or vision plans?
- Do you need to change which family members are covered under your health or insurance benefits?
- Do you want to continue any supplemental life insurance?
- Do you need to add or change beneficiary designations for your life insurance or Health Savings Account (HSA), if applicable?
- Will you or any of your covered family members become eligible for Medicare in 2023?
- Do you have a dependent who is turning age 26 in 2023? If so, their coverage under your plan will end on the last day of their birthday month.

Information at your fingertips

You can access *Summaries of Benefits and Coverage* to help you compare your medical plan options during ABE. From Oct. 25 through Nov. 4, 2022, log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**). From the **Home** page, click **Enroll Now** > **Medical View/Change** > **Compare Medical Options**.

What's new — and what's staying the same — for 2023

Updates for 2023

For individuals who are not eligible for Medicare

Premiums — You may experience an increase in your annual medical premium, depending on your pay tier and which medical plan or carrier you choose. Teammates with Performance Year Cash Compensation (PYCC) of less than $50,000 won't see an increase. If you were in an Annual Benefits Base Rate (ABBR) role, your ABBR is used as your PYCC. Your PYCC is your annual base pay and benefits-eligible cash incentives as of your initial date of disability. See pages 16-17 for more information about PYCC.

Teladoc® — Teladoc consults will continue to be available at no cost[1] in 2023 to most teammates and covered family members enrolled in a U.S. bank medical plan with Aetna, Anthem or UnitedHealthcare. Preventive consultations, such as an annual physical, will remain available at no cost to anyone enrolled in one of these plans. If the current federal applicable law isn't renewed (it's currently set to expire Dec. 31, 2022), there will be a cost for CDHD plan participants for any nonpreventive consultations until they meet their deductible.

Teladoc provides 24/7 access to board-certified doctors, including mental health specialists and primary care physicians (PCPs), by phone or online video for virtual care.

- Doctors of general medicine can provide a diagnosis, treatment and a prescription (when needed) for a range of minor health issues — from colds and allergies to rashes and migraines.
- Eligible teammates and covered family members ages 13 and older can consult with psychiatrists, licensed psychologists or therapists on a wide variety of issues, such as stress, depression, family/marriage issues and eating disorders.[2]
- Earlier this year, the bank expanded its partnership with Teladoc to also include virtual primary care, through Primary360. It allows eligible teammates and covered family members ages 18 and older to schedule a virtual consult with a PCP — for an annual physical or other routine and preventive care needs. Call **855.835.2362** or visit **teladoc.com/bankofamerica**. Appointments for mental health consultations must be scheduled online in advance.

What's staying the same

For individuals who are not eligible for Medicare

Health plans — Our health plans aren't changing. You'll be able to choose from the same medical plans administered by the same medical carriers (Aetna, Anthem, UnitedHealthcare and Kaiser Permanente in select markets). Our prescription administrator will continue to be CVS Health (Caremark) for participants enrolled in Aetna or Anthem and UHC/OptumRx for UnitedHealthcare participants.

Tobacco-user rate — The tobacco-user rate for medical coverage will remain the same for 2023 ($900 per year), and once again, tobacco users will have the opportunity to be eligible for the non-tobacco-user rate if they indicate that they intend to quit in 2023 or complete the reasonable alternative standard form.

Health care account contributions — Any contribution from the bank will continue to help offset out-of-pocket expenses for eligible participants.

Wellness activities — Once again, you'll be able to complete wellness activities to gain insight into your health and keep a credit toward your annual medical plan premium (and an additional credit if your covered spouse or partner completes theirs as well). To keep your 2023 credit, visit **mywellnessresources.com** and complete the required activities by Feb. 28, 2023.

For Medicare-eligible individuals

Health plans — The two Medicare Advantage plans and prescription medication plan are not changing.

For all participants

Vision coverage — Aetna's vision plan premium won't change, and the Aetna Vision Discount Program will continue to be offered at no cost for participants who also choose Aetna as their medical carrier.

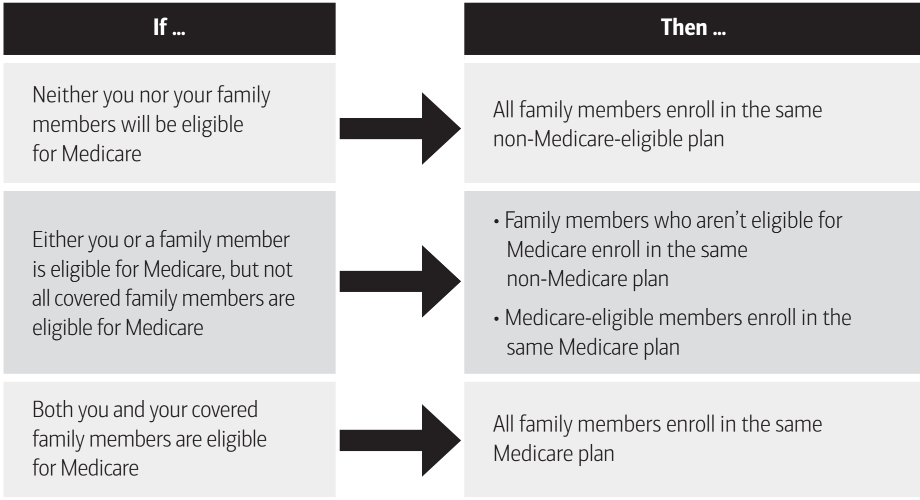
Dental coverage — MetLife dental plan premiums and Aetna DMO rates will not increase.

[1] Teladoc 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. For multiple consults on the same day, by the same covered individual, for the same issue, you may incur a temporary charge for which you will be reimbursed. Kaiser Permanente members can contact Kaiser for details about a similar program offered through their plan and any associated costs.

[2] Only talk therapy is available for those 13–17, not psychiatric support for medication management.

Medical plan eligibility

The medical plans available to you will vary depending on whether you or your family members are eligible for Medicare in 2023. After 24 months of receiving long-term disability (LTD), or if you become eligible for Medicare prior to 24 months, your available medical plans will change to work with Medicare (see pages 10–11 for more information). Your coverage will work differently, and your claims will be paid differently. Note that your applicable dental, vision, life and accident insurance benefits won't change based on the amount of time you receive LTD benefits or your eligibility for Medicare.



If ...	Then ...
Neither you nor your family members will be eligible for Medicare	All family members enroll in the same non-Medicare-eligible plan
Either you or a family member is eligible for Medicare, but not all covered family members are eligible for Medicare	• Family members who aren't eligible for Medicare enroll in the same non-Medicare plan • Medicare-eligible members enroll in the same Medicare plan
Both you and your covered family members are eligible for Medicare	All family members enroll in the same Medicare plan

Medical plans and features — If you're **not** eligible for Medicare

You have two medical choices to make during ABE: your medical carrier and your medical plan

Your *Enrollment Worksheet* shows the plans available to you.

All our national medical carriers — **Aetna**, **Anthem** and **UnitedHealthcare** — offer the same medical plans and are high-quality options with similar services and networks. We'll continue to offer **Kaiser Permanente** in 2023 as a carrier in select markets. Please refer to the **Compare Medical Options** feature on **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) for specific Kaiser Permanente plan information.

You may experience an increase in your annual medical premium, depending on your pay tier and which medical plan or carrier you choose. Teammates with a PYCC of $50,000 or more will see a premium increase of 2% to 7%, depending on their compensation tier. Teammates with less than $50,000 in PYCC won't see an increase. See pages 16-17 for more information about PYCC.

Determining your costs for medical coverage

Monthly costs for medical coverage for individuals who aren't eligible for Medicare are based on pay tiers that use your PYCC in effect as of your date of disability (see pages 16-17). Rates may increase after 12 months of coverage. The pay tiers are:

- Less than $50,000
- $50,000 to less than $100,000
- $100,000 to less than $150,000
- $150,000 to less than $250,000
- $250,000 to less than $500,000
- $500,000 or more

Wellness activities for individuals who aren't eligible for Medicare

You'll get a look at your health, and keep a credit toward your annual medical plan premium by completing voluntary wellness activities (and an additional credit if your covered spouse or partner completes them as well).

You can begin completing voluntary wellness activities now if you're currently enrolled in a bank medical plan, or on Jan. 1, 2023, if you're not currently enrolled in a bank medical plan but are enrolling in one for 2023.

Important dates:

Feb. 28, 2023 — Complete your wellness activities by this deadline.

April 1, 2023 — If you and your spouse or partner choose not to complete your wellness activities, you'll be required to pay the wellness credit back and your monthly medical plan premiums will increase beginning in April.

It pays to stay in network

Staying in network can help you to offset costs, so during ABE, carefully consider your medical plan elections and ensure your preferred providers are in network to avoid additional costs later. Find out if your doctors are in network across the carriers by going to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) > **Enroll Now** > **Medical View/Change** > **Find a Doctor or Hospital**.

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

If you enroll (or remain enrolled) 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 for Aetna ACO networks is determined by your home ZIP code.

Note

Once you know more about your health by completing the wellness activities, you can take advantage of the benefits and programs available to support your wellness. You have access to:

- Free one-on-one health coach sessions
- Programs that can help you quit using tobacco products

Contact your medical plan carrier for more information.

Medical plans and features — If you're **not** eligible for Medicare *(continued)*

	Annual deductible	Coinsurance	Out-of-pocket maximum	Preventive services	Office visits	Prescription medication at retail *(30-day supply)*
Comprehensive PPO Plan (Only available if your PYCC is under $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.
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** copayment for 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.
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.	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.

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.

Medical plans and features — If you're **not** eligible for Medicare *(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.	100% of eligible costs are covered: • For any family member who reaches their individual out-of-pocket maximum • 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 ABE, you can add or remove a spouse, partner or eligible child to or from your coverage.
- 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 16.

✓ Consider this

If you wish to change medical carriers, check the other available carriers' websites to see if your doctor or provider is in network with the carrier of your choice.

*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 and features — If you're **not** eligible for Medicare *(continued)*

Health care accounts available to you, based on your medical plan

	Consumer Directed Plan	Consumer Directed High Deductible Plan
	Health Reimbursement Arrangement (HRA)	**Health Savings Account (HSA)**
Account use	To pay for eligible health care expenses, including dental, vision and prescription medication	To save for future health care expenses, but also to pay for eligible health care expenses, including dental, vision and prescription medication, now
Maximum contribution *(bank + employee)*	The IRS does not allow individual contributions to an HRA. The bank contributes a set amount based on your PYCC and medical plan 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 cannot contribute to an HSA if you're enrolled in Medicare.
Bank contribution	PYCC is less than $50,000 **$500** Employee-only coverage **$750** Employee plus spouse or partner or Employee plus child(ren) coverage **$1,000** Family coverage PYCC is $50,000 to less than $100,000 **$400** Employee-only coverage **$600** Employee plus spouse or partner or Employee plus child(ren) coverage **$800** Family coverage PYCC is $100,000 to less than $250,000 **$300** Employee-only coverage **$450** Employee plus spouse or partner or Employee plus child(ren) coverage **$600** Family coverage	PYCC is less than $50,000 **$500** Employee-only coverage **$750** Employee plus spouse or partner or Employee plus child(ren) coverage **$1,000** Family coverage PYCC is $50,000 to less than $100,000 **$400** Employee-only coverage **$600** Employee plus spouse or partner or Employee plus child(ren) coverage **$800** Family coverage PYCC is $100,000 to less than $250,000 **$300** Employee-only coverage **$450** Employee plus spouse or partner or Employee plus child(ren) coverage **$600** Family coverage
Funds availability	The entire bank contribution amount is available at the beginning of the year.	The entire bank contribution is available at the beginning of the year. If you'd like to contribute while on LTD, you must contact Health Benefit Solutions directly.
Unused funds	Unused funds will automatically roll over to the next year, and you generally will have access to the funds as long as you stay in a medical plan that works with the HRA. If you leave the bank, any balance will be forfeited unless you're enrolled in an HRA-eligible plan and you've met the Rule of 60 (at least 10 years of vesting service, and that number plus your age equals at least 60). See page 19 for more information.	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.[1]

[1] Note that California and New Jersey tax employer and employee contributions to HSAs. In addition, New Jersey taxes employee contributions to Health and Limited Purpose FSAs. This information was accurate as of this guide's release date.

✓ Consider this

You can continue to access any unused balance in your HRA from previous years if you maintain coverage under an HRA-eligible medical plan, such as the Consumer Directed Plan.

Medical plans — If you're eligible for Medicare

You can choose one of two Medicare Advantage plans during ABE, the Medicare Advantage Comprehensive Plan or the Medicare Advantage Core Plan — both are administered by UnitedHealthcare® and prescription coverage is administered by SilverScript® (a CVS Health® company). Depending on where you live, a local Medicare Advantage plan may also be available to you.

About Medicare Advantage plans

Medicare Advantage plans (often called Medicare Part C) are administered by private insurance companies and are approved by the Centers for Medicare & Medicaid Services (CMS). These plans offer the same health care services (and sometimes additional services) as those covered under Medicare Parts A, B and D.

To enroll in a Bank of America Medicare Advantage plan, you must be enrolled in Medicare Parts A and B and continue to pay any required premiums. Once your enrollment in a Medicare Advantage plan is completed, you'll be covered under traditional Medicare and receive your benefits through the Medicare Advantage plan. Your enrollment in a Medicare Advantage plan will be denied if you are not enrolled in parts A and B and you'll be moved to a transition plan.

Note: Federal rules allow you to participate in only one Medicare Advantage plan at a time. The plan you enroll in last is the plan that CMS considers to be your final decision. If you enroll in a Medicare Advantage plan offered through Bank of America and later enroll in a different Medicare plan, you will be disenrolled from your Bank of America coverage.

The four parts of Medicare

Part A: Covers inpatient care in hospitals and skilled nursing facilities, as well as hospice care and some home health care services.

Part B: Covers doctors' services, outpatient hospital care and medical services that Medicare Part A does not cover, including some medically necessary services provided by physical and occupational therapists, and some home health care services.

Part C: Refers to Medicare Advantage plans, provides Parts A and B coverage and can also provide prescription coverage (Part D). **Remember, to be eligible for a Medicare Advantage plan, you must be enrolled in Medicare Parts A and B and pay any required premiums.**

Part D: Provides prescription coverage. Part D can be combined with Medicare Supplement and Medicare Advantage plans. However, when prescription coverage is provided under another Medicare plan, you can't be enrolled in separate Part D coverage.

✓ Consider this

- You should never receive a bill from a health care provider who accepts your Medicare Advantage medical plan. They're fully reimbursed by UnitedHealthcare.
- If you have a Medicare Advantage Comprehensive or Core plan, your SilverScript prescription plan offers coverage without the uncertainty of a coverage gap (or doughnut hole).

Medical plans — If you're eligible for Medicare *(continued)*

The primary difference between the two Medicare Advantage plans we offer nationally is the amount you pay up front and the amount you pay when you receive care. For information about a local Medicare Advantage plan, where available, contact the plan directly. With any Medicare Advantage plan, you can go to any doctor, hospital or other provider that participates in Medicare and accepts Medicare Advantage plans.

✓Consider this

You may also have other plans, like a local Medicare Advantage HMO plan, available to you based on your home ZIP code. Refer to your enclosed *Enrollment Worksheet* for more information about the plans available to you in 2023.

	Comparing Medicare Advantage plans	
	Medicare Advantage Comprehensive Plan	**Medicare Advantage Core Plan**
	• Higher monthly premiums • No annual deductible • Lower copayments • Lower out-of-pocket maximum	• Lower monthly premiums • $300 annual deductible per person • Higher copayments • Higher out-of-pocket maximum
Annual deductible	You pay $0	You pay $300 per person
Primary care visits	You pay a $5 copayment	You pay a $20 copayment
Specialist visits	You pay a $10 copayment	You pay a $30 copayment
Annual medical out-of-pocket maximum	You pay no more than $600	You pay no more than $3,000
Preventive care services	You pay $0, no limit	
Coordination with Medicare	Provides Medicare Parts A and B coverage	
	Prescription coverage*	
Initial coverage	**Retail pharmacy copayment (30-day supply):** Generic: $5 Preferred brand: $20 Nonpreferred brand: $30 **Mail (90-day supply):** 2x retail pharmacy copayment	
Catastrophic coverage	After your annual out-of-pocket costs reach $7,400, you'll pay the greater of: • Generic: $4.15 or 5%, but no more than your standard copayment • All other medications: $10.35 or 5%, but no more than your standard copayment	

* Contact SilverScript for more information on prescription coverage.

Dental coverage

MetLife will continue to be 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.

In select markets, the Aetna Dental DMO Plan is also 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 the 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 out-of-network coverage

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

	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 do not 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 do not count toward annual maximum. Limited to two visits per calendar year. **Dental X-rays:** Plan pays **100%** of covered X-rays; services do not 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.

Tip

If Aetna is your medical carrier, you automatically have access to the Aetna Vision Discount Program, 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**.

Refer to your enclosed *Enrollment Worksheet* for more information about the Aetna vision plan.

	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.

Life and accident insurance

Life and accident insurance can provide income protection for you and your family. This section highlights the coverage you can elect for yourself and your eligible dependents. For more information, refer to the 2021 H&I SPD and 2022 H&I SMM on **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) > **Knowledge Center** > **Plan Information** > **Employee Health & Insurance SPDs**.

✓ Consider this

Be sure to review your beneficiaries and make any needed updates. To check your current life insurance beneficiary designation, log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) and go to **Health and Insurance** > **Coverage Details** > **Beneficiaries** to make and/or confirm your elections.

	Core coverage: Bank of America provides this insurance benefit automatically at **no cost to you**.	**Supplemental coverage:** You can elect to continue, if applicable, these additional insurance benefits during Annual Benefits Enrollment.			
	Associate life insurance	**Associate life insurance**	**Dependent life insurance**	**Accidental death & dismemberment insurance**	**Family accidental death & dismemberment insurance**
What it is	Company-paid associate life insurance provided by MetLife	Supplemental life insurance coverage paid on a post-tax basis	Assists with expenses if your spouse, partner or child dies. You'll choose your coverage level when you enroll. Paid on a post-tax basis.	Additional financial protection in the event of your serious accidental injury or death. Paid on a post-tax basis.	Financial protection in the event of your spouse, partner or child's serious accidental injury or death. Paid on a post-tax basis. Must have employee AD&D coverage to elect.
What it could provide	**Annual base pay or Annual Benefits Base Rate (ABBR) x 1** (or the option of $50,000, if your base pay or ABBR is greater than $50,000, to avoid imputed income tax), to a maximum of $2 million.	**Eligible compensation* x 1–8** up to a maximum of $3 million	**$10,000 – $150,000** spouse or partner **$5,000 – $25,000** each child	**Eligible compensation* x 1–8** up to a maximum of $3 million	**60% of your coverage amount** spouse or partner, up to $600,000 **20% of your coverage amount** each child, up to $50,000

* (Annual base pay + eligible bonus) or ABBR

Enroll Oct. 25 – Nov. 4, 2022

If you're satisfied with the 2023 coverage shown on your enclosed *Enrollment Worksheet*, there's no need for you to take action. If you would like to elect different coverage, or add or remove family members from your coverage, you can do so during 2023 U.S. ABE.

Enroll 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 will not 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, contact a Global HR Service Center representative using the chat function or Submit a Request option on the **Contact Us** page.

Enroll by phone

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).

When you call, have your enrollment elections ready. (You'll also need the last four digits of your Person Number if you've not yet created a Phone Pin.) 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.

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.

Additional steps to complete your enrollment

If you are enrolling in a Medicare Advantage plan, you may have a few more steps to complete.

Following your enrollment in a Medicare Advantage plan, Centers for Medicare & Medicaid Services (CMS) is required to review and approve your enrollment. If you enroll in a **Medicare Advantage Comprehensive Plan** or **Medicare Advantage Core Plan**, your enrollment will be submitted to CMS automatically. You won't need to take any action unless you receive a written request from UnitedHealthcare or SilverScript requesting additional information that may be required for CMS approval.

Note about Medicare Advantage Comprehensive and Core plans: If your enrollment forms are missing any information, such as your permanent street address or Medicare Beneficiary Identifier (MBI), you and your eligible dependents will be enrolled in the Comprehensive Transition Plan or Core Transition Plan. These plans will offer temporary coverage until you complete all the requirements necessary to enroll in a Medicare Advantage plan.

If you newly enroll in a **local Medicare Advantage HMO plan**, you'll receive a Medicare Advantage enrollment form in the mail* with your Confirmation Statement from Bank of America. **You'll need to complete the enrollment form and return it to the Global HR Service Center in the return envelope provided to complete your enrollment.** If you have questions regarding the enrollment form, please call the Global HR Service Center at **800.556.6044**.

Note about Local Medicare Advantage HMOs: If your enrollment forms are missing any information, such as your permanent street address or Medicare Beneficiary Indentifier (MBI), or you don't return the enrollment form for a local Medicare Advantage HMO plan, you and your eligible dependents will be enrolled in the Comprehensive Transition plan. This national plan will offer temporary coverage until you complete all the requirements necessary to enroll in a Medicare Advantage plan.

What to expect once your enrollment is approved

After CMS approves your enrollment, the Global HR Service Center will update your medical coverage to reflect your enrollment in the Medicare Advantage plan.

You'll receive your welcome packets and new plan ID cards from UnitedHealthcare and SilverScript, or your local Medicare Advantage HMO plan, if applicable.

* If you enroll in a Kaiser plan, you'll enroll online, so you won't receive a paper form to complete and return.

Appendix

Important information about your health and insurance benefits

Where to go for more information

- For information about **medical, dental and vision coverage**, contact your carrier directly. You can find telephone numbers for carriers available to you on page 20 of this guide. Log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) > **Enroll Now** > **Medical View/Change** > **Compare Medical Options** for carrier contact information.
- Visit **My Benefits Resources** > **Knowledge Center** > **Plan Information** or contact the Global HR Service Center at **800.556.6044** to request an SPD for information about:
  - Medical (non-Medicare), dental, vision and life insurance plans and health care accounts as of Dec. 31, 2022 (refer to the 2021 H&I SPD and 2022 H&I SMM)
  - Medicare-eligible medical plans (refer to the 2021 LTD SPD)

Benefits eligibility

(For all individuals on LTD)

For detailed information about dependent eligibility, visit **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) > **Knowledge Center** > **Plan Information**.

- If your dependents are not Medicare-eligible, review the 2021 H&I SPD and 2022 H&I SMM.
- If your dependents are Medicare-eligible, review the 2021 LTD SPD, 2021 Retiree SPD and 2022 Retiree SMM.

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

Generally, your child or children are eligible to be covered under our plans until the end of the month in which your child turns age 26, regardless of whether they attend school full- or part-time.

Spouse or partner

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

The U.S. Treasury and IRS guidelines 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 age 65 or older 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 you and be considered a member of your 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

For information regarding health and insurance coverage for adult family members, visit **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) or call the Global HR Service Center at **800.556.6044**. If you're uncertain if an adult family member qualifies as your eligible dependent, call the Global HR Service Center.

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 **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) > **Knowledge Center** > **Plan Information** > **Employee Health & Insurance SPDs**

Medical coverage

(For non-Medicare individuals on LTD)

Performance year cash compensation (PYCC)

Your PYCC is used to determine your available medical plans and medical premium costs.

Your 2023 PYCC is your annual base pay as of Dec. 31, 2021 (or your date of hire, if later), plus any benefits-eligible cash incentives, such as most cash commission pay and any annual cash bonus, earned for 2021 and paid on or before June 30, 2022. Benefits-eligible cash incentives do not include cash incentives, bonuses, relocation payments or similar compensation paid to employees from a non-U.S. payroll. If you were disabled prior to Jan. 1, 2022, your PYCC is your annual base pay and benefits-eligible cash incentives as of your initial date of disability.

When a dependent loses eligibility

You have up to 31 days to call the Global HR Service Center and let us know if one of your dependents should be dropped from your plan — for example, upon divorce. If your dependent receives benefits from a plan after the date their coverage ends, you'll be 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. You won't be refunded premiums if you don't call within 31 days.

Appendix *(continued)*

Annual Benefits Base Rate (**ABBR**)

For some roles, we calculate an Annual Benefits Base Rate (ABBR), which is used as your PYCC.

Your 2023 ABBR is based on your 2021 regular earnings, draw paid in 2021, your 2021 leave pay and any benefits-eligible cash incentives, which include most commission pay and annual bonus earned from 2021 and paid on or before June 30, 2022. If you were disabled prior to Jan. 1, 2022, your ABBR is the ABBR in effect as of your initial date of disability.

To see your 2023 PYCC or ABBR:

Log in to **My Benefits Resources** and click the person icon on the top right of the page to view **My Profile** > **Personal Information** > **Personal Details**.

Any changes to your base salary after Dec. 31, 2021, will not change your PYCC amount.

Wellness

(For non-Medicare individuals on LTD)

If you're pregnant, or it is medically inadvisable or unreasonably difficult for you to participate in the wellness activities based on a medical condition, you may submit a Health Care Provider Medical Waiver Form (2023 Wellness Program) signed by your health care provider in place of completing the health screening and health questionnaire portion of the wellness activities. Your physician will indicate which activities the waiver covers. If your waiver doesn't cover both the health screening and health questionnaire, you'll still need to complete the activity that's not covered by Feb. 28, 2023, to maintain the wellness credit. For additional information on available waivers, please contact My Wellness at **833.525.5788** or **boa.support@virginpulse.com**. Representatives are available Monday through Friday, 8 a.m. to 8 p.m. Eastern (excluding certain holidays).

Tobacco users pay more

(For non-Medicare individuals on LTD)

For 2023, adults who have used tobacco in the last 12 months and are covered under the Bank of America medical plans will continue to pay a tobacco-user rate for their coverage. This rate is $900 more annually than the rate for adults who don't use tobacco.

To qualify for the lower rate, the covered adult must certify during their enrollment period that they have not used tobacco products during the prior 12 months, including, but not limited to, cigarettes, cigars, pipes, chewing tobacco, snuff, dip and loose tobacco smoked by pipe.

If you have previously acknowledged that you're a tobacco user when electing medical coverage or associate supplemental life insurance coverage, your acknowledgment for 2023 will be set to "yes" automatically.

This means your monthly costs for medical coverage in 2023 will reflect the tobacco-user rate. You can change your acknowledgment to "no" if you have quit using tobacco since your last enrollment and have not used any tobacco products in the past 12 months. During Annual Benefits Enrollment, you'll be asked to provide your tobacco-user status separately from the tobacco user status of your spouse or partner.

Note for medical coverage only: If you or your covered spouse or partner currently use tobacco products but intend to quit in 2023, you must indicate this when you enroll and you won't pay the higher tobacco-user rate. You'll be contacted by your medical carrier about the tobacco cessation programs and resources available. The tobacco-user rate will still apply to associate supplemental life insurance or life insurance premiums for your spouse or partner.

If you or your covered spouse or partner or other adult dependent use tobacco and are unable to meet the non-tobacco-user standard, you may still qualify for the lower non-tobacco-user medical rates. Prior to the close of 2023 ABE, contact the Global HR Service Center at **800.566.6044** to discuss an alternative standard and complete certain steps that will provide the same non-tobacco-user medical rates.

Health care accounts

(For non-Medicare individuals on LTD)

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

Bank contributions

Your PYCC, the plan and the coverage level you elect are used to determine how much the bank will contribute to your health care account.

Eligible dependents

Under the health reimbursement arrangement (HRA), eligible dependents include your spouse, children under the age of 26 who are your birth, adopted, placed-for-adoption, step and foster children, as well as other dependents you claimed or could have claimed on your federal tax return.

However, per IRS requirements, the definition of an eligible dependent under a health savings account (HSA) only includes your spouse and family members whom you can claim as dependents on your federal income tax return. If you're 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 Plan with the HRA, you may only submit claims for reimbursement from your HRA for yourself and those eligible 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 HRA balance by enrolling in an HRA-eligible medical plan and remaining employed by the bank. If you're still employed by the bank and choose a plan that's not

HRA-eligible or choose not to enroll in a medical plan, your HRA balance will continue to roll over.

The balance won't be accessible until you re-enroll in an HRA-eligible medical plan or leave the bank after meeting the Rule of 60. HRA-eligible medical plans include the Consumer Directed Plan. If you leave the bank before you've met the Rule of 60 (at least 10 years of vesting service, and that number plus your age equals at least 60), any balance will be forfeited. For more information, refer to the 2021 H&I SPD and 2022 H&I SMM on the **Knowledge Center** tab on **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**).

Health care account 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 will be inactivated and you'll be required to repay any amount you used over your available fund amount and you will be taxed on the amount. For the HSA, there can also be a 20% penalty from the IRS 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, combined with any bank contribution to your HSA, exceeds the IRS limit, you'll pay taxes on the amount of the contribution that exceeds the limit.
- California and New Jersey tax employer and employee contributions to HSAs. In addition, New Jersey taxes employee contributions to Health and Limited Purpose FSAs.

Health Savings Account (HSA)

(Verifying your information)

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, which may result in forfeiture of any bank contributions. The contributions you make would be returned during the year.

Life insurance

(For all individuals on LTD)

Associate supplemental life insurance and dependent life insurance

Tobacco users pay a higher rate. If you or your spouse or partner have previously acknowledged that either of you are a tobacco user when electing associate supplemental or spouse or partner life insurance or medical coverage, the acknowledgment for 2023 will be set to "yes" automatically. This means your monthly cost for associate supplemental or spouse or partner life insurance coverage in 2023 will reflect the tobacco-user rate. You can change either acknowledgment to "no" if you or your spouse or partner have quit using tobacco since your last enrollment and haven't used any tobacco products in the past 12 months.

Imputed income

The value of certain benefits is subject to imputed income, which means that you pay taxes on the value of that coverage. If imputed income affects you, you'll see it on the first invoice you receive after electing your benefits or, if later, your coverage start date. For more information about imputed income, please refer to the 2021 H&I SPD and 2022 H&I SMM on the **Knowledge Center** tab on **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**).

- Associate basic life insurance: You'll have imputed income if your company-paid life insurance coverage exceeds $50,000.
- Dependent life insurance: Some participants may have imputed income on their dependent life insurance coverage (for coverage of more than $2,000).
- Coverage for a partner: The value of coverage for your partner and/or your partner's children who are not your tax dependents is considered imputed income for purposes of medical, dental, vision and AD&D insurance, as well as the value of any bank contributions to your HRA, to the extent you are not paying the full cost of such coverage on a post-tax basis. (If you're enrolling your partner and/or your partner's children whom you can claim as your dependents on your federal income tax return, you must do so through the Global HR Service Center. If you're enrolling your partner and/or your partner's children whom you cannot claim as your dependents on your federal income tax return, you may do so either online at **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) or by calling the Global HR Service Center at **800.556.6044**.

Lifetime maximum on benefits

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.

Appendix *(continued)*

Summary of Benefits and Coverage—Availability Notice

As a result of the Affordable Care Act, Bank of America is required to provide Summaries of Benefits and Coverage (SBCs). The SBCs summarize, in a standard format, important information about the bank's medical plans. This is another resource to help you compare your plan choices. To view SBCs during ABE, log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) and go to **Enroll Now** > **Medical View/Change** > **Compare Medical Options**. 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 be mailed to you, call the Global HR Service Center at **800.556.6044**.

Other legal information

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 **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) and click **Knowledge Center** > **Plan Information** > **Legal Notices** or call the Global HR Service Center at **800.556.6044**.

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 Summary Plan Description for deductibles and copayment information applicable to the medical plan in which you choose to enroll. The Summary Plan Description is available on **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) or upon request by calling the Global HR Service Center at **800.556.6044**.

Fully insured medical plans

Aetna International, Kaiser Permanente, HMSA Hawaii and Triple-S Salud medical plans may have other changes in coverage for 2023. Please contact your carrier with any questions.

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, or after you are no longer eligible for COBRA. There's no special enrollment period if you voluntarily end your COBRA coverage. For more information about specific enrollment rules or plans offered through health care exchanges, please visit **healthcare.gov** or call **800.318.2596** (TTY: **855.889.4325**).

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 shouldn't 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 16 for more information about dependent eligibility.

When you enroll or continue participation in the Bank of America plans, you are acknowledging the benefits you have elected are subject to the provisions of the Bank of America Group Benefits Program and the terms and conditions of the benefit. 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.

Helpful contact information

Medical
Aetna
aetna.com/bankofamerica
877.444.1012
TTY: 800.628.3323
For Aetna ACO phone numbers, see page 6

Anthem
anthem.com/bankofamerica
844.412.2976

Kaiser Permanente*
kp.org
Phone numbers are listed on the back of your ID card

UnitedHealthcare
Non-Medicare plans:
whyuhc.com/findmydoc
877.240.4075

Medicare Advantage plans:
retiree.uhc.com/healthplans
866.460.8856

Dental
Aetna*
aetna.com/bankofamerica
877.444.1012
TTY: 800.628.3323

MetLife
metlife.com/mybenefits
888.245.2920

Vision
Aetna
member.eyemedvision.com/bac
877.444.1012
TTY: 800.628.3323

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

National Advantage plans:
SilverScript
caremark.com
844.449.4726

Local Advantage plans:
Once enrolled, please refer to the number on the back of your ID card.

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)

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

Enrollment information
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

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

This communication provides information about certain Bank of America benefits. Receipt of this document does not automatically entitle you to benefits offered by Bank of America.

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

For convenience, we use the name “Bank of America” in this document because it is used at companies with different names within the Bank of America Corporation family of companies. However, use of the terms “Bank of America” or “bank” does not mean that you are or were employed by Bank of America Corporation; you are or were employed by the entity that directly pays or paid your wages.

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