2023 U.S. ANNUAL BENEFITS ENROLLMENT

Your guide to wellness in the year ahead

BANK OF AMERICA



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

It's time to make your 2023 health and insurance benefits elections

This guide includes details about the retiree health and insurance plans available to you and your eligible family members for 2023. When considering which plans are right for you, use the materials enclosed with this guide to help you understand your choices.

Three tips for successful enrollment

Understand your options

Your options will vary depending on whether you and your covered family members will be eligible for Medicare in 2023.

Know your resources

Contact the Global HR Service Center, online or by phone, if you have questions during the enrollment process or to complete your enrollment.

My Benefits Resources
mybenefitsresources.bankofamerica.com
800.556.6044

Review your elections and enroll

Annual Benefits Enrollment for 2023 is **Oct. 25 – Nov. 4, 2022**. Carefully review your options and make your elections online or by phone by the deadline.

Want to keep your existing coverage?

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

Changing your elections

You can change your elections as many times as you'd like during Annual Benefits Enrollment. In most cases, the choices you make during Annual Benefits Enrollment will remain in effect for the entire 2023 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. If you have questions about your elections after enrollment has closed, call the Global HR Service Center at **800.556.6044**.

What's inside

Make your 2023 health and insurance benefits elections Oct. 25 – Nov. 4

Enroll online:

1. Log in to **My Benefits Resources** at **mybenefitsresources.bankofamerica.com**
2. From the Home page, click **Enroll Now**.
3. **Once you've made your elections, you must confirm and save them** by clicking **Complete Enrollment**. Print your **Confirmation Statement** for your records.

Have questions or need assistance? Contact a Global HR Service Center representative using the **chat function** or **Submit a Request** option on the **Contact Us** page, or call using the number below.

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). Have your benefits elections ready. Once authenticated, say "Annual Benefits Enrollment." A representative will take your benefits elections and validate dependent information.

Medical plans

The medical plans available to you will vary depending on whether you or your family members will be eligible for Medicare in 2023.

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

In most cases, you can change your coverage and add or remove family members during Annual Benefits Enrollment from **Oct. 25 – Nov. 4, 2022**. For additional details about dependent eligibility requirements, see page 12, or log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) > **Knowledge Center** > **Plan Information** to view:

- 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) for medical, dental, vision, life insurance plan and health care account eligibility information **for dependents who are not Medicare-eligible**
- The *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**.

If you waive medical coverage

Certain retirees may be eligible to waive medical coverage and re-enroll during a future enrollment period or within 31 days of a qualified status change. You will be required to provide proof that you've been covered under another medical plan (other than Medicare) for 12 consecutive months before the date you wish to re-enroll. You won't be required to provide proof of other coverage if you want to re-enroll only in dental or vision coverage.

Note: Participants from certain legacy companies or those enrolled in certain legacy medical plans may not cancel medical coverage and re-enroll in future years. Call the Global HR Service Center at **800.556.6044** for information about applicable re-enrollment rules and restrictions.

Factors that determine your medical plan costs

Your costs for the medical plans available to you are based on a number of factors. These may include your legacy company, the plan you choose, the number of people you cover, the ZIP code where you live, when you were hired, your retirement date, and your years of service and age at retirement. Your contribution amounts are shown on your *Enrollment Worksheet* and become effective Jan. 1, 2023. If you or any of your family members are **younger than age 65**, disabled and eligible for Medicare, call the Global HR Service Center at **800.556.6044**.

Some fully insured retiree medical plans may have changes in coverage for 2023 because they are also governed by state insurance laws. Please contact the carriers with any questions.

Medical plans — if you **are** eligible for Medicare

You have two medical plans to choose from during Annual Benefits Enrollment: the Medicare Advantage Comprehensive Plan or the Medicare Advantage Core Plan — UnitedHealthcare is the carrier for both

Depending on where you live, a local Medicare Advantage plan may also be available to you, based on your home ZIP code. Refer to your enclosed *Enrollment Worksheet* for more information about the plans 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.

In order 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're not enrolled in Medicare 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 doesn't 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.

Health care providers and reimbursement

Health care providers who accept Medicare are fully reimbursed under your Medicare plan — you shouldn't receive a bill from a health care provider who accepts Medicare.

Your SilverScript prescription plan

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 **are** eligible for Medicare *(continued)*

The primary difference between the two Medicare Advantage plans we offer nationally is the amount you pay up front 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.

Other medical plans

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.

	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 will pay the greater of: • Generic: $4.15 or 5%, but no more than your standard copayment • All other prescription medications: $10.35 or 5%, but no more than your standard copayment	

* Contact SilverScript for more information on prescription coverage.

Medical plans — if you **are** eligible for Medicare *(continued)*

You may have a few more steps to complete your Medicare Advantage plan enrollment

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 for additional information that may be required for CMS approval.

Important note about Medicare Advantage Comprehensive and Core plans: If your form is missing 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 will 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**.

Important note about Local Medicare Advantage HMO plans: If your form is missing information, such as your permanent street address or Medicare Beneficiary Identifier (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.

Welcome packages and ID cards: You'll receive your 2023 welcome packets from UnitedHealthcare, SilverScript or your local Medicare Advantage plan. UnitedHealthcare will send new plan ID cards.

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

* If you enroll in a Kaiser plan, you'll enroll electronically.

Medical plans — if you are **not** eligible for Medicare

There are no changes to non-Medicare plans for this year. If you are not eligible for Medicare, the following medical plans may be available, depending on your home ZIP code.

Preferred Provider Organizations (PPOs)

A PPO offers a network of doctors, hospitals and other health care providers who have agreed to provide care at negotiated rates. You can also see any licensed doctor outside the network at any time and still receive benefits for covered services. Keep in mind that you'll generally pay less when you use an in-network provider.

Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs)

HMOs and EPOs typically work the same way. Generally, there are no deductibles; you pay a copayment, and the plan covers the remaining cost for most medically necessary services. When you enroll in an HMO or EPO, all of your care must be provided by your plan's network of doctors, specialists and hospitals, except in the case of a medical emergency. Some HMOs and EPOs require you to select a primary care physician to manage your care and, when medically necessary, refer you to specialists, hospitals and other health care facilities.

High-Deductible Health Plans (HDHPs)

An HDHP allows you to receive care from any licensed, eligible provider and still receive benefits. Generally, you will pay less when you use an in-network provider. You need to satisfy an annual deductible before the plan begins to share the cost of your care, with the exception of preventive prescription medications, which are covered at 80% prior to meeting the annual deductible. Once you reach the annual out-of-pocket maximum, your plan pays 100% of your eligible expenses for the rest of the year. As with all retiree health plans, eligible preventive care and screenings received from an in-network provider are covered at 100% with no deductible.

If you enroll in an HDHP, you can open a Health Savings Account (HSA) to help cover your deductible and out-of-pocket costs. See the next page for more on HSAs.

Information at your fingertips

You can compare your medical plan options during Annual Benefits Enrollment. Log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) from Oct. 25 through Nov. 4, 2022, and click **Enroll Now** > **Medical View/Change** > **Compare Medical Options**.

Prescription medication coverage

CVS Health is the prescription administrator for most of our non-Medicare retiree plans, and offers the convenience of mail order service for a 90-day supply of maintenance prescription medications. Register at **caremark.com** to see if your local pharmacy participates.

Note: For Kaiser Permanente, Health Net, HMSA Hawaii and Triple-S Salud medical plans, prescription medication coverage is provided directly by the medical plan.

Behavioral health services

Beginning January 1, 2023, behavioral health services previously offered through Cigna for non-Medicare plans will be offered through your medical plan carrier.

Medical plans — if you are **not** eligible for Medicare *(continued)*

If you enroll in a high-deductible health plan (HDHP), consider contributing to a Health Savings Account (HSA).

An HSA offers a tax-advantaged* way to save and pay for current or future eligible health care expenses. Use your HSA funds to pay for out-of-pocket expenses, such as:

- Medical, dental, vision and prescription medication expenses
- Deductibles and coinsurance
- Eligible medical expenses, including laser eye surgery, acupuncture, hearing aids and batteries
- Long-term care insurance premiums, subject to certain limits
- Medicare premiums, once you become eligible for Medicare

The IRS may require you to prove you used your HSA to pay for an eligible expense, so be sure to keep your receipts. **Note:** You must be enrolled in an HDHP to contribute to an HSA. You may **not** contribute to an HSA if you or a covered family member can be claimed as a dependent on another person's federal tax return, or are enrolled in Medicare or any other medical plan that is not considered a high-deductible plan under IRS rules.

Non-Medicare plans and HSA enrollment

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

Note: If you enroll in the non-Medicare HDHP for the first time in 2023 and are also eligible to elect an HSA, these steps also apply to you.

To enroll:

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

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

* Note that California and New Jersey tax contributions to HSAs.

HSA at a glance

- **In 2023, you can contribute up to:**
  – $3,850 for individual coverage
  – $7,750 for family coverage

Note: If you'll be age 55 or older next year, you can make an additional $1,000 catch-up contribution.

- **Any unused funds are rolled over** to the next year automatically.
- **You can invest your HSA funds for potential additional growth** if your HSA balance is over $1,000. Earnings on your investments are generally tax-free.
- **You can use your HSA funds to pay for the eligible health care expenses of your eligible dependents**. Eligible dependents include your spouse and anyone you claim on your federal income tax return as a dependent.

Your HSA and rolling over a balance

Refer to your enclosed *Enrollment Worksheet* for more information about whether you're eligible to participate in an HSA for next year.

If you already have an HSA through Bank of America, your current health account debit card can be used for any balance that rolls over from this year and new contributions you make next year. If your current card has expired, a new one will be mailed to you.

Dental coverage

There are no changes to retiree dental coverage for this year. Refer to your enclosed *Enrollment Worksheet* for more information about the dental plans available to you.

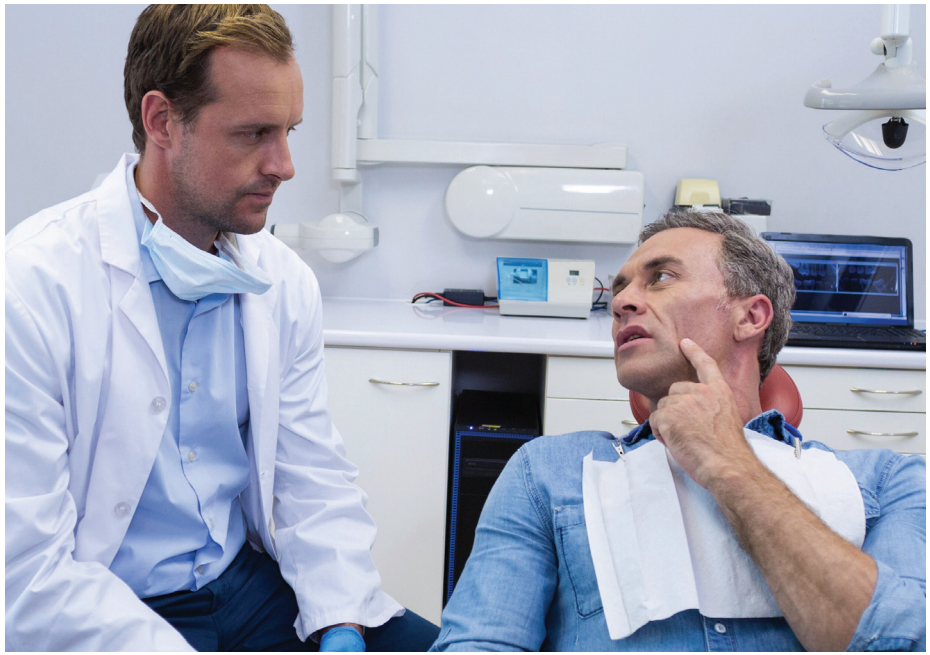
Dental Preferred Provider Organization (PPO)

With the Dental PPO provided by MetLife, you'll have access to a network of dentists who have agreed to accept negotiated rates. You may also see an out-of-network dentist, but you won't be able to take advantage of the negotiated network rates; services will be subject to usual and customary limits for out-of-network services. You'll be responsible for any costs that are above the limit, plus the applicable coinsurance and deductible. Visit **metlife.com/mybenefits** to see if your dentist is in network.

Dental Maintenance Organization (DMO)

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 next year, be sure they're in network and accepting new DMO patients before you elect this dental plan.

Note: Retirees in Puerto Rico who elect the Triple-S Salud medical plan receive dental coverage under that 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/diagnostic care and applies to basic and major expenses. Annual maximum coverage per person (excludes orthodontia): **$1,500** Lifetime maximum for orthodontia (children under age 19): **$1,500** Office visit copayment: None	Annual deductible: None Annual maximum coverage per person (excludes orthodontia): None Lifetime maximum for orthodontia: 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, limited to two visits per calendar year. Cleaning: Plan pays **100%** of covered services; services, limited to two visits per calendar year.	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.
Services	After deductible satisfied: 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. Orthodontia (children only): 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. Orthodontia (children only): You pay **50%** of covered services.

Vision coverage

We offer vision coverage through the Aetna Vision Plan. Refer to your enclosed *Enrollment Worksheet* for more information about the Aetna Vision Plan.

Note: Retirees in Puerto Rico who elect the Triple-S Salud medical plan receive vision coverage under that 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)	Standard progressive: **$65** copayment, in lieu of contacts	Plan pays a reimbursement, up to **$60**.
Premium progressive lenses (once per calendar year)	Premium progressive: **$65** copayment and **80%** of charge, less **$120** allowance in lieu of contacts	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 **$55**.
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 **$40** 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 reimbursement, up to **$105** in lieu of lenses.

Retiree life insurance

If you're eligible for retiree life insurance, your coverage is based on certain provisions in place when you retired and will be listed on your enclosed *Enrollment Worksheet*.

Note that your life insurance is subject to imputed income, which means you pay taxes on the value of any company-paid retiree life insurance that exceeds $50,000 and any dependent life insurance that exceeds $2,000.

Are your retiree life insurance beneficiaries up to date?

An important part of any personal financial wellness plan is to periodically review and update your beneficiaries. To check your current Bank of America retiree life insurance beneficiary designations, log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) and go to **Health and Insurance > Coverage Details > Beneficiaries** to make, update or confirm your designations.

Paying for coverage

You generally have three options for paying for your retiree health and insurance benefit coverage

1. **Automatic deduction from your pension plan annuity benefit (available for most retirees):** If you're receiving a monthly pension from the company, you can have your monthly benefits payment deducted directly from your pension annuity check. Deductions for 2023 coverage will begin in January 2023. However, if any of the following apply to you, deduction from your pension payment won't be available, and you'll need to select either direct debit or invoice billing:
   - Your monthly cost is more than your pension benefits
   - You have a Medical Reimbursement Account (MRA) or Health Care Savings Fund (HCSF)
   - You're a Merrill retiree
   - Your pension service provider doesn't support deducting benefit payments from pension annuities
2. **Direct debit from a checking or savings account:** You may elect to have your monthly benefits payment deducted automatically from your bank account. To begin direct debit in January 2023, 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 Jan. 1, 2023.
3. **Invoice billing:** If you don't request either of the two options above, you'll receive a monthly invoice from the Global HR Service Center. 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 coverage will be terminated if the amount due isn't paid by the due date provided on each invoice. If you use a bill-pay service and the cost of your health and insurance coverage changes, please be sure to update the amount of your payment.

If you're eligible for an MRA or HCSF, you can use this account to pay for coverage

If you have an **MRA** or **HCSF** and enroll in a medical plan, amounts from the MRA or HCSF will be applied automatically to offset your coverage costs.

Retirees with these accounts receive an annual credit from Bank of America. Any remaining amount will be deposited into an MRA or HCSF, administered by Bank of America Health Benefit Solutions, and can be used to pay for eligible health care expenses such as deductibles, coinsurance and copayments. In this case, you will receive a debit card about a week before your coverage becomes effective on Jan. 1, 2023.

If you have an MRA or HCSF, here's how your enclosed *Enrollment Worksheet* will reflect the offset costs:

- **MRA or HCSF:** This is the amount that will be applied from your MRA or HCSF to offset the cost of your coverage.
- **Your total contributions:** This is your monthly payment for coverage after amounts from your MRA or HCSF have been applied.

For additional important information about your MRA or HCSF, see page 13.

Make or change your payment type

You can make or change your payment option at any time. Log in to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**), navigate to the **Review Billing and Payments** section under **Health and Insurance** and click **Change** next to **Current Ongoing Payment Method**. You can also call the Global HR Service Center at **800.556.6044**.

Changes become effective within 30 days.

Using your MRA and HCSF

Even if you don't elect coverage under one of the bank's retiree medical plans, you can use the full amount in your MRA and HCSF to pay for eligible health care expenses.

Appendix

Important information about your retiree health and insurance benefits

Where to go for more information

- For information about **retiree medical, dental and vision coverage**, contact your carrier directly. You can find telephone numbers for carriers available to you on page 15 of this guide. You can also visit **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) > **Enroll Now** > **Medical View/Change** > **Compare Medical Options**.
- Visit **My Benefits Resources** > **Knowledge Center** > **Plan Information** or call the Global HR Service Center at **800.556.6044** to request a Summary Plan Description (SPD) for information about:
  - Medical (non-Medicare), dental, vision and life insurance plans, and health care accounts as of the date of this publication. Refer to 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).
  - Medicare-eligible medical plans. Refer to the *2021 Bank of America Retiree Health & Insurance Summary Plan Description* (2021 Retiree SPD) and the *2022 Bank of America Retiree Health & Insurance Summary of Material Modifications* (2022 Retiree SMM).

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.

Dependent eligibility

Children

Your children qualify as your dependents if they're unmarried, depend on you for primary financial support and are:

- Under age 19
- Under age 24 and a full-time student enrolled in a high school or accredited college, university or similar educational institution (student verification required annually)
- Disabled by a physical or mental condition that began before age 19 (or before age 24 while a full-time student covered under a bank-sponsored medical plan)

Your eligible dependent children may be able to continue coverage after these ages if they're enrolled in a fully insured 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 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.

Imputed income for partner coverage

The value of coverage for your partner and/or your partner's children who aren't your tax dependents is considered imputed income for the purposes of medical, dental and vision coverage 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 through either **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) or the Global HR Service Center at **800.556.6044**. If imputed income affects you in 2023, it will appear on your 2023 W-2.

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 your 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 coverage

Most medical, dental and vision plans will cover either a spouse or partner, or other adult dependent; however, the HMSA Hawaii PPO plan and Triple-S Salud plan don't provide coverage for other adult dependents.

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 whether an adult family member qualifies as your eligible dependent, call the Global HR Service Center.

Appendix *(continued)*

Medical coverage

Special note for rehired retirees

If you're currently a retiree of Bank of America or one of the bank's legacy companies and are later rehired by the bank, you won't be eligible to maintain your 2023 retiree medical coverage (including retiree health care accounts) while actively employed.

- If you're rehired by the bank and are regularly scheduled to work 20 hours or more per week, you'll become eligible for plans offered to active, benefits-eligible bank employees (including medical, dental, vision, health care accounts and life insurance, among others). When you retire again, your retiree benefits — including medical, dental, vision, health care accounts and, if applicable, life insurance coverage — will be available to you again in retirement, subject to plan and eligibility rules in effect at the time of your second retirement.
- If you're rehired by the bank and are a temporary employee or are regularly scheduled to work less than 20 hours per week, you'll become eligible for medical plans and health care accounts offered to active, benefits-eligible bank employees; however, your retiree dental, retiree vision and, if applicable, retiree life insurance benefits will not be impacted. When you retire again, your retiree medical coverage (including retiree health care accounts) will be available to you again in retirement, subject to plan and eligibility rules in effect at the time of your second retirement.

Please refer to the 2021 H&I SPD and 2022 H&I SMM for additional information regarding plans offered to active, benefits-eligible bank employees. Please refer to the 2021 Retiree SPD and 2022 Retiree SMM for additional information regarding plans offered to eligible bank retirees.

Women's Health and Cancer Rights Act

(This Act applies to Triple-S Salud and HMSA Hawaii PPO plans, and does not 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 and 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. For deductible and copayment information, refer to the 2021 H&I SPD and 2022 H&I SMM for plans that are not Medicare-eligible.

Please refer to your Health Plan Comparison Charts, available in the SPD for deductible and copayment information applicable to the medical plan in which you choose to enroll. These documents are available on **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) 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).

Lifetime maximum on benefits

A lifetime maximum, or the most the retiree medical, dental and vision plans will pay for benefits, may apply to certain services. Please check with your plan's carrier or claims administrator regarding any benefit limits.

Health care accounts

Additional information about your MRA or HCSF

Under your MRA, HCSF and/or Retiree Health Reimbursement Arrangement (RHRA), the IRS requires that each purchase is verified as an eligible health care expense. To ensure your Visa debit card remains active, you should log in to your account after each transaction to see if documentation is required to prove a charge qualifies as an eligible health care expense. Since you're responsible for providing this proof, remember to keep and be prepared to submit receipts and records for all transactions you make using your debit card. If you don't verify an outstanding purchase, your debit card will be deactivated, you'll be required to repay the value of any transactions that have not been verified, and you'll be taxed on the amount.

To check for outstanding expenses that need to be verified, log in to **Health Benefit Solutions** (**myhealth.bankofamerica.com**). Click the bell icon or **Message Center** circle on the top right of the home page to access **Messages** and check if **Action Needed** appears, indicating additional documentation is required. Make sure each receipt shows the date, merchant/provider name, amount charged, prescription number (if applicable) and description of the item or service purchased. You can upload your receipt to **Health Benefit Solutions** or fax your receipt to **844.590.0919**. If you fax your required documentation, please make sure to include your claim number on the documentation. We encourage you to log in to your account after each transaction.

Health care reform and retiree health care accounts

If you have a balance in your retiree MRA, HCSF or HRA, you won't be eligible for federal assistance to help pay for the cost of individual coverage purchased through an exchange/marketplace. Refer to IRS Notice 2013-54 at **irs.gov** for more information.

You can find the list of eligible medical expenses by logging in to **Health Benefit Solutions** (**myhealth.bankofamerica.com**) and selecting **Tools & Support** > **Account Support & Forms** > **Qualified Medical Expenses** in case you want to consider spending your health care account balance before purchasing individual coverage through an exchange/marketplace.

Summary of Benefits and Coverage — Availability Notice

Bank of America provides Summaries of Benefits and Coverage (SBCs) for retirees in the HMSA Hawaii PPO and Triple-S Salud plans. The SBCs summarize, in a standard format, important information about the bank's medical plans available to individuals who aren't eligible for Medicare. This is another resource to help you compare your plan choices. To access the SBCs, 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. For a paper copy, call the Global HR Service Center at **800.556.6044**.

Fully insured retiree medical plans

Some fully insured retiree medical plans may have other changes in coverage for 2023 because they are also governed by state insurance laws. Please contact the carriers with any questions.

Marketplace special enrollment windows related to COBRA

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 your covered dependents become eligible for COBRA and after they are no longer eligible for COBRA.

There is no special enrollment period if they voluntarily end their 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 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.

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 Retiree 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

Anthem
anthem.com
855.215.6079

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
800.942.0854
TTY: 888.245.2920

Vision
Aetna
aetnavision.com
877.444.1012
TTY: 800.628.3323

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

Prescription coverage
Non-Medicare plans:
CVS Health
caremark.com
800.701.5833
TTY: 800.231.4403

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
whyuhc.com/findmydoc
877.240.4075

Medicare Advantage plans:
SilverScript
caremark.com
844.449.4726

Enrollment information
Global HR Service Center
mybenefitsresources.bankofamerica.com

Use the chat function or the Submit a Request option on the Contact Us page, or call 800.556.6044

Make sure your personal information is up to date

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)
  Note: Your MBI replaces your Medicare health insurance claim number on your Medicare card
- Telephone number

*Kaiser Permanente and Aetna Dental DMO plans 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 your wages.

If you have questions about your status as a retiree or about retiree benefits, call the Global HR Service Center at **800.556.6044**.

Note: If you are eligible for a plan not described in this guide, please consult your previous summary plan descriptions or contact the plan carrier directly for more information. If you need help contacting the plan carrier, call the Global HR Service Center at **800.556.6044**.

To learn about Bank of America's environmental goals and initiatives, go to **bankofamerica.com/environment**.
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