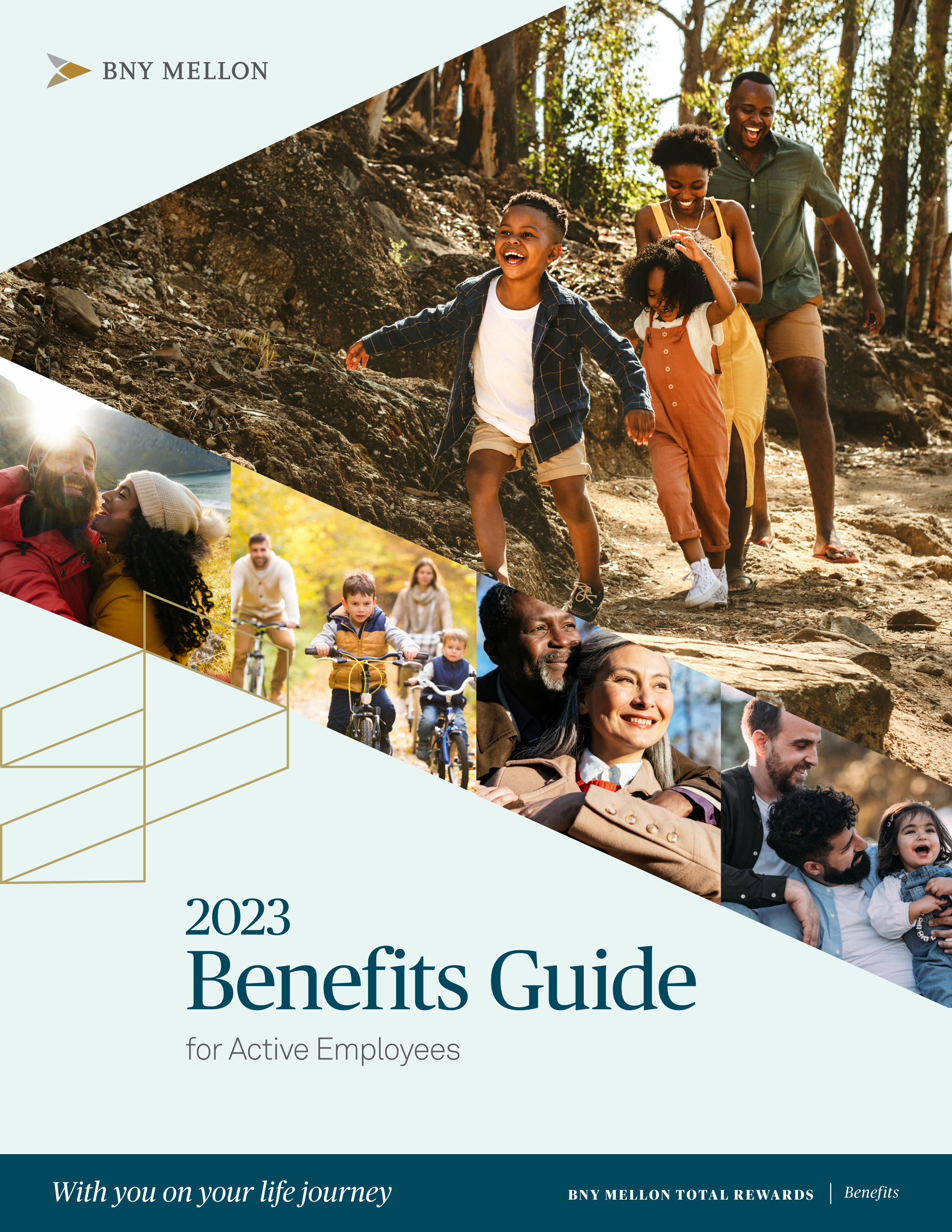

BNY MELLON

2023
Benefits Guide
for Active Employees

With you on your life journey

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Welcome to Your 2023 BNY Mellon Benefits

Make the Most of Your Benefits

BNY Mellon goes *with you on your life journey* by providing resources to support your health and wellbeing through our flexible benefits program. Take some time during this enrollment period to evaluate your anticipated needs and choose the benefits that will best meet those needs.

Open Enrollment for your 2023 BNY Mellon benefits is from Wednesday, October 26 through Wednesday, November 9.

This *2023 Benefits Guide* provides information to help you make the best of your benefit options under The Bank of New York Mellon Health and Welfare Plan (the "Plan" or the "BNY Mellon Plan") as well as other benefits available to eligible BNY Mellon employees and their eligible dependents.*

This Benefits Guide focuses on descriptions of the benefit programs associated with the Open Enrollment period. For a list and description of key changes, please refer to the **FAQs** or **What's Changing for 2023**.

Medicare eligibility may impact your medical plan choices and prescription drug coverage for 2023. Carefully review this document to ensure that you make the best decisions for 2023.

* The information set forth in this Benefits Guide is in summary form. This Benefits Guide is intended to provide important information about BNY Mellon's benefit plans for the Plan year beginning on January 1, 2023. It is not intended to, and does not, provide tax, legal or investment advice and is not a guarantee of employment or benefits of any nature. In the event of any discrepancy between this Benefits Guide and the applicable plan documents and evidence of coverage booklets, the terms of the applicable plan documents and evidence of coverage booklets control. BNY Mellon reserves the right to change or eliminate any of its benefit plans at any time for any reason, subject to applicable law.

If you have questions about how to enroll, call the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940 Monday through Friday, between 8:30 a.m. and 8 p.m. ET.

If you have questions about general healthcare benefits, Anthem ID cards, Anthem claim issues, etc., call your Accolade Health Assistant at 1-833-640-0427, Monday through Friday, between 8 a.m. and 11 p.m. ET.

YOUR PATH TO MAKING THE MOST OF YOUR BENEFITS

Be Informed

Read this Benefits Guide to learn about 2023 health plan details and instructions for enrolling. You can also visit bnymellonbenefits.com for information related to Open Enrollment.

Contact your Health Assistant at Accolade at 1-833-640-0427 or go to **member.accolade.com** if you need more information about your benefits options or help in choosing a health plan that is right for you and your family. **Your Health Assistant is your single point of contact for most of your health benefit and other benefits questions** and is available Monday through Friday, from 8 a.m. to 11 p.m. ET.

Note: For information about Health Savings Accounts only, you can also visit the BenefitWallet microsite at **www.mybenefitwalletsite.com/bnymellon**.

Access enrollment decision tools for the 2023 health plans through the **MyBenefit Solutions** website, which you can access:

- **At Work:** Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Health > Pru).
- **At Home:** Visit **MyBenefit Solutions** at **mybenefits.bnymellon.com**. (If you're a new employee or haven't already registered, you'll need to create a username and password.)

Review and Compare Health Plans

Visit the Open Enrollment page of the **MyBenefit Solutions** website (see access instructions above) to use the health plan decision support tools to compare your health plan options and make your 2023 benefits decisions. See **page 16** for more information.

Enroll on MyBenefit Solutions by the Deadline

See "**How to Enroll**" for details.

Continuing BNY Mellon employees (and their eligible dependents) must enroll each fall during Open Enrollment. (Open Enrollment for 2023 benefits: October 26 to November 9, 2022.)

Employees hired after October 1, 2022 (and their eligible dependents) and continuing BNY Mellon employees who become benefits-eligible after Open Enrollment (and their eligible dependents) must enroll by the deadline provided in their enrollment materials, within 31 days after the later of the date of hire or eligibility date.

Miss Your Enrollment Deadline?
If you miss your enrollment deadline, you will receive the default coverages as shown in **this table**.

Keep the following in mind as you prepare to enroll:

- Check your personal information, such as address and phone number, to ensure that all information is accurate
- Think about your coverage needs, including how much healthcare you and your family may use and whether basic life and disability insurance provides enough protection.
- If you have dependents or beneficiaries, it is also important every year to review them to ensure that they remain eligible for your benefits and to add them or remove them as appropriate

Important – Dependent Attestation
If you elect to cover a new dependent(s) under the BNY Mellon medical, dental and/or vision plans, you may receive a letter at your home address following the close of Open Enrollment asking you to confirm your dependents' eligibility for BNY Mellon benefits by providing the Dependent Verification Center requested documentation by the date shown on your letter. If you receive the letter and do not provide the required documentation by the deadline, or your dependent(s) are not eligible according to BNY Mellon rules, your dependent(s) will no longer be covered under your BNY Mellon health plans.

Even if you do not change your open enrollment dependent elections, you still need to go into the enrollment tool and attest that all covered dependents are eligible dependents. Documentation may be required in the future.

BNY Mellon reserves the right to periodically request submission of satisfactory proof of applicable dependent status (i.e., spouse, qualified domestic partner, dependent child), or your dependent's coverage may be cancelled.

IF YOU DON'T ENROLL

In general, if you miss your enrollment deadline, you will not be able to enroll in benefits during the year, unless you have a qualifying life or special enrollment event.

Note: If you don't enroll and are automatically enrolled in your current elections (see **page 6**), you will be deemed to have authorized per-paycheck premium deductions as described in 2023 Contribution Rates on **bnymellonbenefits.com**, including the surcharges associated with the nicotine attestation.

Keep in mind that you must actively enroll to:

- Ensure you receive the coverage that best fits your and your family's needs.
- Make your nicotine attestation to avoid the $25 ($50 total for employee + spouse/domestic partner) surcharge per pay period.
- Make your annual Health Savings Account contributions (note that these can be changed throughout the year), Flexible Spending Account contributions, and/or Purchased Vacation decisions (**Purchased Vacation** is only available if you are hired on or before November 30, 2022).
- Elect or cancel some of your voluntary benefits including the new hospital indemnity and existing accident, critical illness, and legal services insurances. If you are currently electing these benefits and do not make any changes, they will continue for 2023.
- Confirm that your other benefit elections meet your needs.

The following table shows the default coverage you'll receive for 2023 if you don't enroll by your enrollment deadline:

BENEFIT	COVERAGE YOU WILL AUTOMATICALLY RECEIVE IN 2023	
	IF YOU ARE NOT ENROLLED IN APPLICABLE BNY MELLON COVERAGE IN 2022[1]	IF YOU ARE ENROLLED IN APPLICABLE BNY MELLON COVERAGE IN 2022[2]
Medical	No coverage	Your 2022 plan election, coverage level will remain in effect.
Health Savings Account (HSA) Contributions (available only if you are enrolled in the Lower or Higher Deductible HSA Plan)	No employee contributions. You may change your HSA contribution amount monthly throughout the year.	No employee contributions. However, you may change your HSA contribution amount monthly throughout the year
Dental	No coverage	Your 2022 plan election and coverage level will remain in effect.
Vision	No coverage	Your 2022 plan election and coverage level will remain in effect.
Long-Term Disability Insurance	BNY Mellon-paid coverage equal to 60% of base pay	Your 2022 plan election and coverage level will remain in effect.
Life Insurance	BNY Mellon-paid coverage equal to your base pay, up to $500,000	Your 2022 plan election and coverage level will remain in effect.
Supplemental Life Insurance	No coverage	Your 2022 plan election and coverage level will remain in effect.
Spouse/Qualified Domestic Partner Life Insurance	No coverage	Your 2022 plan election will remain in effect.
Child Life Insurance	No coverage	Your 2022 plan election will remain in effect.
Accidental Death & Dismemberment (AD&D) Insurance	BNY Mellon-paid coverage equal to your base pay, up to $500,000	Your 2022 plan election will remain in effect.
Supplemental AD&D Insurance	No coverage	Your 2022 plan election will remain in effect.
General Purpose Healthcare Flexible Spending Account (FSA)	No participation	No participation. 2022 FSA contribution election does not carry over.[3]
Limited Purpose Healthcare FSA	No participation	No participation. 2022 FSA contribution election does not carry over.[3]
Dependent Care FSA	No participation	No participation. 2022 FSA contribution election does not carry over.[3]
Purchased Vacation (only available if you are hired on or before November 30, 2022)	No participation	No participation. Purchased Vacation does not carry over.

[1] Applies to employees hired after October 1, 2022 (and their eligible dependents) and continuing BNY Mellon employees who become benefits-eligible after Open Enrollment (and their eligible dependents).

[2] You will pay 2023 rates for this coverage including the tobacco surcharge.

[3] **Note:** Special COVID-19 legislation which temporarily allowed carry-over of all unspent funds in General Purpose Healthcare FSAs, Limited Purpose Healthcare FSAs, and Dependent Care FSAs does not apply beyond the 2022 Plan year. Carry-over of funds remaining in General Purpose Healthcare FSA and Limited Purpose Healthcare FSAs as of December 31, 2022 to 2023 is limited to $570. Unused Dependent Care FSA funds cannot be carried over for use in 2023.

Go Paperless

Start paperless delivery to receive benefits documents electronically.

Per Department of Labor regulations, you are entitled to receive certain employee benefit plan disclosures free of charge in paper form. These documents include Summary Plan Descriptions, Summaries of Material Modifications, Summary Annual Reports, Summaries of Benefits and Coverage, and other required Legal Notices. You may also elect to receive these documents electronically.

If you consent to electronic delivery, please update your delivery preference through the **MyBenefit Solutions** website by selecting “Email.” You’ll receive an email notifying you each time a new document is available. If you don’t select a preference, you’ll receive paper communications.

You may revoke your consent to electronic delivery and request paper copies at no charge at any time by changing your preferences online or by contacting the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940 Monday through Friday, between 8:30 a.m. and 8 p.m. ET.

WHO’S ELIGIBLE?

You’re eligible for BNY Mellon health and welfare benefits if you’re an active full-time or part-time salaried employee regularly scheduled to work at least 20 hours per week.

You can also enroll your eligible dependents for medical, dental, vision, and dependent life insurance coverage. Eligible dependents include (subject to the terms of the covered benefits):

- **Your spouse**
- **Your qualified domestic partner**—a person who is in a “spouse-like” relationship with you but who does not qualify as your spouse under applicable federal law and the terms of the Plan will generally be treated as your qualified domestic partner for purposes of the Plan as described more fully under **Qualified Domestic Partner Definition**.
- **Your child up to age 26,** regardless of full-time student status, residency, financial support, marital status, or access to other employer-sponsored coverage
- Your unmarried, dependent child older than age 26 who is **mentally or physically disabled and is financially dependent** on you for support and who became disabled before age 26;
- **Your parents and parents-in-law** (even if not members of your household) for Teladoc Medical Experts only, pursuant to the terms of the covered benefit program

All of your household members (e.g., spouse, qualified domestic partner, children, parents, grandparents) are eligible for the Employee Assistance Program (EAP).

Review and Confirm Your Dependents
BNY Mellon strives to make sure you and your family have access to affordable healthcare coverage. That's why it's our responsibility to employees to make sure those who are covered under the BNY Mellon medical, dental and vision plans are eligible—that includes the dependents of BNY Mellon employees.

If you newly cover a dependent(s) under the BNY Mellon medical, dental and/or vision plans, you may receive a letter at your home address in December asking you to confirm your dependents' eligibility for BNY Mellon benefits by providing the Dependent Verification Center requested documentation by the date shown on your letter. If you receive the letter and do not provide the required documentation by the deadline, or your dependent(s) are not eligible according to BNY Mellon rules, your dependent(s) will no longer be covered under your BNY Mellon health plans.

Dependent Definition

A dependent is someone who is eligible for coverage under an employee's health plan. Eligible dependents include a spouse, domestic partner, or child (ren) under the age of 26 (unless mentally or physically disabled prior to age 26 and are financially dependent on employee). See below for a more detailed description.

Spouse / Child
For purposes of eligibility, (i) "spouse" means a person to whom you are currently legally married, who is treated as your spouse pursuant to Section 125 of the Internal Revenue Code and ERISA, and for whom the marriage has not ended by such means as divorce, dissolution, annulment, or death; and (ii) "child" means your natural child, stepchild, legally adopted child (including those placed with you for adoption), foster child placed with you (until attainment of age 18, at which time foster child status ends, unless otherwise specified by your state of residence), a child for whom you have legal guardianship and the duty of sole financial support by court order (you must provide documentation verifying that a court order gives you both legal custody and the duty of sole financial support before you can enroll the child), or a "child" of your qualified domestic partner.

You can add a child to medical coverage at any time if a Qualified Medical Child Support Order (QMCSO) requires you to cover the child. You can remove a child from medical coverage at any time if a QMCSO requires another individual to cover the child and such coverage is, in fact, provided. You may be asked for documentation of eligibility at the time of enrollment or during any audit checks.

Qualified Domestic Partner Definition

A qualified domestic partner is defined under the Plan as a person (whether of the same or opposite sex) in a "spouse-like" relationship with an eligible employee, and who, together with the eligible employee:

- Are each other's sole qualified domestic partner and intend to remain so indefinitely
- Are at least age 18 and competent to enter into a legal contract
- Are not related in a way that would prevent them from being legally married

- Are not legally married to anyone else, and all prior marriages have been dissolved through death, divorce, dissolution, or annulment
- Are not qualified domestic partners with anyone else, and all prior qualified domestic partnerships have been terminated by such means as death or dissolution
- Share joint responsibility for each other's welfare and financial obligations
- Share a household that is the primary residence of both (although they may live apart for reasons of education, healthcare, work, or military service)
- Are registered qualified domestic partners with any state or local government domestic partnership registry, if residing in a state or locality that provides qualified domestic partner registration.

You may be required to demonstrate proof of this relationship from time to time (e.g., at the time of enrollment, re-enrollment, change of status) by submitting:

- A notarized Affidavit of Domestic Partnership (if residing in a state or locality that makes qualified domestic partner registration available); and
- Two proofs of joint ownership in effect for at least the prior six months (e.g., joint bank account statements, joint credit card accounts, joint ownership, a common leasehold interest in real property).

WHEN COVERAGE BEGINS AND ENDS

If you are currently enrolled in BNY Mellon benefits, the benefits you choose during Open Enrollment (or the default coverage as described above) will become effective on January 1, 2023, and generally will remain in effect through December 31, 2023, or, if earlier, until the last day of the month in which you transition to a status that is ineligible for benefit coverage, including termination, unless you make a permissible election change during the year, as described below.

If you are newly eligible for benefits during 2023 and you enroll within 31 days of your benefit-eligibility date, the choices you make when you enroll remain in effect from the date of your eligibility through the earliest of December 31, 2023, or the last day of the month you transition to a status that is ineligible for benefit coverage, including termination, unless you make a permissible election change during the year, as described below.

Extra Protection for Your Family

If you die while an active employee and your covered dependents are eligible for, and elect, COBRA continuation coverage, BNY Mellon will pay the applicable medical premiums for three months of your covered dependents' COBRA continuation coverage.

This benefit is paid when your dependents elect COBRA and is an offset to the COBRA period.

Once you're covered under the Plan, coverage for a new spouse, new domestic partner or child born, adopted, or placed with you for adoption during the year begins on the date of marriage, new domestic partnership, birth, adoption, or placement. In all cases involving newly eligible dependents, you must notify the BNY Mellon Benefit Solutions Service Center via the **MyBenefit Solutions** within 31 days of the date the dependent became eligible for coverage:

- **From work: MyReward** (MySource > HR & Personal > MyReward > My External Links > Health > MyBenefit Solutions > Life Events)
- **From home: MyBenefit Solutions** at **mybenefits.bnymellon.com** (MyBenefit Solutions > Life Events). (If you're a new employee or haven't already registered, you'll need to create a username and password.)

You can also call the **BNY Mellon Benefit Solutions Service Center** directly at 1-855-354-6940. Customer Service hours are Monday through Friday, between 8:30 a.m. and 8 p.m. ET.

Once enrolled, you can make changes to your benefit selections **only** if you have a qualified life event during the year or one of the special enrollment rights applies. **There is one exception:** You may make changes to your HSA contributions monthly throughout the year.

For more details, review "Changing Coverage During the Year" below.

Note: If you leave BNY Mellon, you and your eligible dependents may be entitled to continue your medical, dental, vision, and General Purpose or Limited Purpose Healthcare FSA coverage under the federal law entitled "COBRA" once your benefits coverage ends. Within three weeks of your termination, you should receive a termination packet describing this information in detail.

For more information, or if you do not receive a termination packet, see "COBRA Rights Notice–Health and Welfare Benefits" in "2023 Legal Notices – Active" on **bnymellonbenefits.com**, MySource, and/or **MyBenefit Solutions** under Plan Documents. You can also call the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940. Customer Service hours are Monday through Friday, between 8:30 a.m. and 8 p.m. ET.

CHANGING COVERAGE DURING THE YEAR

In general, you cannot change the coverage you elect until the next Open Enrollment period. However, if you have a qualified life event, you can enroll in or change your benefits during the year provided the change is consistent with the type of life event you are experiencing. Examples of qualified life events include:

- Marriage or establishment of a domestic partnership
- Divorce or termination of a domestic partnership
- Death of a spouse/qualified domestic partner
- Birth or adoption of a child, or a child placed with you for adoption, legal guardianship, or foster care
- Death of a child or child's loss of eligibility for benefits
- Change in your or your spouse's/qualified domestic partner's employment status that affects eligibility for benefits
- A significant change in your eligible spouse's/domestic partner's medical coverage
- Change in the cost of day care (for the Dependent Care FSA only)

To change your benefit(s) due to a qualified life event, you must do so within 31 days (or 60 days if you lost coverage under a Medicaid or state children's health insurance program [CHIP] or become eligible to receive premium assistance under those programs) from the date of the qualified life event. Otherwise, you'll have to wait until the next Open Enrollment period or other qualified life event.

To report the event and make any benefit change(s), visit the **MyBenefit Solutions** website, which you can access:

- **At Work:** Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Health > MyBenefit Solutions)
- **At Home:** Visit **MyBenefit Solutions** at **mybenefits.bnymellon.com**. (If you're a new employee or haven't already registered, you'll need to create a username and password)

You can also call the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940. Customer Service hours are Monday through Friday, between 8:30 a.m. and 8 p.m. ET.

Please note: You will be asked to certify the eligibility of any dependent(s) you newly enroll under your BNY Mellon medical, dental, and/or vision coverage on **MyBenefit Solutions**:

- During Open Enrollment
- Your new hire or newly benefited enrollment period (as applicable)
- Any time a dependent is added as a result of a qualified life event during the year

To Learn More

For more information about changing your coverage outside of your enrollment period as a benefits-eligible employee, including a full list of qualified life events, the types of benefit changes that can be made due to a qualified life event, and the supporting documentation that may be required, call Accolade at 1-833-640-0427.

PAYING FOR COVERAGE

BNY Mellon pays the full cost of coverage for:

- Life insurance coverage equal to your base pay (up to a maximum of $500,000)
- Basic accidental death and dismemberment (AD&D) insurance coverage equal to your base pay (up to a maximum of $500,000)
- Travel accident insurance coverage
- Long-term disability (LTD) coverage equal to 60 percent of your base pay
- Short-term disability (STD) coverage up to 26 weeks at 100% or 50% of your base pay, based on length of continuous benefit-eligible service with BNY Mellon

You and BNY Mellon share the cost of medical and dental coverage.

You pay the full cost of vision, life (supplemental, spouse/qualified domestic partner, child) insurance, supplemental AD&D insurance, supplemental LTD insurance, and purchased vacation.

Your Per-Pay Period Cost

As an active employee, your share of the cost of the above coverage, as applicable, is made through convenient payroll deductions. All of your contributions, except for spouse/qualified domestic partner and his/her children, child, and supplemental life insurance premiums, are deducted from your pay before taxes are deducted (unless your dependent doesn't meet tax dependent requirements). By contributing on a pre-tax basis, you lower your current taxable income.

The per-pay premiums for each benefit option and coverage level are shown on **MyBenefit Solutions** when you enroll. Note that premiums in 2023 may be influenced by your **Nicotine Attestation**. If you elect certain life insurance coverage or the 50 percent LTD option, you may receive a credit toward your other benefits, as shown when you enroll on **MyBenefit Solutions**—the system will calculate your per-pay costs automatically.

Please note: If you transition to a leave or retiree status, you will be required to pay your premiums directly to the vendor **MyBenefit Solutions** when you no longer receive pay from BNY Mellon.

Attention: Certain Coverage Elections May Result in Taxable (Imputed) Income

For federal tax purposes, the full value of healthcare benefits provided to your qualified domestic partner and/or his or her children is taxable, unless they qualify as your federal tax dependent(s) for health plan purposes or you claim a federal tax exemption for them. This taxable, or imputed, income will be reflected on your paycheck and reported on your W-2 tax form.

Certain other coverage choices (e.g., basic life insurance in excess of $50,000) will also result in imputed taxable income that will be reflected in your paycheck and reported on your W-2 form.

For more information on imputed income, as well as on your state's rules for taxation of benefits provided to qualified domestic partners and their children, consult a tax advisor.

WHEN YOU HAVE OTHER MEDICAL COVERAGE

When you have other medical coverage for you or your dependents, your BNY Mellon coverage will be coordinated with your other plan's benefits. Depending on the covered individual (you, your spouse, your qualified domestic partner, or your other dependent) and the other medical coverage, one of the plans will be designated as the **primary** coverage and will be responsible for paying benefits first; the other plan will be considered secondary (which means it will only pay benefits after the primary plan has paid, and up to a maximum amount of the actual charge).

BNY Mellon's medical plans follow the non-duplication method when coordinating benefits. When the BNY Mellon Plan is determined to be the secondary coverage, the BNY Mellon Plan will pay only the difference between the amount normally reimbursed by the BNY Mellon Plan and the amount reimbursed by the primary coverage. This means that if you're covered under two plans, you may not necessarily receive more benefits than you would if the BNY Mellon Plan were your only coverage.

For more information, see the Plan document posted on **MyBenefit Solutions** > Plan Documents.

Coordination of Medicare and BNY Mellon Medical Coverage

If *you or any of your covered dependents* are enrolled in both Medicare and a BNY Mellon group health plan, whether the BNY Mellon medical plan or Medicare is the primary coverage will generally depend upon your employment status. If you are actively working for BNY Mellon and enrolled in both Medicare, if eligible, and a BNY Mellon medical plan, Medicare is secondary.

Medicare becomes primary for domestic partners when they become eligible for Medicare. BNY Mellon medical coverage will pay secondary to all claims for Medicare parts A and B. If you do not enroll in both Medicare Parts A and B, you may have substantial out-of-pocket expenses because BNY Mellon medical coverage will pay secondary to Medicare and will not cover all of those expenses.

Accolade – One-stop for Your Healthcare Questions

Accolade is your single point of contact for most of your health plan and other benefit questions. Accolade is an independent healthcare advocacy company, which provides you and your family personalized support when making your healthcare decisions—at no cost to you. If you enroll in the Anthem Lower or Higher Deductible HSA Plan or the Copay Plan, your Accolade Health Assistant, supported by a full suite of healthcare resources and technology, can help you:

- Obtain a new Anthem ID card
- Find quality and cost-effective providers in Anthem's network
- Understand your medical costs and coverage
- Coordinate with healthcare providers and manage your care
- Work with Anthem to resolve your claims and billing issues
- Understand your options, to help you make better informed healthcare decisions
- Learn about the various BNY Mellon benefits, programs, and resources available to you, including plans like prescription drug, dental, vision, and life insurance
- Get help managing a chronic condition or disease
- Connect with a nurse 24/7

Additional services are available to you no matter which health plan you choose or if you do not enroll in BNY Mellon medical coverage, including information and guidance about eligibility, qualified life events, wellbeing services, treatment decision support, medical information, nurse triage, and care referral services. Accolade can also connect you with a nurse if you or an eligible dependent has symptoms you need help diagnosing.

You can call your Health Assistant at 1-833-640-0427. You can also reach your Health Assistant through secure messaging via Accolade's online member portal, accessible through **MyReward** and via the Accolade mobile app (available from the App Store or Google Play). Health Assistants are available Monday through Friday between 8 a.m. and 11 p.m. ET. You can use the same Health Assistant if you prefer to interact consistently with a professional that can get to know you and your preferences over time.

Accolade Care and Condition Support Management – Helping You Get the Care You Need

Accolade is here to help you find a specialist, coordinate care, prepare for your appointments, and answer billing questions. This includes nurse triage, condition management, and more. See list below:

- **Behavioral Health:** Accolade can connect you with behavioral health experts that can help you with a wide range of needs. We can answer your questions and help explain your benefits so you know which programs are free and which may have a fee.

- **Condition Management:** Accolade provides extensive support for all acute and chronic conditions. From condition education and finding a great specialist to helping schedule appointments and coordinating your care, Accolade provides support throughout your healthcare journey. We can work with your providers to help find the right treatment plan for you.

- **Case Management:** Members with complex care needs, including high-risk pregnancy, cancer, and transplant, will receive specialized support from Accolade certified case managers. Their goal is to understand your unique situation and create simplicity, making it easier for you to manage your health.

- **Prescription Support:** Accolade can help identify cost savings opportunities, manage multiple medications, and help you to understand and follow the recommended course of treatment.

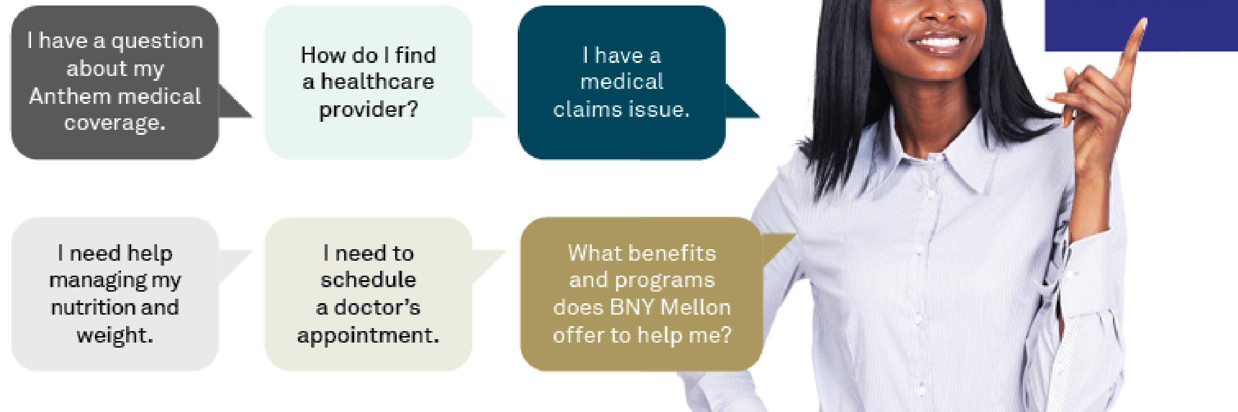
- **Maternity:** Accolade's maternity management program provides you with personalized educational materials to support your specific needs at any point in your journey — fertility, pregnancy, birth, and post-natal care, including lactation consulting. Your Accolade women's health nurse is available to answer questions and further assist you in preparing for the birth experience and taking care of a new baby, including adding your child to your health plan.

- **Pre-Admission and Post-Discharge:** Accolade provides education and support prior to a hospital stay so that you will know what to expect. Our nurses provide follow-up during hospitalization and reach out after discharge to answer any questions and ensure you understand the next steps.

- **Nurse Triage:** Clinical support from nurses is available 24/7. Accolade nurses can triage and educate you on your symptoms. They can also help you choose the right level of care and explore options such as urgent care, primary care, telemedicine, or the emergency room.

- **Lifestyle Coaching:** Accolade can help you create a care plan that is easy to follow and simplify existing healthcare needs. Alongside the medical care you may be receiving, having a care plan in place may help to prevent or stabilize chronic conditions. We can also help you take steps towards positive behavior changes (stress management, exercise, tobacco cessation, etc.)

- **Treatment Decision Support:** Accolade encourages a shared decision-making model, which means we help you to fully understand your diagnostic and treatment options. This allows you to make a decision that is a good fit for you and your family. We can also help you find a doctor for a second opinion so that you can feel more confident about your decision.



* Accolade does not practice medicine or provide patient care. It is an independent resource to support and assist you as you use the healthcare system and receive medical care from your own doctors, nurses, and healthcare professionals. If you have a medical emergency, contact 911 immediately.

How to Enroll

Enroll for your 2023 BNY Mellon benefits during your enrollment period through the **MyBenefit Solutions** website:

- **At Work:** Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Health > **MyBenefit Solutions**).
- **At Home:** Visit **MyBenefit Solutions** at **mybenefits.bnymellon.com**. (You'll need to create a username and password.)

Questions about how to enroll? Call the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940 Monday through Friday, between 8:30 a.m. and 8 p.m. ET.

DECISION SUPPORT TOOLS

These tools will be available on the **MyBenefit Solutions** website to help you make your 2023 benefit decisions during your enrollment period:

TOOL	WHAT YOU CAN DO
Health Care Cost Summary	Find your summarized year-to-date healthcare costs and use for your medical, dental and prescription drug plans to help you get a picture of your total healthcare costs.
Health Plan Comparison Charts	Compare the details of your BNY Mellon medical plan options.
Medical Expense Estimator	Use your past claims history or national estimates, to project out-of-pocket expenses under each of the 2023 medical plan options. You can compare your estimated total annual costs (payroll contributions plus out-of-pocket expenses) under each available option based on the services you and your family expect to use next year.
DecisionDirect™	After you answer a few simple questions about your healthcare needs and preferences, DecisionDirect will suggest a medical plan option for you.
HSA Value Estimator	See up front how the value of your HSA can grow over time when you make pre-tax contributions to the account.

Don't forget: You can also call Accolade at 1-833-640-0427 for help making your medical plan decision.

Your 2023 Benefits Options at a Glance

BNY Mellon offers a comprehensive, competitive benefits program with the flexibility to help meet the needs of our diverse workforce. The benefits available to you are listed below[1].

BENEFIT	OPTIONS
Medical	• No coverage • Anthem Higher Deductible HSA Plan (with a Health Savings Account) • Anthem Lower Deductible HSA Plan (with a Health Savings Account) • Anthem Copay Plan with PrudentRx for specialty medications • Kaiser Permanente (Los Angeles and San Francisco only) • HMSA (Hawaii only) • Aetna International Plan (International Expatriates only)
Pharmacy	• No coverage • If you elect medical coverage through any of the Anthem medical plans, you'll automatically be enrolled for prescription drug coverage through CVS Caremark.
Dental	• No coverage • MetLife PDP Option 1 • MetLife PDP Option 2 • Aetna DMO® (Dental Maintenance Organization) (in-network coverage only)
Vision	• No coverage • Vision Service Plan Option 1 (Base Plan) • New! Vision Service Plan Option 2 (Enhanced Plan)
Health Savings Account (HSA)[2] (available only if enrolled in the Lower Deductible or Higher Deductible HSA Plan)	• No contribution • Elect to contribute up to $3,850 [3,4] (individual) or $7,750,[4] (family) annually pre-tax
General Purpose Healthcare Flexible Spending Account (FSA) (available if not enrolled in the Higher Deductible HSA Plan or Lower Deductible HSA Plan)	• No contribution • Elect to contribute up to $2,850 annually pre-tax
Limited Purpose Healthcare Flexible Spending Account (FSA) (available if enrolled in the Higher Deductible HSA Plan or Lower Deductible HSA Plan, subject to IRS limitations)	• No contribution • Elect to contribute up to $2,850 annually pre-tax
Dependent Care Flexible Spending Account (FSA)	• No contribution • Elect to contribute up to $5,000 annually pre-tax
Short-term Disability (STD)	• BNY Mellon-paid benefit that replaces all or part of your base pay, based on your continuous benefit-eligible service with BNY Mellon
Long-term Disability (LTD)	• 50% of base pay benefit (buy-down option for credit) • 60% of base pay benefit (BNY Mellon-paid coverage) • 70% of base pay benefit (buy-up option)

BENEFIT	OPTIONS
Basic Life Insurance	• BNY Mellon-paid benefit equal to your base pay, up to $500,000 • Elect to buy down to coverage of $50,000 for credit (for eligible employees with salaries greater than $50,000)
Supplemental Life Insurance	• No coverage • Elect additional coverage of one to eight times your base pay ($3 million maximum); Evidence of Insurability (EOI) will be required
Spouse/Qualified Domestic Partner Life Insurance	• No coverage • $25,000 benefit • $50,000 benefit
Child Life Insurance	• No coverage • $10,000 benefit • $15,000 benefit
Basic Accidental Death & Dismemberment (AD&D) Insurance	• BNY Mellon-paid benefit equal to your base pay, up to $500,000
Supplemental AD&D Insurance	• No coverage • Elect additional coverage of one to eight times your base pay ($3 million maximum)
Voluntary Benefits	• No coverage • Elect Accident, Critical Illness, and/or Legal Insurance coverage at the time of hire or during the Annual Open Enrollment Period • New! Hospital Indemnity Insurance through Aflac • Elect Identity Protection Services, Auto and Home, and/or Pet Insurance coverage anytime during the year
Purchased Vacation[5]	• No purchase • Elect to purchase up to five additional vacation days for 2023 (if you are hired on or before November 30, 2022)

[1] This is a comprehensive list of benefits offered to eligible employees and their eligible dependents and is not meant to identify whether the benefits are being offered as an ERISA-benefit under the BNY Mellon Plan. This is not intended to be, and is not, a list of ERISA-covered benefits.
[2] Internal Revenue Service (IRS) rules determine whether you are eligible to open and/or contribute to an HSA. See "**HSA Eligibility**" for information.
[3] Your total annual HSA contribution amount includes your pre-tax payroll contributions, your after-tax lump-sum contributions and any BNY Mellon contributions for which you're eligible, if any.
[4] If you're age 55 or older and eligible to contribute to an HSA, you can make an additional catch-up contribution of up to $1,000 annually.
[5] Under IRS rules, unused Purchased Vacation remaining at the end of the Plan year cannot be carried over to the following Plan year. See "**Purchased Vacation**" for more information.

Medical and Prescription Drug

For 2023, most employees can choose to be covered by one of three national medical plan options, giving you and your family choice and flexibility:

- **Higher Deductible HSA Plan** (a high-deductible health plan [HDHP] with a Health Savings Account [HSA])
- **Lower Deductible HSA Plan** (an HDHP with an HSA)
- **Copay Plan** (a non-HDHP, without an HSA)

All three options offer comprehensive medical coverage provided through Anthem and include prescription drug coverage through CVS Caremark. You may also elect to opt out of BNY Mellon medical coverage for 2023.

While the Copay Plan offers more cost predictability when receiving healthcare compared to the Higher Deductible HSA Plan and Lower Deductible HSA Plan, it may not be the best plan for everyone.

Attention Employees in Los Angeles, San Francisco, Hawaii or on International Assignment
This guide describes the Anthem medical plans only. For information about the Kaiser Permanente, HMSA, and Aetna International Plans (which include prescription drug coverage through the carrier), see the Summaries of Benefits and Coverage on **MyBenefit Solutions**.

Semi-monthly premiums for the Kaiser Permanente and Aetna International Plans are shown starting on **page 31**. (Premiums for the HMSA Plan are shown on **MyBenefit Solutions**.)

Please Note: You must also be in the Copay Plan to be eligible to enroll in **PrudentRx** for specialty medications.

NICOTINE ATTESTATION

All employees and spouses/domestic partners who are enrolled or plan to enroll in one of the **Anthem or Kaiser Permanente medical plans** are required to attest as to whether they have used a nicotine product in the last six months preceding the coverage effective date of January 1, 2023 (including but not limited to: vaporizers, cigarettes, e-cigarettes, other Electronic Nicotine Delivery Systems (ENDS), pipes, cigars, and smokeless nicotine).

If you have used a nicotine product in the last six months preceding the coverage effective date of January 1, 2023, you will be assessed a $25 per paycheck surcharge, totaling $600 per year. The same surcharge and terms apply to covered spouses/domestic partners-for a maximum of $1,200 per year if both employee and spouse/domestic partner have used a nicotine product in the past six months preceding the coverage effective date of January 1, 2023. The surcharge does not apply to employees or spouses/domestic partners using medical nicotine cessation/replacement products – i.e. nicotine gum and patches.

If you (or your spouse/domestic partner) are unable to certify that you are nicotine free, this surcharge can be avoided by certifying that you (and your spouse/domestic partner, as applicable) will participate in a nicotine cessation program during the 2023 calendar year. BNY Mellon does not require a specific cessation program so you may choose which one you want to use.

BNY Mellon will not provide compensation or reimbursement related to your participation in a cessation program. However, one no-cost nicotine-cessation option available to you and/your spouse domestic partner is provided through Virgin Pulse. See below for details.

Specifically, the nicotine attestation options are as follows for the employee. The same options will appear for covered spouses/domestic partners and must be completed separately for them if applicable:

- Nicotine User ($25 per paycheck surcharge)
- Nicotine Free ($0.00 surcharge)
- Nicotine Cessation Program Participant ($0.00 Surcharge)

Important: All employees who are in or enroll in one of the Anthem or Kaiser medical plans will be required to attest actively in the system. The default election is that you and/or your spouse/domestic partner are a nicotine user, so make sure to go into the system, enroll in your Medical Plan this year, and make your attestation even if you plan to continue in your existing Medical Plan. Employees who do not go into the system to elect their Medical Plan and make the nicotine attestation will be assessed the nicotine surcharge. The surcharge is non-refundable for employees and their spouse/domestic partner.

Tobacco Free, One Step at a Time

Through Virgin Pulse, you have access to Journeys digital health coaching on a variety of topics, including five related to Being Tobacco/Nicotine Free. Journeys are multi-week, guided courses that help you successfully form and adopt new healthy habits. Each Journey breaks a key behavior or a larger goal into smaller achievable steps, helping you form new habits as you go.

Get Started with Nicotine Cessation

Sign up with Virgin Pulse via **join.virginpulse.com/bnymellon**, and then download the app for quick and convenient access. U.S. spouses and domestic partners enrolled in a BNY Mellon Medical Plan also have access. They can use the 9-digit employee ID + the letter “S” to register (i.e., 000123456S).

In your Virgin Pulse account, under **Health** click on **Journeys** at the top of the page. Scroll down to the **Being Tobacco Free** section and click **View All** to see all five options, called “paths”. Click on the one you would like to begin. Each Journey step will provide you with information and tips. Click **Will Do** when you are finished to record your progress. Participation in any or all the five paths satisfies the nicotine cessation program attestation.

ABOUT ANTHEM

Anthem will continue as our single, national medical carrier in 2023 because of their:

- Enhanced virtual care services through the Sydney Health Mobile App and Anthem.com
- A broad national network of doctors, specialists, and Centers of Excellence.
- A national recognition program, Blue Distinction Specialty Care, which helps make it easier for you to find quality specialty care.
- The ability to process your claims more effectively, making it easier for you to manage your healthcare.

New! Enhanced virtual care services available through the Sydney Health Mobile App and Anthem.com

Anthem Virtual Care

Visits, which offers convenient, affordable on-demand and scheduled secure medical text-chat and video visits for primary care spanning urgent care, prevention/wellness, and condition management. Medical text-chat available for adults ages 18-64. Virtual visits for Medical and Behavioral Health available for all ages.

ABOUT THE ANTHEM HIGHER DEDUCTIBLE AND LOWER DEDUCTIBLE HSA PLANS

Under the Higher Deductible and Lower Deductible HSA Plans:

In-network preventive care is covered at 100 percent.

You save through negotiated discounts when using in-network providers for non-preventive care, while having the freedom to use out-of-network providers at a higher cost. Unless your claim is a Surprise Billing Claim, note that in addition to their higher cost, out-of-network providers may, in some cases, balance bill you for charges above the Higher Deductible HSA Plan's or Lower Deductible HSA Plan's, as applicable, Maximum Allowed Amount, subject to applicable law. See "**Terms You Should Know**" for more information about Surprise Billing Claims.

Watch for Your New Medical ID Card

If you are enrolling for the first time, changing your plan option, or changing dependent coverage, you and each dependent covered will receive a new medical ID card from Anthem in the mail after your enrollment period ends. Show this card when you receive medical care.

After you reach your annual deductible, BNY Mellon pays 80 percent of the cost of most other eligible in-network care and you pay 20 percent. This includes Anthem Virtual Care Visits and Premise Health onsite clinic visits.

For in-network coverage, your out-of-pocket medical costs are limited to an annual in-network maximum—including your in-network deductible and coinsurance—which is the most you'll pay for in-network medical costs in any year.

For out-of-network coverage, the amounts you pay for coinsurance will count toward your out-of-network deductible and out-of-pocket maximum. Any amounts you pay above the Maximum Allowed Amount won't count toward your deductible or out-of-pocket maximum, subject to applicable law. For out-of-network services, the Plan has set the Maximum Allowed Amount at the 70th percentile of FAIR Health. See "**Terms You Should Know**" for more information about Maximum Allowed Amount and FAIR Health.

Expenses for in-network and out-of-network care **only** count toward the respective deductible and out-of-pocket maximum, subject to applicable law. In-network expenses don't apply to the out-of-network deductible and out-of-pocket maximum, or vice versa.

Provided you're eligible under Internal Revenue Service (IRS) rules, you can participate in a tax-advantaged HSA, which you can use to pay for eligible healthcare expenses now or in the future. BNY Mellon automatically contributes to your HSA if your base pay is less than $100,000 and you are not enrolled in any part of Medicare or TRICARE; you can choose to make your own contributions as well. See "**Health Savings Account (HSA)**" for information.

ABOUT THE ANTHEM COPAY PLAN

The Copay Plan offers a lower deductible and more cost predictability when you receive healthcare, with lower out-of-pocket costs when you need healthcare compared to the Higher Deductible HSA Plan and Lower Deductible HSA Plan.

Unlike the Higher Deductible and Lower Deductible HSA Plans, the Copay Plan is not an HDHP as defined by the Internal Revenue Service (IRS). This means that if you enroll in the Copay Plan, you cannot make or receive Health Savings Account (HSA) contributions. However, if you have a balance in an HSA, you may use funds in the account for eligible healthcare expenses.

Under the Copay Plan

- You must enroll in **PrudentRx** if you or your eligible dependent currently take one or more medications included on your plan's exclusive specialty drug list
- In-network preventive care is covered at 100 percent and does not require a copay
- Anthem Virtual Care Visits and Premise Health onsite clinic visits are also covered at 100 percent and do not require a copay
- You pay fixed amounts, called copays, for in-network visits to primary care and specialist providers, urgent care centers, retail clinics, and the emergency room, as well as for prescription drugs. You pay copays for these types of visits whether or not you have met your deductible. Copays count toward your out-of-pocket maximum, but not your deductible.
- After you reach your annual deductible, BNY Mellon pays 80 percent of the cost of most other eligible in-network care and you pay 20 percent. You save through negotiated network discounts, while having the freedom to use out-of-network providers at a higher cost. Unless your claim is a Surprise Billing Claim, note that in addition to their higher cost, out-of-network providers may, in some cases, balance bill you for charges above the plan's Maximum Allowed Amount, subject to applicable law. See "**Terms You Should Know**" for more information about Surprise Billing Claims.

For in-network coverage, your out-of-pocket medical costs are limited to an annual in-network maximum—including your in-network deductible, coinsurance, and copays—which is the most you'll pay for in-network medical costs in any year.

For out-of-network coverage, the amounts you pay for coinsurance will count toward your out-of-network deductible and out-of-pocket maximum. Any amounts you pay above the Maximum Allowed Amount won't count toward your deductible or out-of-pocket maximum. For out-of-network services, the Plan has set the Maximum Allowed Amount at the 70th percentile of FAIR Health. See "**Terms You Should Know**" for more information about Maximum Allowed Amount and FAIR Health.

Expenses for in-network and out-of-network care **only** count toward the respective deductible and out-of-pocket maximum, subject to applicable law. In-network expenses don't apply to the out-of-network deductible and out-of-pocket maximum, or vice versa.

You can make pre-tax contributions to a General Purpose Healthcare FSA, which you can use to pay for eligible healthcare expenses.

Copay Program – Enroll for $0 Out-of-Pocket for Specialty Drugs through CVS Caremark Specialty

In order to provide a comprehensive and cost-effective prescription drug program for you and eligible dependents in the Anthem Copay Plan, BNY Mellon is offering the PrudentRx copay program for certain specialty medications. Participating members will have $0 out-of-pocket (OOP) cost for medication on your plan's exclusive specialty drug list. To confirm the list of drugs covered under the program please call PrudentRx.

These drugs are often expensive but also important to the health of you and your covered dependents. Examples include drugs that are used for the treatment of complex, chronic conditions such as autoimmune diseases, hepatitis, hemophilia, cancer, and others. The PrudentRx program can help you manage these costs. Drugs like these can be expensive because they will have no price cap in the 2023 Copay Plan.

PrudentRx will help manage enrollment and renewals on your behalf. Even if there is no copay card program for your medication, your OOP cost will be $0 for as long as you are enrolled in the PrudentRx program.

Enrollment

If you or a covered family member currently take one or more medications included on your plan's exclusive specialty drug list and are enrolled in the Anthem Copay medical plan, you will receive a welcome letter and phone call from PrudentRx. Be sure to read the letter and complete the step to finalize enrollment. **You must complete your enrollment by December 15, 2022.**

If you or an eligible dependent are not currently taking but will start a new medication covered under the PrudentRx copay program, you can reach out to PrudentRx, or they will proactively contact you so that you can take full advantage of the program.

If you do not return the call, choose to opt-out of the program, or if you do not affirmatively enroll in copay assistance program as required by the manufacturer, you will be responsible for the 30% coinsurance on your prescription drug.

You can enroll in the program at any time throughout the year. Once enrolled in the program and, if available, a manufacturer's copay assistance program, you will have $0 OOP costs for you covered medication. However, these terms will not apply to medication filled prior to enrollment.

If you have questions about how to enroll or about your eligibility, you can reach out directly to PrudentRx at 1-800-578-4403.

REMINDER: This program is not available to those enrolled in the Higher or Lower Deductible HSA Plans.

HOW THE MEDICAL PLANS COMPARE

The table below shows a summary of your coverage under each Anthem medical plan option. Note that the table shows in-network and out-of-network coverage for select services **only**. For more information, including additional covered services, see the Health Plan Comparison Chart on **MyBenefit Solutions**.

PLAN FEATURE	HIGHER DEDUCTIBLE HSA PLAN	LOWER DEDUCTIBLE HSA PLAN	COPAY PLAN WITH PRUDENTRX
Annual Deductible[1,2] (Individual / Family)	In-Network: $2,200 / $4,400 Out-of-Network: $4,400 / $8,800	In-Network: $1,500 / $3,000 Out-of-Network: $3,000 / $6,000	In-Network: $500 / $1,000 Out-of-Network: $1,000 / $2,000
Type of Family Deductible[2]	True Family[3]		Individual/Family[4]
Annual Out-of-Pocket Maximum (Individual / Family)[2]	Includes deductible, copays, and coinsurance for medical and prescription drugs. Excludes any amounts over Maximum Allowed Amount[5], and non-covered expenses.		
Base Pay Range			
$0 – $29,999	In-Network: $2,800 / $5,600 Out-of-Network: $5,600 / $11,200	In-Network: $2,100 / $4,200 Out-of-Network: $4,200 / $8,400	In-Network: $2,100 / $4,200 Out-of-Network: $4,200 / $8,400
$30,000 – $49,999	In-Network: $4,000 / $8,000[6] Out-of-Network: $8,000 / $16,000	In-Network: $3,400 / $6,800 Out-of-Network: $6,800 / $13,600	In-Network: $3,400 / $6,800 Out-of-Network: $6,800 / $13,600
$50,000 – $79,999	In-Network: $5,000 / $10,000[6] Out-of-Network: $10,000 / $20,000	In-Network: $4,600 / $9,200[6] Out-of-Network: $9,200 / $18,400	In-Network: $4,600 / $9,200 Out-of-Network: $9,200 / $18,400
$80,000 – $124,999	In-Network: $6,000 / $12,000[6] Out-of-Network: $12,000 / $24,000	In-Network: $5,800 / $11,600[6] Out-of-Network: $11,600 / $23,200	In-Network: $5,800 / $11,600 Out-of-Network: $11,600 / $23,200
$125,000+	In-Network: $6,650 / $13,300[6] Out-of-Network: $13,300 / $26,600	In-Network: $6,450 / $12,900[6] Out-of-Network: $12,900 / $25,800	In-Network: $6,450 / $12,900 Out-of-Network: $12,900 / $25,800
Coinsurance	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		In-Network: You pay 20% after the deductible for select services Out-of-Network: You pay 40% after the deductible for select services

PLAN FEATURE	HIGHER DEDUCTIBLE HSA PLAN	LOWER DEDUCTIBLE HSA PLAN	COPAY PLAN WITH PRUDENTRX
Preventive Care	In-Network: 100% covered; deductible doesn't apply Out-of-Network: You pay 40% after the deductible		
Office Visit, Non-preventive Including Telehealth (Other than Anthem Virtual Care)	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		*Primary Care Physician:* In-Network: You pay $10 copay Out-of-Network: You pay 40% after the deductible *Specialist:* In-Network: You pay $40 copay Out-of-Network: You pay 40% after the deductible
Premise Health Onsite Clinic	In-Network: You pay $20 Out-of-Network: Not applicable		In-Network: 100% covered Out-of-Network: Not applicable
Anthem Virtual Care Visits (Urgent Care, Primary Care, Behavioral Health)	*Urgent Care, Primary Care, Behavioral Health:* You pay 20% after the deductible		*Urgent Care, Primary Care, Behavioral Health:* 100% covered
Anthem Virtual Care Preventive/Well Exam Visits	In-Network: 100% covered; deductible doesn't apply Out-of-Network: N/A		
Retail Clinic / Urgent Care	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		*Retail Clinic:* In-Network: You pay $40 copay Out-of-Network: You pay 40% after the deductible *Urgent Care*: In-Network: You pay $75 copay Out-of-Network: You pay 40% after the deductible
Emergency Room	In-Network: You pay 20% after the deductible Out-of-Network: You pay 20% after the deductible for medical emergency only		In- and Out-of-Network: You pay $250 copay (waived if admitted)
Inpatient Hospital	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		
Outpatient Surgery	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		

PLAN FEATURE	HIGHER DEDUCTIBLE HSA PLAN	LOWER DEDUCTIBLE HSA PLAN	COPAY PLAN WITH PRUDENTRX
Outpatient Physical, Occupational, and Speech Therapy	Combined In- and Out-of-Network: Limit of 60 visits per calendar year for all therapies combined; additional visits may be approved by Anthem based on medical necessity In-Network: You pay 20% after the deductible; preauthorization may be required Out-of-Network: You pay 40% after the deductible; preauthorization may be required		Combined In- and Out-of-Network: Limit of 60 visits per calendar year for all therapies combined In-Network: You pay $40 copay; preauthorization may be required Out-of-Network: You pay 40% after the deductible; preauthorization may be required
Lab/Radiology	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		
Travel Reimbursement Benefit[7]	In-Network: 100% covered up to the benefit limit after the deductible; eligibility must be confirmed through Accolade Out-of-Network: Not covered (Limit: $1,000 per occurrence)		In-Network: 100% covered up to the benefit limit; deductible does not apply; eligibility must be confirmed through Accolade Out-of-Network: Not covered (Limit: $1,000 per occurrence)
Mental Health/Substance Abuse – Outpatient	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		In-Network: You pay $10 copay Out-of-Network: You pay 40% after the deductible
Mental Health/Substance Abuse – Inpatient	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		
Prenatal, Delivery, and Postnatal Care by OB/GYN	In-Network: You pay 20% after the deductible (preventive prenatal care is 100% covered) Out-of-Network: You pay 40% after the deductible		
Bariatric Services	In-Network: Preauthorization required; must use an Anthem Blue Distinction or Blue Distinction+ facility, if available: You pay 20% after the deductible Out-of-Network: Not covered		
Fertility Services	In-Network: Must use an Anthem Blue Distinction or Blue Distinction+ facility[8], if available: You pay 20% after the deductible; lifetime combined medical and Rx maximum of $50K Out-of-Network: Not covered		
Spine and Joint Surgery	In-Network: Preauthorization required; if you use an Anthem Blue Distinction or Blue Distinction+ facility, if available: 100% covered after the deductible All Other In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible		
Transplant Surgery	In-Network: Preauthorization required; must use an Anthem Blue Distinction or Blue Distinction+ facility, if available: You pay 20% after the deductible Out-of-Network: Not covered		

PLAN FEATURE	HIGHER DEDUCTIBLE HSA PLAN	LOWER DEDUCTIBLE HSA PLAN	COPAY PLAN WITH PRUDENTRX
Hearing Aids	In-Network: You pay 20% after the deductible Out-of-Network: You pay 40% after the deductible (Max coverage of $5,000 every 2 years, In- and Out-of-Network combined)		
Applied Behavioral Therapy (ABA)	In-Network: You pay 20% after the deductible; preauthorization required Out of Network: You pay 40% after the deductible; preauthorization required		In-Network: You pay 20% after the deductible or $10 copay, as billed, depending on place of service; preauthorization required Out-of-Network: You pay 40% after the deductible; preauthorization required

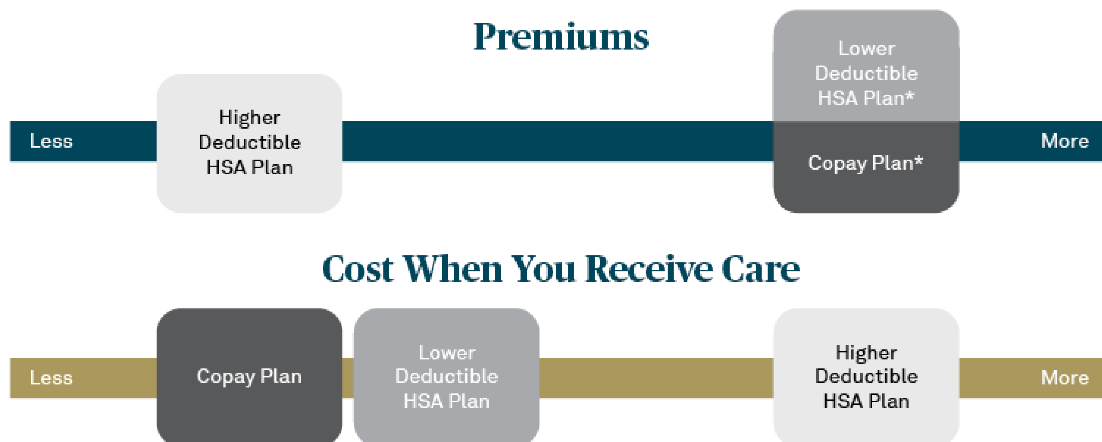
[1] Copays count toward your out-of-pocket maximum but not toward your deductible.
[2] Family applies to the Employee + Child(ren), Employee + Spouse/Qualified Domestic Partner, and Employee + Family levels of coverage.
[3] Under a true family deductible, the full family deductible must be met before the Plan begins to pay for non-preventive services.
[4] Under an individual family deductible, once one family member meets the individual deductible, coinsurance applies for that family member only.
[5] Maximum Allowed Amount. The Plan has set this limit at the 70th percentile of FAIR Health for professional services; local plan pricing will be used for facility services. Maximum Allowed Amount limits apply to out-of-network services only.
[6] This footnote represents an Embedded out of pocket maximum for those plans noted. Embedded means the Family amount can be satisfied by any combination of family members but an individual would never satisfy more than their own individual amount. For these plans with the footnote, the In-Network individual max amount on a family plan is $7,900.
[7] This benefit is available when the member is unable to locate a Network or Out-of-Network provider within their state of residence. Limitations to this benefit apply, you can reference the Travel Reimbursement section of the Anthem Schedule of Benefits or call Accolade for more information.
[8] Covered only when performed in Blue Distinction Center/Blue Distinction Center+ Facility Only. Members home has to be 50 miles or more from the nearest Blue Distinction Center for consideration for a Network Provider (non-BDC+/BDC Facility) to be used upon advanced approval from Anthem.

THINGS TO CONSIDER WHEN CHOOSING YOUR MEDICAL PLAN OPTION

When deciding which medical plan option to choose, consider when you want to pay for care:

Would you prefer to pay **more** in premiums and **less** when you receive care? Typically, this is appealing for those who expect to use more healthcare services.

Or would you rather pay **less** in premiums and **more** when you receive care? Typically, this is appealing for those who do not expect to use a lot of healthcare services.



*Note that the Lower Deductible HSA Plan and Copay Plan will continue to have the same premiums for 2023.

While the Copay Plan offers more cost predictability when receiving healthcare compared to the Higher Deductible HSA Plan and Lower Deductible HSA Plan, it may not be the best plan for everyone. **You must also be in the Copay Plan to enroll in PrudentRx for specialty medications.** PrudentRx allows you to get select specialty medications at no cost to you. That means $0 out-of-pocket (OOP) for any medications on your plan's exclusive Specialty Drug List when you are enrolled in the program.

For other employees, the Lower and Higher Deductible HSA Plans may provide the best overall option when considering your premiums paid, healthcare needs, and opportunity to contribute to a Health Savings Account (HSA).

When making your medical plan decision for 2023, think about the amount of care you'll need in 2023 (including prescription drugs) and whether you'd prefer to pay more in premiums and less when you receive care. Also note that when you enroll in the Copay Plan, you cannot receive contributions or contribute to the HSA to save for current and future eligible medical expenses. However, any contributions you've previously made to an HSA, as well as any contributions that BNY Mellon may have made to a Legacy Health Reimbursement Account (HRA) on your behalf, can be used to pay for eligible out-of-pocket healthcare, dental care, and vision care expenses.

For a side-by-side comparison of the key features of all three medical plans, see "**How the Medical Plans Compare**".

For help determining which medical plan option is right for you, call your Accolade Health Assistant at 1-833-640-0427, or use the decision support tools on the **MyBenefit Solutions** website.

SPECIALTY CARE WITH ANTHEM BLUE DISTINCTION AND BLUE DISTINCTION+

As an Anthem member, you will also have access to a national recognition program created by Blue Cross and Blue Shield—Blue Distinction Specialty Care—to make it easier for you to find specialty care that's right for you. The Blue Distinction Program recognizes doctors and hospitals for their expertise and quality in delivering care, from general health and wellness to more complex and specialty procedures. There are two designations across 11 areas of specialty care:

- **Blue Distinction Center**—Demonstrates quality care and treatment expertise
- **Blue Distinction Center+**—Demonstrates more affordable care in addition to quality care and treatment expertise

These designations are awarded to doctors and hospitals based on a thorough, objective evaluation of treatment expertise and quality care outcomes.

The areas of specialty care where hospitals and doctors are recognized through Blue Distinction include:

- Bariatric surgery (mandatory use for coverage)
- Cancer care*
- Cardiac care
- Cellular immunotherapy—CAR-T*
- Fertility care (mandatory use for coverage)
- Gene therapy*
- Knee and hip replacement
- Maternity care
- Spine surgery
- Substance use treatment and recovery*
- Transplants (mandatory use for coverage)

* Blue Distinction Center designation only; all others listed carry Blue Distinction Center+ designation

When searching for providers at **anthem.com/bnymellon**, you can narrow your search results to find Blue Distinction Centers using the Blue Distinction option on the left side of the screen. Alternatively, call your Accolade Health Assistant at 1-833-640-0427.

NEW! FAMILY PLANNING – ENHANCED FERTILITY OPTIONS AND MORE

Effective January 1, 2023, we're enhancing our Family Planning benefit, giving employees and dependents enrolled in one of the Anthem Medical Plans greater financial assistance and flexibility with fertility medical services and fertility prescriptions.

Previously, fertility-related coverage was subject to a separate lifetime maximum of $25,000 for medical services and $10,000 for prescription drugs. Beginning 2023, the overall lifetime maximum will be combined for a total lifetime maximum benefit of $50,000,* an overall coverage increase of $15,000. The coverage can be used in any combination of fertility-related medical services** and prescription drugs depending on your needs (for example, IVF, egg- and sperm-freezing).

In addition:

- an infertility diagnosis will no longer be required as a condition of coverage for fertility treatments
- certain elective egg preservation coverage (for up to 12 months) has been added as a covered benefit (subject to the dollar limit above and the terms and conditions of the applicable plans).

Kaiser, HMSA Hawaii, and Aetna International members have separate coverage and maximums through their respective health plans. For additional information, refer to the *Summary of Benefits and Coverage* located on *MyBenefits Solutions* under *Plan Information.*

BNY Mellon continues to evaluate programs in support of families that build on already existing policies such as global parental leave, bereavement leave, and global caregiver leave. More details coming as these efforts evolve.

* All fertility-related medical services and prescription drug expenses covered-prior to 2023 under your medical and prescription drug plans will count toward the increased lifetime maximum of $50,000. For example, effective 1/1/2023 you will have coverage available in the amount of the difference between $50,000 minus any expenses for fertility related medical services and prescription drugs previously covered by your medical and prescription drug plans. Expenses covered under the Anthem medical and CVS Pharmacy plans will be cross accumulated (totaled) when determining whether you have reached the fertility lifetime maximum.
** Fertility medical services are covered only when performed in Blue Distinction Center/Blue Distinction Center+ Facilities. The employee home (or that of their covered dependent, if appliable) home has to be 50 miles or more from the nearest Blue Distinction Center for consideration for a Network Provider (non-BDC+/BDC Facility) to be used upon advanced approval from Anthem. Coverage for fertility medical services and prescription drugs are also subject to plan terms, which may include deductibles, coinsurance and copays and other limitations.

2023 MEDICAL PREMIUMS

The rates shown in the table below are the 2023 semi-monthly health plan premium amounts. These amounts will be withheld from each pay, based on your annual base pay. Your base pay for purposes of determining premiums for the 2023 Plan year is determined as of September 1, 2022, or as of your date of hire, if later. Remember that medical plan premiums are adjusted depending on your **nicotine attestation**.

If you're eligible for medical coverage through HMSA, your per-pay rates will be shown on the **MyBenefit Solutions** website when you review your 2023 benefit elections.

2023 SEMI-MONTHLY EMPLOYEE MEDICAL PREMIUMS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAY)[1]					
ANNUAL BASE PAY/ COVERAGE LEVEL	**HIGHER DEDUCTIBLE HSA PLAN**	**LOWER DEDUCTIBLE HSA PLAN**	**COPAY PLAN**	**KAISER PERMANENTE PLAN**	**AETNA INTERNATIONAL PLAN**
Eligible for HSA Company Contributions	Yes, if base pay is less than $100,000[2,3]	Yes, if base pay is less than $100,000[2,3]	No	No	No
Under $30,000					
Employee Only	$12.50	$22.50	$22.50	$45.38	$41.67
Employee + Child(ren)	$26.00	$48.50	$48.50	$97.58	$88.50
Employee + Spouse/Qualified Domestic Partner	$32.50	$59.00	$59.00	$119.13	$109.08
Employee + Family	$47.50	$88.00	$88.00	$177.54	$160.54
$30,000 – $39,999					
Employee Only	$21.50	$48.50	$48.50	$76.00	$67.42
Employee + Child(ren)	$45.50	$103.00	$103.00	$162.79	$144.08
Employee + Spouse/Qualified Domestic Partner	$55.50	$126.50	$126.50	$199.67	$176.50
Employee + Family	$82.50	$187.50	$187.50	$296.08	$261.92
$40,000 – $49,999					
Employee Only	$25.00	$56.00	$56.00	$94.17	$86.96
Employee + Child(ren)	$53.59	$120.00	$120.00	$200.25	$184.71
Employee + Spouse/Qualified Domestic Partner	$66.00	$146.50	$146.50	$246.17	$226.92
Employee + Family	$98.00	$217.00	$217.00	$364.71	$336.54

2023 SEMI-MONTHLY EMPLOYEE MEDICAL PREMIUMS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAY)[1]					
ANNUAL BASE PAY/ COVERAGE LEVEL	HIGHER DEDUCTIBLE HSA PLAN	LOWER DEDUCTIBLE HSA PLAN	COPAY PLAN	KAISER PERMANENTE PLAN	AETNA INTERNATIONAL PLAN
$50,000 – $79,999					
Employee Only	$28.00	$60.50	$60.50	$116.83	$111.17
Employee + Child(ren)	$61.00	$130.00	$130.00	$248.46	$236.17
Employee + Spouse/Qualified Domestic Partner	$75.00	$159.00	$159.00	$304.04	$289.17
Employee + Family	$110.00	$236.00	$236.00	$452.08	$430.17
$80,000 – $99,999					
Employee Only	$36.50	$71.50	$71.50	$142.38	$116.79
Employee + Child(ren)	$77.00	$152.50	$152.50	$303.46	$250.08
Employee + Spouse/Qualified Domestic Partner	$94.50	$187.00	$187.00	$372.08	$306.67
Employee + Family	$140.00	$277.50	$277.50	$552.46	$455.38
$100,000 – $124,999					
Employee Only	$46.00	$91.50	$91.50	$152.58	$160.54
Employee + Child(ren)	$98.00	$194.00	$194.00	$325.58	$344.25
Employee + Spouse/Qualified Domestic Partner	$120.00	$238.50	$238.50	$399.33	$421.42
Employee + Family	$178.50	$354.00	$354.00	$592.17	$626.75
$125,000 – $149,999					
Employee Only	$55.00	$107.50	$107.50	$191.71	$164.67
Employee + Child(ren)	$116.50	$229.00	$229.00	$409.54	$349.92
Employee + Spouse/Qualified Domestic Partner	$143.00	$281.50	$281.50	$502.54	$429.67
Employee + Family	$212.00	$417.50	$417.50	$745.33	$638.04
$150,000 – $249,999					
Employee Only	$66.50	$131.00	$131.00	$199.67	$188.33
Employee + Child(ren)	$142.00	$278.50	$278.50	$425.42	$401.88
Employee + Spouse/Qualified Domestic Partner	$175.00	$343.00	$343.00	$523.00	$492.96
Employee + Family	$259.00	$508.50	$508.50	$774.83	$730.67

2023 SEMI-MONTHLY EMPLOYEE MEDICAL PREMIUMS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAY)[1]					
ANNUAL BASE PAY/ COVERAGE LEVEL	HIGHER DEDUCTIBLE HSA PLAN	LOWER DEDUCTIBLE HSA PLAN	COPAY PLAN	KAISER PERMANENTE PLAN	AETNA INTERNATIONAL PLAN
$250,000 and Above					
Employee Only	$78.00	$153.00	$153.00	$228.58	$204.79
Employee + Child(ren)	$166.50	$326.50	$326.50	$488.38	$436.33
Employee + Spouse/Qualified Domestic Partner	$204.50	$401.00	$401.00	$598.42	$535.67
Employee + Family	$302.50	$594.50	$594.50	$888.29	$793.96

[1] If you attest to being a nicotine user in the system for 2023, you will be assessed a $25 semi-monthly surcharge ($50 if your spouse is a user too). Therefore, you will be paying $25 (or $50) plus the above semi-monthly premium for the plan and tier you are in.
[2] For purposes of eligibility for BNY Mellon annual HSA contributions for 2023, your base pay is determined as of September 1, 2022, or your hire date, if later.
[3] You are not eligible to receive BNY Mellon annual HSA contributions if you are enrolled in any part of Medicare or TRICARE. However, you are eligible to receive any applicable BNY Mellon contributions for which you are eligible through payroll as taxable wages.

PRESCRIPTION DRUG BENEFITS

If you elect medical coverage through any of the Anthem medical plans, you'll automatically be enrolled for prescription drug coverage through CVS Caremark. Prescription drug expenses under all three plans count toward the medical out-of-pocket maximum.

The CVS Caremark prescription plan offers lower prices for generic drugs, a mail order option for preventive and maintenance medications, and coverage for specialty drugs. It also requires mandatory generic substitution.

You can purchase 30-day supplies of acute medications at any retail pharmacy, although you may save money when you use an in-network pharmacy. To find a local network pharmacy, call Accolade at 1-833-640-0427.

Watch for Your Prescription Drug Card
If you are enrolling for the first time or changing your coverage, you will receive a new prescription drug card from CVS Caremark in the mail after Open Enrollment ends. Use this card when you order prescriptions through a retail pharmacy, Maintenance Choice or the CVS Caremark Mail Service. This card is separate from your medical card.

New for this year: Remember that employees in the Anthem Copay Plan are eligible to participate in the **PrudentRx Copay Program** for $0 out-of-pocket (OOP) costs for Specialty Medications covered under the program.

Maintenance Drugs and More
If you use maintenance drugs, you can purchase them through either the Maintenance Choice program (pick up at any CVS pharmacy) or CVS Caremark Mail Service. You can fill a 30-day maintenance prescription **twice** at a retail pharmacy. Starting with the third fill, you must fill your prescription in a 90-day supply through the Maintenance Choice program or CVS Caremark Mail Service; otherwise, you'll pay the full cost out of your own pocket.

Prescription Drugs under the Anthem Medical Plans

Here's how prescription drugs are covered under the three medical plans. **Please note:** Prescription drugs with an over-the-counter (OTC) equivalent aren't covered by any of the BNY Mellon medical plans.

	HIGHER DEDUCTIBLE HSA PLAN	LOWER DEDUCTIBLE HSA PLAN	COPAY PLAN[1]
Retail (30-day supply)			
Preventive Drugs[2]			
Generic	$10 copay; deductible doesn't apply		$10 copay
Formulary (Preferred) Brand	25% ($50 minimum / $75 maximum); deductible doesn't apply		$30 copay
Non-Formulary (Non-Preferred) Brand	40% ($75 minimum / $100 maximum); deductible doesn't apply		$60 copay
Non-Preventive Drugs[3]			
Generic	20% after the deductible		$10 copay
Formulary (Preferred) Brand	20% after the deductible		$30 copay
Non-Formulary (Non-Preferred) Brand	40% after the deductible		$60 copay
Maintenance Choice or CVS Caremark Mail Service (90-day supply)[3,4]			
Preventive Drugs			
Generic	$25 copay; deductible doesn't apply		$25 copay
Formulary (Preferred) Brand	25% ($125 minimum / $187.50 maximum); deductible doesn't apply)		$75 copay
Non-Formulary (Non-Preferred) Brand	40% ($187.50 minimum / $250 maximum); deductible doesn't apply)		$150 copay
Non-Preventive Drugs			
Generic	20% after the deductible		$25 copay
Formulary (Preferred) Brand	20% after the deductible		$75 copay
Non-Formulary (Non-Preferred) Brand	40% after the deductible		$150 copay
Specialty Drugs[5]; retail only (30-day supply)			
Generic	20% after the deductible		$50 copay
Formulary (Preferred) Brand	20% after the deductible		$100 copay
Non-Formulary (Non-Preferred) Brand	40% after the deductible		$150 copay
Specialty Drugs; PrudentRx Copay Program[6]			
Generic	N/A		$0 copay[6]
Formulary (Preferred) Brand	N/A		$0 copay[6]
Non-Formulary (Non-Preferred) Brand	N/A		$0 copay[6]

[1] Copay Plan copays for prescription drugs count toward your out-of-pocket maximum but not toward your deductible. The deductible does not apply to prescription drugs under the Copay Plan.
[2] Examples of preventive drugs include diabetes, cholesterol, and high blood pressure medications. For the most current and complete information, call Accolade at 1-833-640-0427.
[3] Must use mail order for maintenance drugs after two retail fills or pay full cost of drug at retail.
[4] Medications for chronic conditions must be filled in 90-day quantities through Maintenance Choice (pick up at any CVS pharmacy) or the CVS Caremark Mail Service after the prescription is filled twice at a retail pharmacy; mandatory generic and/or Step Therapy programs will apply. Call Accolade at 1-833-640-0427 for additional details.
[5] Drugs filled outside the CVS Caremark network will initially be denied, and you'll be responsible for 100 percent of the cost. You'll need to fill out an out-of-network paper claim to be reimbursed by the Plan up to the out-of-network coinsurance amount, after your deductible has been met.
[6] The copay for certain specialty medications will be $0 as long as you are enrolled in PrudentRx. If you choose to opt out of the program, or do not affirmatively enroll in a copay assistance program as required by the manufacturer, you will be responsible for the 30% coinsurance on your prescription drug.

Out-of-Network Coverage
BNY Mellon's plan is set up to ensure that no matter where you are, you will always be able to access the services you need. Drugs filled at a pharmacy that is considered to be outside of the CVS Caremark network will initially be denied, and you will be responsible for 100% of the cost. That said, you can be reimbursed based on what the in-network coverage for the medication filled is. In order to receive reimbursement, you will need to fill out an out-of-network paper claim form. This can be done through the Caremark mobile app, which can be downloaded to your phone. Through the app, you will be able to access the claim form and find instructions on how to complete the process.

CVS Caremark Value Formulary

The prescription drug formulary (Value Formulary) is updated regularly. For a copy, call Accolade at 1-833-640-0427. Be sure to review it with your doctor. If your medication isn't on the list, discuss with your doctor whether your treatment plan can include a generic alternative or, if not available or tolerated, a high-quality, preferred name-brand, formulary drug.

Step Therapy

Step therapy helps ensure that you receive appropriate, safe, and cost-effective drug therapy. It encourages therapies that should be tried first, before other treatments are covered, based on clinical practice guidelines and cost-effectiveness.

If your doctor prescribes a brand-name drug for an ongoing condition, you're required to try a medically equivalent but lower-cost alternative first. CVS Caremark will contact you before implementing step therapy and give you a list of the alternative drugs available. After you review the list, you or your pharmacist can contact your doctor to approve the change. If your doctor doesn't authorize the switch to the preferred drug, the request will be clinically reviewed, and you'll be informed of the outcome.

CVS Caremark Opioid Management Program

CVS Caremark aligns its opioid management with the Centers for Disease Control and Prevention's (CDC's) *Guideline for Prescribing Opioids for Chronic Pain*. For information, call Accolade at 1-833-640-0427.

Receiving Treatment for an Ongoing Condition?
Review the CVS Caremark Value Formulary with your doctor. Your doctor will help determine whether your treatment plan can include a generic alternative or, if not available or tolerated, a high-quality, preferred brand-name drug on the formulary. For a copy of the Value Formulary Quick Reference List, call Accolade at 1-833-640-0427.

Special Prescription Drug Guidelines May Apply
CVS Caremark requires prior authorization, quantity limits and/or specialty guideline management for select medications. These requirements may change from time to time. For a list of current medications subject to these special guidelines, call CVS Caremark at 1-800-685-4130.

Dispense as Written (DAW) Provision

Sometimes, your doctor may determine that it's medically necessary for you to take the brand- name version of a drug, even if a generic equivalent is available, and write "DAW" at the bottom of the prescription. DAW means that your prescription must be filled with the brand-name version of the medication.

If you use a DAW prescription and receive a drug's brand-name version, you'll be required to pay the brand copay plus the cost difference between the brand and generic drugs. If you cannot take a generic equivalent for clinical reasons (e.g., you're allergic to the generic filler), your doctor can contact CVS Caremark to appeal. If your appeal is approved, you can take the brand-name drug without paying the cost difference.

Compound Prescriptions

Due to the lack of U.S. Food and Drug Administration (FDA) approval and their high cost, compounded medications may not be covered by your prescription drug plan or may require prior authorization. If the compound ingredients aren't covered, you'll pay the full cost of those ingredients. If the ingredients are covered through prior authorization, you'll pay the share of the cost specified by your prescription drug plan.

Preventive Drugs

Preventive drugs are medications (e.g., blood pressure and cholesterol-lowering drugs) that can help prevent a health condition from developing. For a list of drugs considered to be preventive, call Accolade at 1-833-640-0427.

Maintenance Drugs

Maintenance drugs are medications prescribed for treating chronic, long-term conditions, such as high blood pressure, heart disease, asthma, and diabetes, and are taken on a regular, recurring basis.

Special Programs Available Through Your CVS Prescription Drug Benefit

Diabetes Discount Program

The Diabetes Discount Program provides a 50 percent discount on diabetes prescriptions and supplies when purchased through CVS. The discount is provided to all benefits-eligible participants who are enrolled in an Anthem medical plan option and have completed an A1c test in the prior 12 months.

Not all diabetic medications and supplies are eligible for the program discount:

Certain diabetic medications and supplies are considered preventive, and the discount will apply based on the applicable preventive drug copay tier.

For an individual covered by the Lower Deductible or Higher Deductible HSA plan, the 50 percent discount won't apply for non-preventive diabetic medications until you've met the annual deductible.

The discount doesn't apply to any medications on the CVS Caremark Value Priced Generics Drug List (available by calling Accolade at 1-833-640-0427).

If you have questions about this program, the specific coverages for diabetic medications and supplies, the **Livongo Diabetes Management Program**, or the A1c testing requirement, please call Accolade at 1-833-640-0427.

Specialty Drug Services

Specialty drugs are prescriptions used for treating complex, chronic conditions such as hepatitis, hemophilia, and cancer. CVS Specialty® can provide you with convenience (including express delivery), follow-up care calls, expert counseling, and superior service.

Specialty medications (excluding HIV and transplant therapies) aren't eligible for a grace fill at non-CVS retail pharmacies or other non-CVS specialty pharmacies. A one-time, annual grace fill is available for HIV and transplant therapies. All other specialty prescriptions must be filled through CVS Specialty and will be accepted at all CVS retail pharmacies.

Specialty Medications and Copay Card Programs

Third-party, manufacturer copay card programs are often used to help lower patient copay/coinsurance amounts owed at the point of sale.

Regardless of the program you participate in or discounts that you receive, only the amount you actually pay out of pocket for your prescription drugs is applied toward your deductible or out-of-pocket maximum.

Call CVS Specialty® Customer Care at 1-800-237-2767 for any questions about specialty medications. CVS pharmacy locations with a MinuteClinic® can also provide education regarding the specialty medications you're taking.

Remember that the PrudentRx Copay Program allows employees enrolled in the Anthem Copay Medical Plan to get select specialty medications at no cost. That means $0 out-of-pocket (OOP) for any medications on your plan's exclusive Specialty Drug List when you fill by CVS Specialty®. See the **PrudentRx** program description for details.

CVS Health Pharmacy Advisor Counseling Program

If you or a covered family member has a chronic condition, this program can help you improve your medication adherence and close gaps in care. Consult with a CVS pharmacist at your convenience for quick, confidential advice, information about medications and their effects, and guidance to help you stay on track with your medications.

CVS Caremark Resources and Savings

While **Accolade** can support you with general inquiries about your prescription drug plan, **caremark.com**, with its secure, encrypted web environment for transactions and information, offers tools and resources to empower you to make cost-effective and informed healthcare decisions. You'll find:

- Fast and convenient mail service for new prescriptions and online refills
- Expedited new prescription mail service orders with Fast Start
- Your prescription history
- Tools that allow you to check for lowest-price options
- Ask-a-Pharmacist and Customer Care to answer your questions
- Information about drug interactions with other drugs, vitamins, and foods
- Health information about specific conditions through Self-Care Centers.

Go to **caremark.com/register** to get started. It's a fast, free, and easy way to make the most of your prescription drug coverage.

Get Care Fast with a CVS Health MinuteClinic®

If you're enrolled in one of the Anthem medical plan options under the BNY Mellon-Plan, CVS Health MinuteClinic is available for non-emergency care. Their on-staff nurse practitioners and physician assistants specialize in family care for people 18 months and older. Present your medical plan ID card to receive Anthem's negotiated in-network rate. To find a nearby CVS Health MinuteClinic, visit **cvs.com/minuteclinic/clinic-locator**.

Note: Not all CVS Health MinuteClinics are in-network, and you should confirm network status before receiving care. If you receive care at a CVS Health MinuteClinic that is not in the medical plan network, your claim will be paid at the out-of-network benefit level. To find out if a MinuteClinic is in-network, call Accolade at 1-833-640-0427.

Questions About Your Prescription Drug Coverage?
Call Accolade at 1-833-640-0427.

Health Savings Account (HSA)

If you enroll in the Anthem Higher Deductible HSA Plan or the Lower Deductible HSA Plan, you may be eligible to contribute and receive BNY Mellon contributions to an HSA, which you can use to pay for eligible healthcare expenses. While you aren't eligible for an HSA if you enroll in the Copay Plan, you may use funds previously contributed to an HSA for eligible healthcare expenses. See "**HSA Eligibility**" for additional rules about who can contribute to an HSA.

The HSA offers these advantages:

BNY Mellon contributes to your account if (i) your annual pay is less than $100,000 on September 1, 2022, or your hire date, if later, and (ii) you are not enrolled in any part of Medicare or Tricare. If you are a newly benefits-eligible employee, once you enroll in and open an HSA, a pro-rated BNY Mellon contribution (if eligible) will be deposited to your HSA after your account opening is completed and then annually thereafter.

You can budget and save. You can contribute your own pre-tax (and/or lump-sum after-tax) contributions. You can use the money to pay for eligible healthcare expenses you expect to have during the year—for example, your medical deductible. **Remember:** Any money in your account that you don't use rolls over from one year to the next.

Your account isn't taxable. You don't pay federal taxes on any money you and BNY Mellon put into your HSA, subject to IRS limits, or on any money you take out—as long as it's used to pay for eligible healthcare expenses. In most states, HSA contributions and earnings are also exempt from state income taxes. Be sure to consult your tax advisor with any questions.

It's always your money. The money in your HSA is yours—to pay for eligible healthcare expenses today or in the future, even if you leave BNY Mellon for any reason at any time.

Attention HSA Participants

An HSA is offered together with the Higher Deductible and Lower Deductible HSA Plans **only**, as a voluntary benefit directly from BenefitWallet. The HSA isn't governed by ERISA.

BNY Mellon neither endorses BenefitWallet as the HSA vendor, nor does it sponsor the HSA program. BNY Mellon is compensated for custodial work it provides to BenefitWallet.

You Must Re-elect Your HSA Contribution Each Year

To continue contributing to your HSA, you must make a new contribution election each year during Open Enrollment. **Your current contribution amount won't automatically roll over year to year.**

Your HSA contribution election is in addition to your health plan election (assuming you enroll in the Higher Deductible HSA Plan or the Lower Deductible HSA Plan and remain eligible to contribute to an HSA).

You can increase or decrease your HSA contribution monthly throughout the year.

For a detailed list of healthcare expenses eligible for reimbursement through your HSA—which include over-the-counter (OTC) drugs without a prescription and menstrual care products—see *IRS Publication 502 (Medical and Dental Expenses)*, which is available through **irs.gov/forms-instructions**.

HSA ELIGIBILITY

Internal Revenue Service (IRS) rules determine whether you're eligible to open an HSA and make and receive HSA contributions. You must also meet all conditions of the USA PATRIOT Act before Benefit Wallet can open the HSA account. For assistance with the USA PATRIOT Act, contact Benefit Wallet, 1-877-472-4200.

You **can participate in the HSA** if you are enrolled in the Higher Deductible HSA Plan or Lower Deductible HSA Plan and you:

- Are not covered by any other health plan (as an individual, spouse or qualified domestic partner) that is not a qualifying high-deductible health plan, including a General Purpose Healthcare FSA or Health Reimbursement Arrangement (limited coverages, such as vision, dental, or cancer plans, are permitted);
- Are not enrolled in any part of Medicare (including Part A, Part B, Part D, etc.) or TRICARE®; and
- Cannot be claimed as a dependent on another individual's federal tax return.

Contributing to an HSA? Consider the Limited Purpose Healthcare Flexible Spending Account (FSA) for Additional Tax Savings

If you choose to contribute to the Limited Purpose Healthcare FSA, you can use it to pay for eligible dental, vision, preventive drug, and out-of-network preventive care expenses only, until you meet your medical plan's annual deductible.

Once you meet the deductible, you can also use the Limited Purpose Healthcare FSA for other eligible medical expenses (including eligible over-the-counter [OTC] items). To learn more, see "**Flexible Spending Accounts (FSAs)**".

Keep in mind:

If you're enrolled in the Higher Deductible HSA Plan or Lower Deductible HSA Plan **and** in any part of Medicare or TRICARE, you cannot make or receive contributions to an HSA. However, you **are** eligible to receive any applicable BNY Mellon contributions for which you are eligible through payroll as taxable wages.

Although you may elect healthcare coverage for eligible adult children up to age 26, this rule does not extend to HSAs. If your child does not meet the IRS definition of a "qualifying child" or "qualifying relative" (i.e., lives with you for more than half the year and provides less than half of his or her own support), any HSA amounts used to pay your child's medical expenses will be subject to taxes and IRS penalties.

By law, if you enroll in either the Higher Deductible HSA Plan or Lower Deductible HSA Plan, any funds remaining in a General Purpose Healthcare Flexible Spending Account (FSA) will be reclassified as Limited Purpose Healthcare FSA funds. You can use these funds only for reimbursement of eligible dental, vision, preventive drug, and out-of-network preventive care expenses before you meet your medical plan's annual deductible. After you've met the deductible, you can also use these funds for reimbursement of eligible medical expenses (including eligible over-the-counter [OTC] items). You will need to provide proof that your deductible has been met.

HSA CONTRIBUTIONS

During 2023, you can contribute to your HSA up to the annual IRS limit of:

- $3,850 if you elect Employee Only coverage
- $7,750 if you elect Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren), or Employee + Family

Beginning in the year you reach age 55, you can make an additional catch-up contribution of up to $1,000 annually. If you exceed the annual IRS limit, you may be subject to additional taxes and penalties.

In addition to your contribution, BNY Mellon also contributes to HSAs for employees earning less than $100,000 base pay as of September 1, 2022, or on your date of hire, if later. Note that if your base pay is $100,000 or more, or if you are enrolled in any part of Medicare or TRICARE, you are not eligible to receive BNY Mellon annual HSA contributions.

Remember that the maximum amount you can contribute to the HSA includes the amount you receive from BNY Mellon (if any). See the chart below for the maximum amount you can contribute based on your base pay. Note, if you first become eligible for the HSA after the beginning of the 2023 Plan year, BNY Mellon's HSA contribution (if any) will be pro-rated.

BASE PAY AND COVERAGE LEVEL	2023 HSA CONTRIBUTION LIMITS		
	IRS COMBINED MAXIMUM ANNUAL CONTRIBUTION	BNY MELLON'S ANNUAL CONTRIBUTION (AUTOMATIC)[1,2]	ANNUAL CONTRIBUTION (VOLUNTARY)[3]
Under $30,000			
Employee Only	$3,850	$700	$3,150
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren), or Employee + Family	$7,750	$1,400	$6,350
$30,000 – $39,999			
Employee Only	$3,850	$600	$3,250
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren), or Employee + Family	$7,750	$1,200	$6,550
$40,000 – $49,999			
Employee Only	$3,850	$500	$3,350
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren), or Employee + Family	$7,750	$1,000	$6,750

BASE PAY AND COVERAGE LEVEL	2023 HSA CONTRIBUTION LIMITS		
	IRS COMBINED MAXIMUM ANNUAL CONTRIBUTION	BNY MELLON'S ANNUAL CONTRIBUTION (AUTOMATIC)[1,2]	ANNUAL CONTRIBUTION (VOLUNTARY)[3]
$50,000 – $79,999			
Employee Only	$3,850	$400	$3,450
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren), or Employee + Family	$7,750	$800	$6,950
$80,000 – $99,999			
Employee Only	$3,850	$200	$3,650
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren), or Employee + Family	$7,750	$400	$7,350
$100,000 and above			
Employee Only	$3,850	$0	$3,850
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren), or Employee + Family	$7,750	$0	$7,750

[1] If you are enrolled in any part of Medicare or TRICARE, you are not eligible to receive BNY Mellon annual HSA contributions. However, you are eligible to receive any applicable BNY Mellon contributions for which you are eligible through payroll as taxable wages.
[2] If you first become eligible for the HSA after the first of the 2023 Plan year, the BNY Mellon HSA contribution (if any) will be pro-rated.
[3] You're responsible for monitoring your contributions during the year to ensure you don't exceed the annual IRS limit. Beginning in the year you reach age 55, you may make an additional catch-up contribution of up to $1,000 annually. If you exceed the annual IRS limit, you may be subject to additional taxes and penalties.

HOW THE HSA WORKS

BenefitWallet™, an independent vendor, administers the HSA. Your HSA won't become active until after the date you've completed the BenefitWallet HSA enrollment process, your enrollment in either the Higher Deductible HSA Plan or Lower Deductible HSA Plan has been received, and your health plan coverage becomes effective. Unless your health plan coverage begins on the first day of the month, your HSA will not be active until the first day of the following month.

All HSA deposits are first credited to an FDIC-insured, interest-bearing BenefitWallet HSA Checking Account. No minimum balance is required to open and maintain the checking account.

Newly Enrolling in an HSA?
You'll receive a BenefitWallet Welcome Kit shortly after you open your HSA. Be sure to read it and provide BenefitWallet with any requested information required to activate, contribute to, and use your HSA.

Note: If you already have an HSA at another institution, you can roll over or transfer your funds to your BenefitWallet HSA. See your Welcome Kit for information.

Once your HSA checking account balance reaches $1,000, you generally can invest any amount over $1,000 in a BenefitWallet Investment Account. BenefitWallet selects and monitors the fund lineup.

You can pay for HSA-eligible expenses:

- Using your BenefitWallet HSA debit card at the point of purchase or time of service,
- Writing a check from your Benefit Wallet HSA Checking Account, or
- Paying out-of-pocket and then reimbursing yourself from your Benefit Wallet HSA Checking Account

These methods are more fully described in the BenefitWallet Welcome Kit you'll receive after enrolling (which includes your debit card).

Please note: To use the BenefitWallet HSA investment platform, you must maintain a minimum of $1,000 in your BenefitWallet HSA Checking Account. BNY Mellon will pay the applicable fees while you're an active employee if you choose to use the platform. There are no additional transaction fees, loads, or commissions.

If you participate in an HSA and leave BNY Mellon, you'll be charged an account maintenance fee of $3.25 per month if you keep your checking account open, and an additional investment management fee of $2.90 per month if you continue to invest your account.*

* These rates are subject to change by BNY Mellon in its discretion.

MAKING YOUR HSA CONTRIBUTIONS

When you enroll in an HSA, you'll need to choose how to make your contributions. You can contribute via:

- Pre-tax payroll deductions;
- After-tax lump-sum contributions made directly to BenefitWallet; or
- A combination of pre-tax payroll and after-tax lump-sum contributions.

IRS rules determine whether you are eligible to open an HSA (i.e., you must be enrolled in a qualified high deductible health plan) and whether you are eligible to make and receive HSA contributions.

Active employees who are enrolled in an HSA Plan (and do not participate in any part of Medicare or TRICARE): You may make pre-tax and after-tax contributions to an HSA and will be eligible to receive any BNY Mellon HSA contributions for which they are eligible.

Active employees enrolled in an HSA Plan or Higher Deductible HSA Plan who are enrolled in any part of Medicare or TRICARE: You may not make or receive contributions to an HSA.

Employees enrolled in an HSA Plan who are on long-term disability, retired or on COBRA (and do not participate in any part of Medicare or TRICARE): You may make contributions to an HSA on an after-tax basis only and are not eligible to receive BNY Mellon contributions but may deduct the after-tax HSA contributions on their 2023 federal tax form.

To the extent that contributions are made to your HSA after your Medicare coverage starts, you may be subject to a tax penalty. If you would like to continue contributing and/or receiving BNY Mellon's automatic contributions to your HSA (if eligible), you should not apply for any part of Medicare (including Part A, Part B, Part D, etc.), Social Security or Railroad Retirement Board (RRB) benefits.

The Copay Plan, HMSA Hawaii Plan, Kaiser Permanente Plan, and Aetna International Plan are not qualified high-deductible health plans: Employees enrolled in these plans are not eligible to make HSA contributions or receive BNY Mellon contributions.

Important: If your **total** HSA contributions (i.e., pre-tax payroll contributions, after-tax lump-sum contributions, and any BNY Mellon contributions for which you're eligible) exceed the IRS limit, you can withdraw the excess without penalty until the deadline for filing your federal tax return for the tax year (including extensions) for which the excess contribution was made. After that time, any excess contributions are subject to both income taxes and an excise tax. Be sure to consult with your tax advisor if you have questions.

For general questions about how your HSA works, contact Accolade at 1-833-640-0427. For specific questions about your BenefitWallet HSA, contact BenefitWallet at 1-877-472-4200.

Calculating Your Personal HSA Contribution Limit

Under IRS rules, HSA contribution limits must generally be prorated by the number of months you are eligible to contribute. Eligibility is based on your coverage status on the first day of the month.

To calculate your personal contribution limit for the year:

- Take the total annual HSA contribution limit based on your HSA coverage level (individual or family) and, if you are age 55 or older, the annual catch-up contribution amount of $1,000
- Divide that amount by 12
- Multiply it by the number of months you qualify for the HSA in that year

Here's an example: Assume that you are age 36, have enrolled in employee-only coverage under the Higher Deductible HSA Plan, and are eligible to contribute to an HSA for six months of this year. For 2023, the HSA contribution limit (individual) is $3,850 for persons who are eligible to contribute for all 12 months. However, because you are eligible to contribute for only six months, your personal contribution limit for 2023 is reduced:

($3,850 ÷ 12) x 6 = $1,925 contribution for 2023

Note: This limit includes any BNY Mellon base pay-based annual contribution for which you're eligible (prorated based on your HSA-eligibility date). If you're eligible, **be sure to reduce your personal HSA contribution by any BNY Mellon contribution you receive during the year.** You are responsible for monitoring your contributions during the year to ensure you don't exceed the applicable annual IRS limit. If you exceed the applicable IRS limit, you may be subject to additional taxes and penalties. Be sure to consult with your tax advisor if you have questions.

MEDICARE, SOCIAL SECURITY, AND YOUR HSA

Under IRS rules, becoming **eligible** for Medicare doesn't prevent you from contributing to or taking withdrawals from your HSA—even if your spouse has enrolled in Medicare—assuming you otherwise remain HSA-eligible.

Once you enroll in **any** part of Medicare, however, you can no longer make or receive contributions to your HSA. However, you can still use your balance to pay for the same eligible healthcare expenses you've always used it for, plus:

- Medicare Part A deductible and premiums;
- Medicare Part B premiums and coinsurance;
- Medicare Part D prescription drug premiums;
- Medicare Advantage premiums; and/or
- Medicare out-of-pocket expenses.

You cannot use your HSA to pay premiums for a Medicare supplemental (Medigap) policy tax-free.

If you use your HSA for eligible medical expenses, the distributions from your account remain tax-free. If you use your HSA for non-eligible expenses, the distribution becomes taxable. However, once you're age 65, it's exempt from the 20 percent penalty.

It's important to note that if you elect to receive Social Security retirement benefits and you are Medicare-eligible due to a disability or being age 65, you will be automatically enrolled in Medicare Parts A and B. You can opt out of Part B based on your current employment, but you cannot waive the automatic Part A coverage. Medicare is primary for any retiree enrolled in any part of Medicare or those covered by COBRA.

If you're older than age 65 when you sign up for Social Security retirement benefits, your enrollment in Part A could be retroactively effective to the month in which you turned age 65 or, if longer, by as much as six months. That retroactive coverage makes you ineligible to make or receive HSA contributions during the retroactive period.

If you or BNY Mellon contribute to your HSA during this time, your contributions may be included in your taxable income and be subject to tax penalties. Consider stopping your HSA contributions for at least six months before you apply for Social Security retirement benefits to avoid any adverse tax consequences. For more information, consult a tax advisor and/or visit **medicare.gov**.

Additional Health Programs

What virtual or electronic service for what purpose?

BNY Mellon provides you with access to comprehensive virtual care through multiple vendors. See below to learn when to use each service and how to access:

Virtual Service	Where to Go
Preventive Care	Visit **anthem.com** or download the Sydney Health Mobile App to your phone.
Primary and Urgent Care	Visit **anthem.com** or download the Sydney Health Mobile App to your phone.
Behavioral Health	Visit **anthem.com** or download the Sydney Health Mobile App to your phone.
Second Opinion from a Medical Expert	Visit **teladoc.com/medicalexperts** or download the Teladoc Mobile App to access Medical Experts.
Diagnosis and Treatment Support	Visit **teladoc.com/medicalexperts** or download the Teladoc Mobile App to access Medical Experts.
Find a Provider	Visit **teladoc.com/medicalexperts** or download the Teladoc Mobile App to access Medical Experts. Visit **anthem.com** or download the Sydney Health Mobile App to your phone.
Nutrition Support	Access a combination of tools to support nutrition management. Log into Virgin Pulse by following the steps below or download the Virgin Pulse Mobile App to use the service.
Don’t Know Where to Start?	Call Accolade at 1-833-640-0427 to speak with a Health Assistant.

MEDICAL EXPERT SECOND OPINIONS THROUGH TELADOC: HELP WITH IMPORTANT MEDICAL DECISIONS

Teladoc Medical Experts, a virtual care service that provides access to experts for medical advice and medical opinions, is available to you, your eligible dependents, and parents and parents-in-law at no cost, whether or not enrolled in medical coverage under the BNY Mellon Plan. You can use Teladoc Medical Experts for:

- Confirmation of a recent diagnosis
- A review of an upcoming surgery or treatment plan
- Help with a chronic condition
- Help with a specific question about your health
- Help finding a doctor who specializes in your condition

You can use **teladoc.com/medicalexperts** and the Teladoc mobile app to access Medical Experts. To access Medical Experts, you'll need to register and create an account.

If you have questions, call Accolade at 1-833-640-0427, and speak with your Health Assistant, who will refer you to the most appropriate resource to meet your needs.

ANTHEM VIRTUAL CARE VISITS: FOR TELEHEALTH SERVICES

You have access to Anthem Virtual Care Visits*, where you can have a private and secure video visit with a board-certified doctor or licensed therapist on your smartphone, tablet, or computer with a webcam. It's an easy way to get the care you need at home or on the go.

Anthem Virtual Care Visits are available 24/7 and can help with common health conditions, like pink eye, allergies, and sinus infections. A doctor can assess your treatment, provide a treatment plan, and even send a prescription to your pharmacy, if it's needed! And, if you're feeling anxious or having trouble coping on your own and need some support, you can have a video visit with a therapist or psychiatrist using Anthem Virtual Care Visits.

Anthem Virtual Care Visits are available to all employees and their dependents who are eligible for BNY Mellon medical coverage—whether or not enrolled in Anthem medical coverage under the BNY Mellon Plan. Note that if you are not enrolled in Anthem medical coverage under the BNY Mellon Plan, you will be billed for your virtual visit, and if you are enrolled in the Lower Deductible or Higher Deductible HSA Plan, you will pay 20% after the deductible. If you are enrolled in the Copay Plan, Anthem Virtual Care Visits will be paid in full by the Plan.

Beginning in January 2023, with the Sydney Health app or anthem.com, you can chat with a doctor 24/7 without an appointment to receive care for health issues like allergies, a cold, or the flu. The doctor can write new prescriptions if needed. You can also schedule a virtual primary care visit* for routine care, including a virtual annual preventive care (wellness) visit* and prescription refill. Your virtual care team can create personalized care plans for you if you have a chronic condition, such as asthma or diabetes.

The Sydney Health app also includes a Symptom Checker to help you assess how you are feeling and direct you to the right level of care. This feature is always available to you at no extra cost.

* Available for adults ages 18-64

VIRGIN PULSE

Virgin Pulse* is a wellbeing app designed to help improve your physical wellbeing by cultivating good lifestyle habits through access to personalized content based on interests and digital coaching on a variety of topics, including nutrition, nicotine cessation and activity challenges. In addition, employees can earn WOW recognition awards for Virgin Pulse achievements.

Sign up for your Virgin Pulse account by going to **join.virginpulse.com/bnymellon**. Already a member? Sign in from work or home through the BNY Mellon Network at **https://hr.bnymellon.net/wellbeing** or your Personal Network at **https://hr.bnymellon.com/wellbeing**. Once you're signed up, download the Virgin Pulse mobile app for iOS or Android. Access your account and track your activity anywhere, anytime.

LIVONGO DIABETES MANAGEMENT PROGRAM

The Livongo Diabetes Management Program* is available to you if you are enrolled in Anthem medical coverage under the BNY Mellon Plan and you or a covered family member has diabetes. Livongo will contact you and/or your covered family members age 18 or older who qualify for the program. Children age 13 to 17 who qualify can be enrolled by an adult parent or caregiver.

The program provides the following at no cost to you:

- A free smart touch, connected glucometer and free test strips on an ongoing basis; the readings are transmitted to Livongo, a firm specializing in the care of patients with diabetes
- Real-time virtual coaching and help managing glucose levels from Livongo's Certified Diabetes Educators
- Predictive and personalized insights through Livongo's smart analytics program

If you have questions about the Livongo Program, call Accolade at 1-833-640-0427, and speak with your Health Assistant.

SLEEPIO

Getting a good night's sleep is essential to your health. Sleepio* is a digital sleep improvement program you can use anytime through your computer, tablet, or smartphone—at no cost to you.

You start by taking a simple, online quiz, which provides a sleep score and tips you can try immediately.

- Over time, you'll learn techniques to improve your sleep using Cognitive Behavioral Therapy (CBT) to help quiet your mind and overcome negative emotions that can cause insomnia.
- You'll receive access to a library of articles and guides to help you deal with common problems such as problems sleeping during pregnancy, jet lag, shift work and menopause.

Sleepio is available to all benefits-eligible employees as well as their spouses/qualified domestic partners and adult dependents over age 18 who are enrolled in medical coverage under the BNY Mellon Plan. Visit **sleepio.com/bnymellon** to get started.

* While BNY Mellon makes the services and programs provided by Teladoc Medical Experts, Anthem Virtual Care Visits, Livongo and Sleepio available to its US eligible employees and, as applicable, their eligible dependents, it does not review, recommend or endorse any health advice or information, program physician, specialist, medical facility, financial planning, or investment advice or information. Should you elect to utilize Teladoc Medical Experts, Anthem Virtual Care Visits, Livongo or Sleepio services or programs, including with regard to any health, or other advice, you are solely responsible for any outcomes resulting therefrom. BNY Mellon does not assume any liability for your or your dependents' utilization of these services or programs, including with regard to relying on advice that you receive, and by utilizing these services and programs, you agree not to hold BNY Mellon liable for such utilization. Teladoc Medical Experts, Anthem Virtual Care Visits, Livongo and Sleepio are not affiliated with BNY Mellon and BNY Mellon receives no consideration (monetary or otherwise) in connection with the provision of such services and programs.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) let you set aside money from your pay on a tax-free basis to pay for eligible healthcare and dependent care expenses and save on taxes. You can choose to enroll in one of two Healthcare FSAs, depending on the medical plan you elect.

If you enroll in the Copay Plan, you can contribute to a General Purpose Healthcare FSA. You can also contribute to a General Purpose Healthcare FSA if you opt out of medical coverage or enroll in the Kaiser Permanente, HMSA, or Aetna International Plan.

If you enroll in the Higher Deductible HSA Plan or Lower Deductible HSA Plan, you can contribute to a Limited Purpose Healthcare FSA.

You can also participate in a Dependent Care FSA, whether or not you're enrolled in medical coverage.

To participate in an FSA, you must actively enroll and elect your contribution amount(s) during your enrollment period. Going forward, you must actively enroll and elect your contribution amount(s) each year during Open Enrollment. **Your current elections won't automatically roll over year to year.** If you don't take action, your FSA contribution amount(s) will be set to $0 for the following year.

For 2023, you can contribute up to:

- General Purpose Healthcare FSA *or* Limited Purpose Healthcare FSA: $2,850
- Dependent Care FSA: $5,000

To determine how much will be deducted from each paycheck, divide your annual contribution by 24. Alternatively, if you enroll mid-year as a newly eligible employee or as a result of a qualified life event, divide your annual contribution by the number of pay periods remaining in the year.

Please note: Special COVID-19 legislation which temporarily allowed carry-over of all unspent funds in General Purpose Healthcare FSAs, Limited Purpose Healthcare FSAs, and Dependent Care FSAs does not apply beyond the 2022 Plan year. Carry-over of funds remaining in General Purpose Healthcare FSA and Limited Purpose Healthcare FSAs as of December 31, 2022 to 2023 is limited to $570. Unused Dependent Care FSA funds cannot be carried over for use in 2023.

HOW FSAS WORK

You decide how much to contribute to each account each year, based on the eligible out-of-pocket healthcare and/or dependent care expenses you anticipate incurring during the upcoming calendar year. Your contribution amount(s) must be in dollars and cents, and the number of cents must be an even number.

Contributions are deducted from your pay before federal, Social Security and, in most cases, state taxes are calculated. (If you live in New Jersey or Pennsylvania, Dependent Care FSA contributions aren't exempt from state taxes.)

You can use your FSAs to reimburse yourself for eligible healthcare and dependent care expenses you have during the year (January 1 – December 31), using tax-free dollars.

If you leave BNY Mellon or transition to a non-benefits-eligible position, you can file a claim through June 30 of the year following your termination or transition for expenses you incurred while eligible for the FSA, subject to any COBRA rights that may apply to your General Purpose Healthcare FSA or Limited Purpose Healthcare FSA.

Paying for Eligible Expenses

You can pay many of your eligible healthcare and dependent care expenses directly from your applicable FSA online. It's quick, easy, secure, and available 24/7. **Note:** You must still provide documentation.

Keep Your Receipts!
If you're asked for documentation for an expense and don't have a receipt, the claim will be denied.

Log in to your applicable FSA at **MyBenefit Solutions** (using single sign-on through **MyReward**, or at **mybenefits.bnymellon.com**). Hover over the **Healthcare** or **Dependent Care** tab, select **Submit Healthcare Claim** or **Submit Dependent Care Claim**, and follow the prompts. Most claims are processed within one to two business days after they are received, and payments are sent soon thereafter.

If you prefer, you may download claim forms from **MyBenefit Solutions** and submit them for reimbursement, along with your documentation, via mail or fax.

Using Your FSA Debit Card for Eligible Healthcare Expenses

If you contribute to a General Purpose Healthcare FSA and do **not** have an HSA, you can also use an FSA debit card to pay for eligible healthcare expenses at the point of purchase. **Note:** You cannot use an FSA debit card to be reimbursed for Limited Purpose Healthcare or Dependent Care FSA expenses; you'll instead need to submit claims for reimbursement of eligible expenses through **MyBenefit Solutions**.

Keep Your Debit Card
Your FSA debit card is valid for three years and will be re-activated each year that you participate in the General Purpose Healthcare FSA. You'll automatically receive a new card when your current card expires.

You can use your debit card at providers' offices and when you make eligible healthcare purchases at most pharmacies, grocery stores, and discounts stores. **Most eligible transactions will be approved automatically** by Your Spending Account (YSA).

In some cases, you may receive a letter or email requesting documentation to support certain expenses. Be sure to respond within 30 days; otherwise, your card will be suspended until you supply the requested information or submit another claim for an eligible healthcare expense to cover the non-documented expense.

For more information, access YSA on **MyBenefit Solutions** (using single sign-on through **MyReward**, or at **mybenefits.bnymellon.com**).

ELIGIBLE FSA EXPENSES

General Purpose Healthcare FSA

Expenses are eligible for reimbursement from a General Purpose Healthcare FSA if they:

- Are the type of eligible medical expenses described under Code Section 213(d); and
- Are not reimbursable under any healthcare benefits arrangement or plan covering you or your family members. Examples of eligible healthcare expenses include:
  - Deductibles, coinsurance, copays, and prescription drugs;
  - Over-the-counter (OTC) drugs (no prescription required) and medical supplies, including insulin and diabetic supplies;
  - Certain non-drug OTC purchases, such as contact lens cleaner, bandages, blood pressure monitors, menstrual care products, and personal protective equipment (PPE), such as face masks, hand sanitizer, and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19;
  - Costs for hearing exams; and
  - Any costs above what your plan pays.

Access Your General Purpose Healthcare FSA or Limited Purpose Healthcare FSA on the YSA Website
Sign up on the YSA website to receive text alerts that will provide information on your account balance and notify you when action is needed on a debit card claim.

Newly enrolled in a General Purpose Healthcare FSA or Limited Purpose Healthcare FSA?
You'll receive a Welcome Letter with instructions after you've enrolled.

You can't use a General Purpose Healthcare FSA to reimburse yourself for premiums you pay for healthcare coverage or for dietary supplies, such as vitamins.

For a detailed list of eligible healthcare expenses, see *IRS Publication 502 (Medical and Dental Expenses)*, which is available through **irs.gov/forms-instructions**.

Limited Purpose Healthcare FSA

Expenses eligible for reimbursement from a Limited Purpose Healthcare FSA are the same as for a General Purpose Healthcare FSA (see "General Purpose Healthcare FSA" above), except as provided below.

Your contributions to the Limited Purpose Healthcare FSA can **only** be used for reimbursement of eligible dental, vision, preventive drug, and out-of-network preventive care expenses before you meet your medical plan's annual deductible. After you've met the deductible, you can also use your account for reimbursement of eligible medical expenses (including eligible over-the-counter [OTC] items). You will need to provide proof that your deductible has been met.

Dependent Care FSA

In general, you can use a Dependent Care FSA to pay for eligible daycare expenses for your eligible dependents if:

- Both you and your spouse work; or
- You are a single working parent; or
- Your spouse attends school full time

For purposes of Dependent Care FSA, your eligible dependents are:

- Your child(ren) under age 13;
- A disabled spouse who lives with you for more than half of the year
- Any other relative or household member who receives more than half of his or her support from you, resides in your home, is physically or mentally unable to care for himself or herself, and who is not the qualifying child of the employee or any other individual.

Examples of eligible dependent care expenses include the cost of:

- Daycare provided in your home, as long as the care provider is not a dependent under age 19;
- Daycare provided outside your home, for example by a qualified daycare facility, day camp, preschool or before- or after-school program; and
- Any other childcare or eldercare expense allowed by the IRS as a qualified expense.

See *IRS Publication 503 (Child and Dependent Care Expenses)*, which is available through **irs.gov/forms-instructions**.

Please note: The IRS has requirements for Dependent Care FSA (DCFSA) programs which place limits on the benefits highly compensated employees (HCEs) can receive under the DCFSA as compared to benefits non-HCEs receive. If the benefits provided to HCEs exceed this limit, benefits to HCEs under the DCFSA may become taxable as imputed income. (According to the IRS, an HCE for the 2022 Plan year is any employee whose total pay was greater than $135,000 in 2022. This amount may increase for the 2023 Plan year.) Total pay includes, by way of illustration and not limitation, items such as bonuses, commissions, overtime, and shift differential. HCEs should consider the potential impact of imputed income before electing or increasing contributions.

IMPORTANT FSA RULES

Because of the tax advantages they offer, FSAs must adhere to certain federal rules, including:

- You must decide how much to contribute before the plan year begins. Once you make your election, you cannot stop, start or change contributions unless you have a qualified life event. See "**Changing Coverage During the Year**" for more details on qualified life events.
- You may carry over up to $570 left in your General Purpose or Limited Purpose Healthcare FSA at the end of the year to the following year. You will forfeit any amount greater than $570 left in your Healthcare FSA at the end of the year. You will have until June 30, 2024 to claim reimbursement for eligible healthcare expenses incurred during 2023
- "Use it or lose it." You must use the full amount in your Dependent Care FSA by the end of the year, or you will forfeit any money left over. You will have until June 30, 2024, to claim reimbursement for eligible dependent care expenses incurred during 2023
- You cannot transfer contributions between FSA accounts
- You cannot use contributions from one year to pay for any other year's expenses, with the exception of the $570 General Purpose and Limited Purpose Healthcare FSA carry-over
- You cannot "double-dip." If you're reimbursed from the General Purpose Healthcare or Limited Purpose Healthcare FSA, you cannot receive reimbursement for these same expenses through an HSA or health reimbursement account, nor deduct those expenses on your federal income tax return
- An employer can exclude up to $5,000 per year from an employee's income for dependent care assistance. This limit applies both to your Dependent Care FSA contributions and to the value of childcare services provided by BNY Mellon under the Backup Dependent Care program. The value of the childcare services you use through this program will be added to your contributions to the Dependent Care FSA to determine if you've exceeded the $5,000 limit. If so, the excess will be reported as wages and be subject to income and payroll taxes
- You cannot claim childcare or eldercare expenses on both the Dependent Care FSA and the federal Dependent Care Tax Credit. You should consult a tax advisor to determine which is a better choice for you.

HOW THE HEALTHCARE ACCOUNTS COMPARE

	HSA[1]	GENERAL PURPOSE HEALTHCARE FSA	LIMITED PURPOSE HEALTHCARE FSA
Who owns it?	You	BNY Mellon	
Who contributes?	BNY Mellon if your base pay is less than $100,000)[2,3] and You	You	
Do unused amounts roll over?	Yes, entire balance	Yes, up to $570 of funds remaining as of December 31, 2023 can be carried over for use in the following Plan year.[4]	
Does it earn interest?	Yes You can invest any balance over $1,000	No	
Can I still participate through COBRA?	No	Yes	
What is the 2023 IRS contribution limit?	$3,850 for employee-only coverage and $7,750 for other coverage levels	$2,850	
Are tax-free catch up contributions allowed?	Yes. If you're age 55 or older, you can contribute up to an extra $1,000 per year.	No	

	HSA[1]	GENERAL PURPOSE HEALTHCARE FSA	LIMITED PURPOSE HEALTHCARE FSA
What are the tax benefits?	BNY Mellon contributions (if you're eligible), your payroll contributions, and any reimbursements for eligible healthcare expenses are tax-free.	Both your contributions and reimbursements for eligible healthcare expenses are tax-free.	
What healthcare expenses can be paid from the account?[4]	Any eligible medical, prescription drug, dental, and/or vision expenses during the year (including over-the-counter [OTC] products without a prescription)		**Before you meet your medical plan's annual deductible:** you can use your account to pay for eligible dental, vision, preventive drug, and out-of-network preventive care expenses **only** **After you've met your deductible:** you can also use your account to pay for eligible medical expenses (including eligible OTC items)
Can I use it to pay for non-healthcare expenses for those over age 65?	Yes	No	
Can I use it to be reimbursed for COBRA premiums	Yes	No	
Must an eligible healthcare expense occur during the Plan year the contribution is made?	No, as long as the expense is incurred after the account is opened	In general, yes. However, you can carry over up to $570 of funds remaining as of December 31, 2023 into the following Plan year.	
Can I use a debit card?	Yes	Yes	No
Can I contribute if I'm enrolled in any part of Medicare or TRICARE?	No	Yes	No
What happens to my account if I leave BNY Mellon?	You can take your account with you.	You forfeit any unused amounts. You can file a claim for expenses you incurred prior to your coverage ending by June 30 of the year following your termination.	
Are other healthcare accounts available at the same time?	Only a Limited Purpose Healthcare FSA	No	Only an HSA

[1] See "**Health Savings Account (HSA)**" for detailed information.
[2] For purposes of eligibility for BNY Mellon annual HSA contributions for 2023, your base pay is determined as of September 1, 2022, or your hire date, if later.
[3] Employees whose base pay is $100,000 or more, and employees enrolled in any part of Medicare or TRICARE, are not eligible to receive BNY Mellon annual HSA contributions.
[4] For a list of eligible expenses, see *IRS Publication 502 (Medical and Dental Expenses)*, which is available through **www.irs.gov/forms-instructions**.

FINANCIAL PLANNING AND EDUCATION RESOURCES

Wellbeing is more than improving physical health – it's also building financial stability. That's why your BNY Mellon Benefits package includes personal financial coaching with access to online tools and resources that can help you manage your finances. These financial wellbeing services are provided at **no cost to you** by **Goldman Sachs Ayco Personal Financial Management*.**

Ayco Financial coaches are specially trained in BNY Mellon's benefit programs and are available to provide confidential, unlimited, personalized, one-on-one financial counseling over the phone. They can help you plan for your future use of healthcare; answer questions about HSAs and FSAs; address your other insurance needs, including life, accident, and disability insurance; and assist you with other broad-based financial questions. To learn more:

By phone: Call 1-800-334-6978 Monday through Friday between 9 a.m. and 5 p.m. ET. Evening appointments are available Monday through Thursday until 8 p.m. ET.

At work: Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Wealth > Ayco Financial Planning).

At home: Visit **ayco.com/login/bnymellon**. You can log in using the username and password you created during registration through **MyReward** at work or register as a new user.

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Dental and Vision

The BNY Mellon Plan provides a choice of dental and vision plans.

DENTAL BENEFITS

Dental coverage helps with the cost of routine dental care and major services for you and your family. You'll choose from three options:

- MetLife Option 1 (Preferred Dental Program without orthodontic coverage)
- MetLife Option 2 (Preferred Dental Program with orthodontic coverage)
- Aetna DMO

You Won't Receive a Dental ID Card
Neither MetLife nor Aetna issues dental ID cards to members.

For the MetLife options, give your MetLife dentist your employee ID number, and he or she will submit your claim. **Your group number is 116273**.

For the Aetna DMO, tell your dentist your name, date of birth, and member ID number (available on the secure member website at **aetna.com**).

MetLife Dental Options

Both MetLife options are Preferred Dental Program (PDP) organizations. You can visit any provider you choose, but the Plan pays a greater benefit when you use network providers because they offer lower negotiated rates. Network providers also file claims for you.

If you use an out-of-network provider, you'll have to pay out-of-pocket at the time of service and then submit your claim for reimbursement. Out-of-network reimbursement is based on usual, customary, and reasonable (UCR) charges and may result in higher out-of-pocket costs. You'll pay your share of the UCR charge, plus the difference between the UCR charge and your dentist's actual fee. Out-of-network UCR charges are charged at the 80th percentile. This means that 80 percent of dentists in your geographic area charge that fee or less.

MetLife's negotiated fees with in-network dentists may extend to services not covered under your plan and to services received after your plan maximum has been met, where permitted under state law. If you receive services from an in-network dentist that are a) not covered under the Plan, or b) after you have reached the annual maximum, you may be responsible for the in-network fee (where permitted by law).

Aetna DMO

The Aetna DMO is a Dental Maintenance Organization. You receive benefits only when you use a participating provider. You must select a primary care dentist (PCD), who will provide most of your dental care and referrals, if needed. If you elect coverage for any eligible dependents, each dependent must also choose a PCD; however, family members don't all have to choose the same PCD.

There are no deductibles or dollar maximums for covered services. Most diagnostic, preventive, and basic services are covered in full, with no out-of-pocket cost to you, with the exception of major services and orthodontia. There is no annual or lifetime limit for orthodontia.

Choosing Your Primary Care Dentist (PCD) if You Enroll in the Aetna DMO

Note: Be sure you have access to an Aetna DMO PCD before you enroll in this plan.

If you enroll in the Aetna DMO, go to the secure member website at **aetna.com** and click "Log In/Register." You'll be prompted to enter your PCD's six-digit dental office number for each covered person. If you don't have a PCD, go to **aetna.com**, log in as a guest and search for participating dentists in your area or call 1-855-855-8112. No form is required.

When choosing a PCD, you must make your selection by the 15th of the month in order to use the provider as of the first of the following month.

If you re-enroll in the Aetna DMO and want to change your PCD, contact the plan directly. See **Contact Information** for details.

Important note for employees in Arizona and California: If you enroll in the Aetna DMO and don't select a PCD, one may be selected for you. Check your ID card online at **aetna.com** to find out if a PCD was selected on your behalf.

Things to Consider

As you make your dental coverage decision, consider the following:

Would your family members consistently use primary dentists? If so, consider the Aetna DMO option, which is less expensive because it's limited to in-network coverage.

Do you or your children need braces? If so, consider MetLife Option 2, which provides orthodontia coverage for children, or the Aetna DMO, which covers orthodontia for children and adults.

How often do you need dental care? If your usual expenses are lower than the dental plan premiums, you may want to use your General Purpose Healthcare or Limited Purpose Healthcare FSA or HSA pre-tax dollars, as applicable (see "**Flexible Spending Accounts [FSAs]**" and "**Health Savings Account [HSA]**"), to cover those expenses instead of choosing dental coverage. Even if you have dental coverage, you can still use the General Purpose or Limited Purpose Healthcare FSA or HSA, as applicable, to pay out-of-pocket dental expenses.

Dental Coverage Summary

The table below is a summary of covered services under each of the dental plan options. Age, frequency limitations, or exclusions may apply to certain services. For more information, see the Dental Plan Comparison Charts and Dental Plan Summary Plan Description on **MyBenefit Solutions**.

	METLIFE PDP OPTION 1	METLIFE PDP OPTION 2	AETNA DMO[1]
Annual Deductible	$75 per individual, $150 per family[2]	$50 per individual, $100 per family[2]	None
Choice of Any Provider	Yes	Yes	No
Diagnostic and Preventive Services (e.g., routine cleanings, exams and X-rays)	In-Network: 100% of PDP fee[3] Out-of-Network: 80% of UCR[3]	In-Network: 100% of PDP fee[3] Out-of-Network: 90% of UCR[3]	100% of PCD fee Must use primary dentist or coordinated care

	METLIFE PDP OPTION 1	METLIFE PDP OPTION 2	AETNA DMO[1]
Basic Services (e.g., fillings and simple extractions)	In-Network: 80% of PDP fee[3,4] after the deductible Out-of-Network: 60% of UCR[3] after the deductible	In-Network: 90% of PDP fee[3,4] after the deductible Out-of-Network: 80% of UCR[3] after the deductible	100% of PCD fee Must use primary dentist or coordinated care
Major Services (e.g., bridges and crowns)	In-Network: 50% of PDP fee[3,4] after the deductible Out-of-Network: 30% of UCR[3] after the deductible	In-network: 60% of PDP fee[3,4] after the deductible Out-of-Network: 50% of UCR[3] after the deductible	60% of PCD fee Must use primary dentist or coordinated care
Orthodontia Services[5]	Not covered	50% up to $1,500[3] Covered for dependents under age 19	50% of the participating provider contracted amount Covered for adults and children
Annual Maximum	$1,500 per individual	$2,000 per individual	None
Lifetime Orthodontia Maximum	Not applicable	Up to $1,500 per child under age 19	None

[1] Aetna covers services only when your PCD coordinates your coverage; no coverage is available out of network.
[2] Family applies to the Employee + Child(ren), Employee + Spouse/Qualified Domestic Partner, and Employee + Family levels of coverage.
[3] If you use an out-of-network dentist, plan payments are based on UCR charges.
[4] MetLife pays this percentage after you meet the annual deductible.
[5] Orthodontia is eligible on a monthly basis only. *(**For the MetLife plans only:** If treatment continues into the next Plan year, you must elect the plan with the orthodontia coverage to continue to be reimbursed for eligible expenses.)* Charges for services not yet rendered are not allowed. Upfront reimbursement for the entire procedure is prohibited unless treatment is complete and braces have been removed. You must remain covered under this plan to receive continued reimbursement for orthodontic services.

2023 Dental Premiums

The rates shown in the table below are the 2023 semi-monthly dental plan premiums. These amounts will be withheld from each pay.

2023 SEMI-MONTHLY EMPLOYEE DENTAL PREMIUMS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAY)			
COVERAGE LEVELS	METLIFE PDP OPTION 1	METLIFE PDP OPTION 2	AETNA DMO
Employee	$9.22	$18.19	$4.32
Employee + Child(ren)	$20.74	$40.94	$9.72
Employee + Spouse/Qualified Domestic Partner	$18.17	$35.86	$8.51
Employee + Family	$33.30	$65.74	$15.60

VISION BENEFITS

The Vision Service Plan (VSP) now includes two coverage options for exams, glasses, or contact lenses, and discounts for laser surgery. You can see any provider you want, but you'll save money if you use the VSP network of eye care doctors and for vision services and supplies:

- Vision Service Plan Option 1 (Base Plan)
- New! Vision Service Plan Option 2 (Enhanced Plan)

For both plans, if you go out-of-network, you'll have to pay the provider in full and out-of-pocket at the time of service and then submit your claim to VSP. The Plan will reimburse you a set dollar amount toward the cost of exams, lenses, and frames.

Get Help from VSP
To find a list of network providers in your area or request a claim form for an out-of-network provider, call VSP at 1-800-877-7195 or visit **vsp.com**.

Note: If you're reviewing provider information on the VSP website, you can see a disclaimer stating that VSP cannot guarantee that the doctors on the list participate in your plan. Disregard this statement, as the BNY Mellon Plan allows you to use the full network of VSP doctors.

Vision Coverage Summary

The table below is a summary of covered vision services. Note that the new Vision Service Plan Option 2 (Enhanced Plan) offers:

- **A higher frame allowance of $250** to spend on frames or elective contacts every calendar year. Or, choose a Featured Frame Brand* and get $270 to spend on frames you love
- **Increased frame frequency** to allow you one new set of frames every calendar year versus every other year with the Base Plan
- **Lens enhancements covered in full**, which includes progressive lenses, Anti-glare coating, UV protection, and more
- **VSP LightCare**, where you can choose ready-made non-prescription sunglasses to help protect your eyes from Ultraviolet light or ready-made non-prescription blue light filtering glasses to help reduce the impacts of Blue Light, instead of prescription glasses or contacts

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.

For detailed information, see the VSP Benefit Summary located on **MyBenefit Solutions** (using single sign-on through **MyReward**) or at **mybenefits.bnymellon.com**.

	Vision Service Plan Option 1 (Base Plan)			Vision Service Plan Option 2 (Enhanced Plan)		
	In-Network	Out-of-Network	Frequency	In-Network	Out-of-Network	Frequency
Exam	Covered in full after $10 copay	Up to $50 after $10 copay	Every calendar year	Covered in full after $10 copay	Up to $50 after $10 copay	Every calendar year
Lenses[1] • Single • Lined Bifocal • Lined Trifocal • Lenticular	Covered in full	• Up to $50 • Up to $75 • Up to $100 • Up to $125	Every calendar year	Covered in full	• Up to $50 • Up to $75 • Up to $100 • Up to $125	Every calendar year
Lens Enhancements[2]	N/A	N/A	N/A	Covered in full	N/A	Every calendar year
Frame	Up to $150, then 20%	Up to $70	Every other calendar year	Up to $250, then 20%	Up to $70	Every calendar year
Contact Lenses[3]	Medical: Covered in full Elective: Up to $130	Medical: Up to $210 Elective: Up to $105	Every calendar year	Medical: Covered in full Elective: Up to $250	Medical: Up to $210 Elective Up to $105	Every calendar year
Laser Vision Correction	15% off[4]	N/A	N/A	15% off[3]	N/A	N/A
VSP LightCare[5]	N/A	N/A	N/A	Up to $250	Up to $70	Every calendar year

[1] Polycarbonate lenses for dependent children are covered in full. The enhanced plan also covers all progressives (standard, custom, Premium) at no cost in-network, and up to $75 reimbursement out-of-network.
[2] Lens enhancements include anti-glare coating, tints, light-reactive lenses, impact resistant for children and adults, UV protection, and high-index lenses.
[3] This allowance applies to the cost of your contacts. The cost of the fitting and evaluation will be no more than $60 for the Base Plan and Enhanced plan. This exam is in addition to your vision exam to ensure proper fit of contacts.
[4] Or you have the option to receive 5% off the promotional price from contracted facilities.
[5] Non-prescription sunglasses or blue light filtering glasses in lieu of prescription glasses or contacts.

You Won't Receive a Vision Plan ID Card
VSP doesn't issue vision ID cards. Once you enroll, simply call a VSP provider to schedule an appointment. Be sure to tell the provider's staff that you have VSP coverage when you call and be prepared to provide the last four digits of your Social Security number. The provider and VSP will handle the rest.

Your group number is **12156679.**

Paying for Vision Services

The way you pay for vision services depends on the type of provider you use:

In-Network Provider—Contact your VSP provider to schedule an appointment. Tell the provider that you have VSP coverage and ask that the provider obtain an authorization for you. At the time of your visit, pay the provider the required copay and any overages.

Out-of-Network Provider—Pay the provider directly and submit a claim for reimbursement. Get claim forms at **vsp.com** or by calling 1-800-877-7195. You must file claims within six months of the date of service.

2023 Vision Premiums

The rates shown in the table below are the 2023 semi-monthly vision plan premiums. These amounts will be withheld from each pay.

2023 SEMI-MONTHLY EMPLOYEE VISION PREMIUMS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAY)		
COVERAGE LEVELS	**VSP PLAN 1 (BASE PLAN)**	**VSP PLAN 2 (ENHANCED PLAN)**
Employee	$3.32	$9.34
Employee + Child(ren)	$7.10	$19.97
Employee + Spouse/Qualified Domestic Partner	$6.63	$18.65
Employee + Family	$11.25	$31.62

Enjoy Extra VSP Discounts and Savings
When you visit a VSP network doctor, you'll receive:

30 percent off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20 percent off from any VSP doctor within 12 months of your last WellVision Exam.

An average 35 to 40 percent savings on all non-covered lens options.

15 percent discount off the cost of contact lens exam (fitting and evaluation).

Average of 15% off the regular price of Laser Vision Correction; discounts available at contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Life and Disability Insurance

BNY Mellon offers life and accident insurance and disability benefits that help safeguard your and your family's financial wellbeing in the event of an illness, injury, or death.

LIFE AND ACCIDENT COVERAGE

Life and accident coverage, administered by MetLife, helps provide financial protection for your family in case of your death or serious injury. BNY Mellon automatically provides basic life insurance, basic accidental death & dismemberment (AD&D) insurance, and basic travel accident insurance coverage at no cost to you. You can also purchase supplemental life insurance for yourself and dependent life insurance coverage for your spouse/qualified domestic partner and/or eligible children.

Things to Consider

As you make your life and accident coverage decisions, consider the following:

- Would your family have other sources of income if you were unable to work?
- What predictable costs (such as college tuition or mortgage payments) would you like to see taken care of if something happened to you?
- Do you have a private source of insurance in addition to BNY Mellon coverage?
- Do you have enough protection for your family?
- Does your spouse/qualified domestic partner earn a steady income? If so, you may not need as much insurance coverage as you would if you were the sole wage earner.

Employee Coverage

Your employee life and accident insurance coverage is based on your annual base pay as of September 1, 2022 or on your date of hire, if later. If one times your annual base pay results in a number that isn't a multiple of $1,000, your coverage will be rounded up to the next higher $1,000. For example, if your annual base pay is $64,750 and you have life insurance coverage of one times your base pay, your coverage amount would be $65,000.

Life Insurance

The BNY Mellon Plan automatically provides you with basic life insurance coverage equal to your annual base pay, up to a maximum benefit of $500,000 at no cost to you. Additional benefits include but aren't limited to:

- An accelerated death benefit; and
- Portability and/or the ability to convert your policy.

You may also elect supplemental life insurance coverage for yourself of one to eight times your base pay, up to a maximum benefit of $3 million. If you elect additional supplemental life insurance coverage, you will be required to provide simplified Evidence of Insurability (EOI) or proof of good health, to MetLife.

Additionally, if you have elected coverage through the MetLife supplemental life plan through your employer[1], you have access to additional services. With your insurance coverage, you get access to services that support, protect, and help you plan for the future—at no cost to you:

SERVICE	CONTACT INFORMATION
Will Preparation Services[2] Offers you and your spouse/domestic partner unlimited face-to-face or telephone meetings with an attorney, from MetLife Legal Plans' network of over 17,500 participating attorneys, to prepare or update a will, living will, and Power of Attorney.	For more information, contact Hyatt Legal Plans, Inc. at 1-800-821-6400.
Estate Resolution Services[2] Estate representatives and beneficiaries may receive unlimited face-to-face legal assistance with probating your and your spouse's/domestic partner's estates. Beneficiaries can also consult an attorney for general questions about the probate process.	
Digital Estate Planning[3] Allows you to create and execute key estate planning documents (Last Will & Testament, Living Will and Power of Attorney) online by answering a few simple questions. You can also have your estate planning documents witnessed and notarized from the comfort of your home.	For more information visit **legalplans.com/estateplanning**, create an account and follow the online instructions.
Funeral Assistance[4] Services designed to simplify the funeral planning process for your loved ones and beneficiaries to assist them with organizing an event that will honor a loved one's life from a self-paced funeral planning guide to services such as locating funeral homes, florists, and local support groups.	For confidential 24/7 support, call 1-888-319-7819 or visit **metlifegc.lifeworks.com**. Username: metlifeassist Password: support

[1] BNY Mellon does not endorse, provide or otherwise require you to purchase these benefits. BNY Mellon's sole function with respect to these benefits is to permit MetLife to publicize the benefit to employees, collect premiums through payroll deduction and remit the premiums to MetLife. The premium charged is determined by MetLife at all times.

[2] Will Preparation Services and Estate Resolution Services are offered by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, Will Preparation Services and Estate Resolution Services are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and its affiliates, Warwick, RI. These services are provided at no additional cost to those who purchase Supplemental Life Insurance only. Certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

[3] Digital Estate Planning is currently not available for customers sitused in FL, GU, PR and VI. Online Notary is not available in all states. At this time, the Digital Estate Planning services does not support domestic partnerships, however members in a domestic partnership may use a plan attorney for their estate planning needs. Digital Estate Planning services are not included with dependent life coverages.

[4] Funeral Assistance is not available in New York. Funeral Assistance services are provided through an agreement with LifeWorks. US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife.

Accidental Death & Dismemberment (AD&D) Insurance

AD&D insurance helps provide financial protection for your family if you die or are seriously injured in an accident. The BNY Mellon Plan automatically provides you with basic AD&D insurance coverage equal to your annual base pay, up to a maximum benefit of $500,000 at no cost to you.

The plan pays the full coverage amount to your beneficiary if you die as the result of an accident. For certain serious accidental injuries, the plan pays a portion of the coverage amount to you.

You can also elect supplemental AD&D insurance coverage for yourself of one to eight times your base pay, up to a maximum benefit of $3 million.

Choosing a Beneficiary

A beneficiary is the person(s) or entity(ies) you name to receive your life and AD&D insurance benefits if you die. You choose your beneficiary(ies) for your own coverages. You're the beneficiary for any supplemental coverage you elect for your dependents.

We encourage you to designate your life and AD&D insurance beneficiary(ies) on **MyBenefit Solutions** and to review and update them each year.

Travel Accident Insurance

In addition to AD&D insurance, BNY Mellon provides you with travel accident insurance administered by National Union Fire Insurance Company of America. It provides accident protection for you while you travel on BNY Mellon business.

Coverage is equal to five times your annual base pay, with a minimum coverage amount of $250,000 and a maximum coverage amount of $4 million. This coverage is provided automatically at no cost to you; you don't need to enroll.

If you're on a BNY Mellon business trip and have an accident, travel accident insurance pays full benefits in the event of your death, or partial benefits if you suffer certain serious injuries (e.g., dismemberment—loss of a limb, eye, or ear).

Dependent Coverage

Spouse/Qualified Domestic Partner Life Insurance

This benefit provides life insurance coverage for your spouse or qualified domestic partner. If you elect this coverage, you'll pay for it with after-tax dollars. You're automatically the beneficiary for this coverage.

Child Life Insurance

This benefit provides life insurance coverage for one or more of your dependent children. If you elect this benefit, it covers all of your eligible dependent children*—you cannot elect separate coverage for each child. You'll pay for this coverage with after-tax dollars. You're automatically the beneficiary for this coverage.

* Your children up to age 26, regardless of full-time student status, residency, financial support, marital status, or access to other employer-sponsored coverage. No person can be insured as a dependent of more than one BNY Mellon employee under the policy.

Life and Accident Coverage at a Glance

The table below provides a summary of the life and accident insurance coverage options available to you and your family. Additional details are available on **bnymellonbenefits.com**.

EMPLOYEE COVERAGE OPTIONS	
Life Insurance You must choose a primary beneficiary.	• **Basic:** You automatically receive BNY Mellon-paid coverage equal to your annual base pay, up to benefit of $500,000. • **Buy down:** You can "buy down" to $50,000 of coverage and receive a credit (if your annual base pay is greater than $50,000). • **Supplemental:** You can purchase additional coverage of one to eight times your annual base pay, up to a $3 million maximum benefit (simplified Evidence of Insurability (EOI) or proof of health required).
AD&D Insurance You must choose a primary beneficiary.	• **Basic:** You automatically receive basic BNY Mellon-paid coverage equal to your annual base pay, up to benefit of $500,000. • **Supplemental:** You may purchase additional coverage of one to eight times your annual base pay, up to a $3 million maximum benefit.
Travel Accident Insurance Your beneficiary is the same as your basic life insurance beneficiary.	• You automatically receive BNY Mellon-paid Basic coverage equal to five times your annual base pay, with a minimum coverage amount of $250,000 and a maximum coverage amount of $4 million. • This coverage pays a benefit if you have a serious accident while traveling on BNY Mellon business. • The Plan pays a full benefit in the event of death and a partial benefit if you suffer certain serious injuries.
DEPENDENT COVERAGE OPTIONS	
Spouse/Qualified Domestic Partner Life Insurance You're automatically the beneficiary for this coverage.	• No coverage • $25,000 • $50,000
Child Life Insurance You're automatically the beneficiary for this coverage.	• No coverage • $10,000 • $15,000 **Note:** If you elect coverage, it includes all of your dependent children—you don't elect separate coverage for each child.

Cost of Coverage

Your cost for life and AD&D insurance coverage is based on your age as of January 1, 2023, the level of coverage you select, and your base pay as of September 1, 2022, or your hire date, if later. Base pay doesn't include overtime pay, bonuses, or other special forms of pay. Only the first $500,000 of annual base pay is considered for this purpose.

If the total amount of basic life insurance coverage exceeds $50,000, federal tax law requires that the value of the coverage above $50,000 (called "imputed income") is taxable to you as federal income and subject to Social Security. The amount that is taxable to you (calculated using an age-related table published by the IRS) will be shown on your pay statement in the earnings column.

Supplemental and dependent coverage isn't subject to the age-related table rules. You'll pay premiums for any supplemental and/or dependent coverage you elect with after-tax dollars.

DISABILITY COVERAGE

Disability coverage helps provide financial protection for you and your family by continuing all or part of your base pay when an illness or injury prevents you from working.

Short-term Disability (STD)

BNY Mellon provides STD benefits through its salary continuance payroll practice at no cost to you; there is no need to enroll. This benefit generally replaces 100% or 50% of your base pay, based on length of continuous benefit-eligible service with BNY Mellon, for up to 26 weeks if an illness or injury keeps you away from work for more than seven consecutive days.

Things to Consider
As you make your LTD coverage decision, consider the following:

How much money would it take to maintain your current lifestyle? If you became disabled, would 60 percent of your base pay be enough to meet your current expenses?

Does your spouse/qualified domestic partner earn a steady income?

Long-term Disability (LTD)

LTD coverage, administered by Prudential*, provides income for you if you are disabled longer than 26 weeks and meet the definition of disability in BNY Mellon's long-term disability plan.

You have three LTD coverage options:

- Replace 50 percent of base pay (buy-down option for credit)
- Replace 60 percent of base pay (core option; available at no cost to you)
- Replace 70 percent of base pay (buy-up option paid for through pre-tax payroll deductions)

LTD payments are determined using a percentage of your base pay (capped at $300,000) and doesn't include overtime pay, bonuses or other special forms of pay.

Please note: Because you pay for buy-up LTD coverage with pre-tax dollars, any LTD payments you receive will be subject to federal (and, in most cases, state and local) income taxes.

Any LTD income you receive from this Plan will be reduced by benefits you or your family receive from other sources, related to your disability, such as Social Security or Worker's Compensation.

If currently receiving LTD benefits, please refer to documentation from your LTD provider for additional information.

Purchased Vacation

BNY Mellon believes in a healthy balance of work and personal responsibilities. In addition to your regular earned vacation, you can purchase additional vacation time during Open Enrollment (or during your newly benefits-eligible enrollment period, provided you are hired on or before November 30, 2022). The number of additional vacation days you can purchase will depend on your assigned standard weekly working hours, as shown in the table below.

Important: If you elect to purchase additional vacation days, you cannot change your election after Open Enrollment (or your newly benefits-eligible enrollment period) ends.

HOW PURCHASED VACATION WORKS

You may only elect Purchased Vacation during Open Enrollment (or during your newly benefits-eligible enrollment period, provided you are hired on or before November 30, 2022). Elections, once made, cannot be changed during the Plan Year. Purchased Vacation may only be used once you have exhausted your entire regular annual vacation allotment, including carry-over days from the prior calendar year.

Purchased Vacation cannot be refunded, returned, carried over into the next calendar year or cashed out except as described below in connection with your termination of employment or otherwise as required by law. So, if you don't use your Purchased Vacation days during the calendar year, you'll lose them.

Do You Need to Purchase Additional Vacation?
Additional vacation days can be helpful if you're sure you'll use them.

Consider whether you have an upcoming event that will require extra time away from work, like getting married, having a child, attending a family reunion or planning a move, and then decide.

Each additional vacation day is based on your assigned weekly standard hours. For example, if you are assigned to work 40 standard hours during a five-day week, each additional vacation day is eight hours. Your total number of purchased vacation hours cannot exceed your assigned standard weekly working hours, as follows:

IF YOUR ASSIGNED STANDARD WORKING HOURS PER WEEK ARE…	YOU MAY PURCHASE UP TO…
40 or more	Five additional vacation days
32 − 39	Four additional vacation days
24 − 31	Three additional vacation days
Less than 24	Two additional vacation days

If you purchase more vacation days than allowed, your election will be adjusted down to the next lower option after the close of the enrollment window, and coverages will be shown on "Your Future Coverage" page on **MyBenefit Solutions**. For example, if you work 30 hours per week and elect to purchase four additional vacation days, your purchase election will be adjusted down to three additional vacation days.

YOUR COST

The cost of each purchased vacation day is your hourly pay rate (as of September 1, 2022, or your hire date, if later) times the number of purchased hours, divided by 24. If your employment ends during the year, monies that were paid for any unused Purchased Vacation will be refunded. Conversely, employees are responsible for reimbursing the Company for any used but not yet paid for Purchased Vacation.

Voluntary Benefits – Hospital Indemnity, Accident, Critical Illness, Legal Services & More

BNY Mellon makes certain voluntary benefits available through Mercer* to help protect you from life's uncertainties and safeguard your and your family's financial wellbeing in the event of an illness, injury, or death. Pay for any coverage you elect through after-tax per-pay deductions. While you could purchase coverage for these benefits outside of BNY Mellon, they're conveniently offered through the Voluntary Benefit Program, which often offers lower premiums than if you were to purchase an individual policy on your own.

You can enroll in or make changes to these voluntary benefits during Open Enrollment, when newly eligible for benefits, or if you experience a qualified life event during the year:

- **New! Hospital Indemnity Insurance**–pays a cash benefit for the costs of a hospital admission that may not be covered by other insurance
- **Accident Insurance**—pays a cash benefit in the event of an injury, death, or dismemberment caused by a covered accident
- **Critical Illness Insurance**—pays benefits when you are diagnosed with specified critical illnesses
- **Legal Services Insurance**—offers representation for a range of legal issues, including document review, traffic ticket defense, wills, family matters, real estate transactions and more

You can enroll in, make changes to, or drop these voluntary benefits anytime during the year:

- **Identity Protection Services**—provides identity protection experts committed around the clock to helping you safeguard your financial and personal information
- **Auto and Home Insurance**—offers discounted rates on homeowners, renters, and auto insurance with national providers
- **Pet Insurance**—provides coverage for most household pets for routine care and more complex treatments

For more details about the voluntary benefits available to you, go to **voluntarybenefits-bnymellon.com** or call 1-866-250-4510.

* BNY Mellon employee participation in any of these voluntary programs and/or use of these services and/or products is completely voluntary. While BNY Mellon makes this program provided by Mercer ("Vendor") available to its US eligible employees, and, as applicable, their eligible dependents, it does not recommend or endorse any services or products. Should you elect to participate in any of Vendor's programs and or utilize any of its services or products, you are solely responsible for the cost, taxes and any outcomes resulting therefrom. No contributions are made by BNY Mellon. The sole function of BNY Mellon with respect to the program is to permit the Vendor to publicize the program to employees, collect premiums through payroll deduction and remit the premiums to the insurer. BNY Mellon does not assume any liability for your or your dependents' use of the Vendor or its services or products, including with regard to relying on advice that you may receive. By using this Vendor and its services and/or products, you agree not to hold BNY Mellon liable for such use. The Vendor is not affiliated with BNY Mellon and BNY Mellon receives no consideration (monetary or otherwise) in connection with the provision of such services and products.

Aflac Hospital Indemnity Insurance

When you're in the hospital due to a covered accidental injury or sickness Hospital indemnity insurance helps soften the financial burden of hospitalization. It pays employees a cash benefit for occurrences which could include:

- Initial admission into the hospital
- Daily inpatient hospital stays
- Daily intensive care unit stays
- Daily inpatient rehabilitation, substance abuse and mental disorder stays
- Discretionary spending as the employee chooses, including deductibles and copays, medical equipment, daily living expenses (e.g., mortgage/rent, groceries, travel) and Caregiving assistance

Benefit checks are sent directly to you (unless otherwise assigned) -- not a doctor or hospital, and you can spend the money however you'd like -- to help cover deductibles, co-payments or even bills piling up at home. Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).

401(k) Savings Account

Building financial security for tomorrow means planning and saving today! BNY Mellon believes that saving for retirement is a shared responsibility. This means providing you with a 401(k) plan that encourages you to save, while helping you reach your retirement savings goals with Company contributions and other financial planning features.

Voya Retirement Advisors* (VRA), powered by Edelman Financial Engines, is here to help you make informed decisions through online tools or through professional management services. As you consider your healthcare options, this may also be a good time for you to review your 401(k) savings. To help get you started, VRA can evaluate your current 401(k) investment and savings elections and estimate your future annual retirement income. Log on to **MyReward** and scroll to bottom to find 'My External Links' and click the link for your 401(k) Account to view your Retirement Evaluation.

Choosing a Beneficiary

It's important to choose a beneficiary and keep your designation up-to-date — especially if you get married or divorced or have a child. This will help to ensure your 401(k) Plan assets go to exactly who you want.

To make or review your beneficiary election, visit the 401(k) Plan website through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Wealth > 401(k) Account). From the 401(k) Plan home page, under Hi, [Your Name] in the upper right corner, select My Profile > Personal Information > Beneficiary Information.

* While BNY Mellon makes the services provided by Voya Retirement Advisors and certain related entities of VRA (collectively, "Voya Entities") available to its eligible employees, BNY Mellon does not review, recommend or endorse any financial planning, investment advice or other recommendations or information provided by any of the Voya Entities or is advisors. Should you elect to utilize VRA's services, including with regard to relying on VRA's financial or investment advice, you are solely responsible for any outcomes resulting therefrom. BNY Mellon does not assume any liability for your utilization of any of Voya's services, including with regard to financial or investment advice that you receive, and by utilizing the services you agree not to hold BNY Mellon liable for such utilization. Voya is not affiliated with BNY Mellon and BNY Mellon receives no consideration (monetary or otherwise) from Voya in connection with its services.

Terms You Should Know

The following terms are typically used regarding group health plans and are included to provide you with useful definitions; however, you should refer to the actual plan document and summary plan description for more specific and detailed definitions.

BASE PAY

For Open Enrollment purposes, base pay determines what band you fall into for medical plan premiums. As used in this Benefits Guide, “base pay,” generally means your annualized base pay as of September 1, 2022, or your hire date, if later, based on a normal work week not exceeding 40 hours. It generally excludes commissions, overtime pay, bonuses, payments in lieu of vacation, all non-regular payments, and any other special purpose payments. For commissioned employees, base pay is determined by using the Annual Benefits Base Rate (ABBR), which is determined annually. In addition, the IRS limits the amount of base pay that can be considered in determining plan benefits each year. Salary reduction contributions, Code Section 132(f) transportation plan and similar salary reductions, as well as any deferred compensation contributions, are included in the calculation of your base pay.

BENEFICIARY

A **beneficiary** is an individual or entity that you properly designate to receive certain payments under certain benefit options offered under the Plan in accordance with the terms of each such option. In the absence of a valid beneficiary designation for a particular benefit option (or if the existing beneficiary designation is invalid) and unless specified otherwise by the Reference Document for such option, your beneficiary will first be your spouse, if living, or, if you are not married or your spouse is deceased, your heir under the intestacy laws of your state of domicile at the time of your death, or if no heir is then-living, your estate.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the validly issued regulations thereunder. This federal law requires most employers providing group health insurance to give employees and their covered dependents the opportunity to continue their employer-sponsored group health coverage at the employee’s or dependent’s sole expense (including an administrative expense) after it would otherwise end.

COINSURANCE

The portion of the cost covered services not paid for by your medical, dental, and vision options, and for which you are responsible.

COPAYMENT (OR COPAY)

A fixed dollar amount you must pay out of your own pocket at the time you receive certain medical services. Copayments do not apply toward deductibles or coinsurance, but they do apply toward out-of-pocket maximums.

DEDUCTIBLE

Some plans require you to pay a certain amount for necessary healthcare expenses each year before the plan begins to pay all or part of your remaining expenses. To help limit the number of individual deductibles a family must pay each year, some plans have a "family" deductible, which is the total amount you and your covered family members have to pay in deductibles each year, regardless of the size of your family.

DEPENDENT

Person who is eligible for coverage under an employee's health plan. Eligible dependents include a spouse, domestic partner, or child (ren) under the age of 26 (unless mentally or physically disabled prior to age 26 and are financially dependent on employee).

DISPENSE AS WRITTEN (DAW)

This means that your prescription must be filled with the brand-name version of the medication. (Substitution of a generic equivalent is not allowed.) Under the BNY Mellon Plan, if you use a DAW prescription to get a drug's brand-name version, you will be required to pay the brand copayment plus the cost difference between the brand and generic drug. If you are unable to take a generic equivalent drug for clinical reasons (e.g., you are allergic to the generic filler), your physician can appeal. If your appeal is approved, you can take the brand-name drug without paying a penalty.

DOMESTIC PARTNER (OR SEE SPOUSE BELOW)

A person (whether of the same or opposite sex) in a "spouse-like" relationship with an eligible employee, and who, together with the eligible employee:

- are each other's sole qualified domestic partner and intend to remain so indefinitely
- are at least eighteen (18) years of age and competent to enter into a legal contract
- are not related in any way that would prevent them from being legally married
- are not legally married to anyone else, and all prior marriages have ended by such means as death, divorce, dissolution, or annulment
- are not qualified domestic partners with anyone else, and any prior domestic partnerships have ended by such means as death or dissolution
- share joint responsibility for each other's welfare and financial obligations
- share a household that is the primary residence of both (although they may live apart for reasons of education, healthcare, work, or military service)
- are registered domestic partners with any state or local government domestic partnership registry, if residing in a state or locality that provides domestic partner registration

FORMULARY

A list of preferred, commonly prescribed prescription drugs. These drugs are chosen by a team of doctors and pharmacists because of their clinical superiority, safety, ease of use, and cost. The formulary list may differ, depending on the carrier.

HEALTH SAVINGS ACCOUNT (HSA)

A special tax-sheltered savings account that is similar to a traditional individual retirement account (IRA), but designated for qualified healthcare expenses. You can use a Health Savings Account to pay for future qualified healthcare expenses on a tax-free basis. Contributions, earnings, and distributions are exempt from federal income and Social Security (FICA) taxes when used to pay for qualified healthcare expenses. In most states, HSA contributions and earnings are also exempt from state income taxes. Be sure to consult your tax advisor with any questions. To participate in a Health Savings Account, you must enroll in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan under Anthem.

HIGH-DEDUCTIBLE HEALTH PLAN

A plan with a higher deductible than a traditional medical insurance plan. You pay more out of your own pocket before insurance coverage begins to pay all or a portion of expenses. However, you generally have the opportunity to contribute tax-free dollars to a Health Savings Account if you enroll in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan to help meet your deductible.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and the validly issued regulations thereunder. HIPAA protects health coverage for workers and their families when they change or lose jobs. HIPAA safeguards against losing existing healthcare coverage, eases your ability to switch health plans and/or helps you buy coverage on your own if you lose health coverage and have no other coverage available, as well as providing certain privacy protections.

IMPUTED INCOME

Imputed income constitutes additional taxable income reportable on each pay statement throughout the year. Any imputed income will be included on your IRS Form W-2 at the end of the year. Under the BNY Mellon Flexible Benefits Program, you will have imputed income if you receive:

- A total amount of basic life insurance coverage greater than $50,000; or
- Coverage for your qualified domestic partner or his or her children, unless the children qualify as your federal tax dependent(s) for health plan purposes or you claim a federal tax exemption for them.

IN-NETWORK OR NETWORK CARE

Care received from physicians, dentists, eye care doctors, hospitals, and healthcare facilities that have agreed to charge participants a pre-negotiated—and often discounted—rate for services and treatment. When you go to a network provider, you receive a higher, “in-network” level of benefits, which means your out-of-pocket costs are lower and there are no claim forms for you to complete.

MAXIMUM ALLOWED AMOUNT

This is the maximum amount your Anthem medical plan will pay for a covered health care service from an out-of-network provider. If your provider charges more than the Anthem medical plan's Maximum Allowed Amount, you may have to pay the difference.

OUT-OF-NETWORK CARE

Your care is considered out-of- network if you visit a provider who is not an in-network provider. You pay more for out-of-network care, and you may be responsible for submitting your own claims. Call the provider for additional information.

OUT-OF-POCKET MAXIMUM

This is the total amount you spend on medical and pharmacy bills in a calendar year. Once your share of the cost of covered services* reaches the out-of-pocket maximum, the plan will cover most eligible expenses at 100 percent.

* Includes deductibles, coinsurance, and copayments; does not include premiums, any amounts over Maximum Allowed Amount, non-covered expenses, and precertification penalties.

PREFERRED/NON-PREFERRED BRAND DRUG

Your cost for a prescription drug depends partly on how that medication is classified by your prescription drug provider (PDP). A preferred brand drug is included in the PDP's list of covered drugs (formulary), and it may or may not have a generic alternative. A non-preferred drug is one for which a clinically equivalent alternative is available.

Your cost is lowest when you have your prescription filled with a generic drug. If you purchase the PDP's preferred brand-name drug, you pay a higher copayment. Your cost is highest if you purchase a non-preferred brand-name drug.

PRE-TAX OR TAX-FREE CONTRIBUTIONS

Contributions or deposits to your General Purpose Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or HSA, as applicable, that are generally exempt from federal income and Social Security taxes, as well as many state income taxes.

PREVENTIVE CARE

Healthcare benefits that are generally intended to help you avoid illness and improve your health and, depending on your age, gender, and health condition, such care can include such items as screenings, shots, preventive medication, or counseling services. Preventive care is not generally subject to copay, coinsurance, or deductibles if it meets specific criteria, as determined by the Department of Health and Human Services and provided at **hhs.gov/healthcare/about-the-aca-preventive-care/index.html**. Health plans are required to provide these preventive care services only through an in-network provider. The BNY Mellon Plan may allow you to receive these services from an out-of-network provider but may charge you a fee. In addition, your doctor may provide a preventive care service, such as a cholesterol-screening test, as part of an office visit. Accordingly, if the preventive care service is not the primary purpose of the visit or if your doctor bills you for the preventive care services separately from the office visit, then you could be required to pay some costs of the office visit. Please contact your provider to determine whether services will be covered as preventive.

PRIMARY CARE PHYSICIAN (PCP)

A provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics, or any other provider as allowed by the plan. A PCP supervises, coordinates, and provides initial care and basic medical services to a member and is responsible for ongoing patient care.

PRIMARY CARE DENTIST (PCD)

A licensed dentist who has a contract to provide services as part of the Aetna DMO. Your primary dentist is responsible for providing most of your dental care and referring you to specialists when necessary.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

In certain situations, courts may issue orders directing that health benefits under an employer-sponsored plan be provided to certain children who are eligible dependents of an employee or retiree.

SPOUSE (OR SEE DOMESTIC PARTNER ABOVE)

For the purposes of the BNY Mellon Plan, a “spouse” is a person to whom you are legally married and who is treated as your spouse or surviving spouse pursuant to the Internal Revenue Code and ERISA.

SURPRISE BILLING CLAIMS

Surprise Billing Claims are claims that are subject to the No Surprises Billing Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at a Network Facility; and
- Out-of-Network Air Ambulance Services.

Refer to Anthem Benefit Booklet under, “Consolidated Appropriations Act of 2021 Notice” for additional detail.

TRUE FAMILY DEDUCTIBLE

Under a true family deductible, the full family deductible must be met before the plan begins to pay for non-preventive services.

USUAL, CUSTOMARY, AND REASONABLE (UCR)

The usual fee a dental provider charges the majority of patients for similar services; the customary fee that falls within the range of charges in the area for similar services; and the reasonable fees charged because unusual circumstances or complications require additional time, skill, and experience.

Contact Information

Make Accolade Your First Point of Contact Whenever You Have Questions About Your BNY Mellon Health Benefits or If You Aren't Sure Where to Go

For personalized, confidential support, connect with your Accolade Health Assistant at 1-833-640-0427 or at **member.accolade.com**. Your Health Assistant is available Monday through Friday, from 8 a.m. to 11 p.m. ET.

Contact information for the individual benefits vendors is also provided below.

GENERAL BENEFITS INFORMATION			
BNY Mellon Benefit Solutions Service Center	1-855-354-6940 Mon – Fri, 8:30 a.m. – 8 p.m. ET	From work: Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Health > MyBenefit Solutions) From home: **mybenefits.bnymellon.com**	For enrollment questions or help
NATIONAL HEALTH PLANS			
Anthem Higher Deductible HSA Plan, Lower Deductible HSA Plan, and Copay Plan	Call your Health Assistant at Accolade at 1-833-640-0427, Mon – Fri, 8 a.m. – 11 p.m. ET	**member.accolade.com** **anthem.com/bnymellon**	To find an in-network provider, go to **anthem.com/bnymellon**
CALIFORNIA (LOS ANGELES AND SAN FRANCISCO) AND EXPATRIATE HEALTH PLANS			
Kaiser Permanente California (Los Angeles and San Francisco)	1-800-464-4000	**kaiserpermanente.org**	To find a doctor or facility: • Highlight the "Locate Our Services" tab • Highlight and click "Find Doctors & Locations" • Select your region
Aetna International (Expatriates)	• 1-800-231-7729 (toll-free) • 813-775-0190 (direct)	**aetnainternational.com**	

PRESCRIPTION DRUG PLAN FOR ANTHEM PLANS			
CVS Caremark	1-800-685-4130	**caremark.com**	• Members: Enter login ID and password • If not registered: Click "Not Registered" and enter required fields, then click "Member Quick Links"
CVS Health Pharmacy Advisor Counseling Program	1-800-685-4130	**caremark.com**	• Members: Enter login ID and password • If not registered: Click "Not Registered" and enter required fields
CVS Specialty® Customer Care	1-800-237-2767		
DENTAL PLANS			
MetLife PDP Options 1 and 2	1-866-665-1494	**metlife.com/mybenefits**	Company Name: BNY Mellon Click "Find a Dentist," then enter search criteria
Aetna DMO	1-855-855-8112	**aetna.com/dse/search?site_id=dse&externalPlanCode=DMO|DMO**	Click "Start a New Search," then "Search for Dentists," then: • Search for: "Dentists (Primary Care)" • Type: "Primary Care Dentists (PCD)" • Plan: "Aetna DMO"
VISION PLAN			
Vision Service Plan (VSP)	1-800-877-7195	**vsp.com**	• Click "Members" and log in: first-time users must register • Click "Find a VSP Doctor" You may see a disclaimer stating that VSP cannot guarantee that the doctors on the list participate in your plan. Disregard this statement, as the Plan participates in the Signature Network plan with the full network of doctors.

COBRA THIRD-PARTY ADMINISTRATOR			
MyBenefit Solutions	1-855-354-6940 Mon – Fri, 8:30 a.m. – 8 p.m. ET	**mybenefits.bnymellon.com**	
LIFE INSURANCE/AD&D			
MetLife	1-855-354-6940 Mon – Fri, 8:30 a.m. – 8 p.m. ET	From work: Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Health > MyBenefit Solutions) From home: **mybenefits.bnymellon.com**	
FLEXIBLE SPENDING ACCOUNTS			
MyBenefit Solutions (Your Spending Account)	1-855-354-6940, Mon – Fri, 8:30 a.m. – 8 p.m. ET	From work: Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Health > MyBenefit Solutions) From home: **mybenefits.bnymellon.com**	
HEALTH SAVINGS ACCOUNT			
BenefitWallet	1-877-472-4200	From work: Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My Total Wealth > Account Links to Health Savings Account) From home: **mybenefitwallet.com**	
HEALTHCARE DECISION SUPPORT			
Medical Expert Second Opinions through Teladoc	1-800-Teladoc (1-800-835-2362)	**teladoc.com/medicalexperts**	You have access to medical experts with your Expert Medical Opinion benefit. Our experts can give you medical advice on any diagnosis, treatment option or surgery by web, phone, or app at no cost to you
PERSONAL WELLBEING			
Employee Assistance Program (EAP)	1-855-55ACCESS (1-855-552-2237)	**achievesolutions.net/bnym**	Access confidential, professional consultation for life's challenges
Anthem Virtual Care Visits	1-888-548-3432	**anthem.com/bnymellon**	Access a national network of doctors 24/7 to manage common medical and behavioral health issues

CVS Health MinuteClinics	1-866-389-2727	**cvs.com/minuteclinic**	Quickly and easily get the non-emergency care you need at affordable prices
Livongo Diabetes Management Program	1-800-945-4355	**member.accolade.com**	• Available to individuals and covered family members who qualify • Get free tools and coaching to help manage diabetes
Virgin Pulse	1-888-671-9395	**join.virginpulse.com/bnymellon**	• Track healthy activities • Create and join challenges • Get personalized tips and more
FINANCIAL PLANNING AND EDUCATION RESOURCES			
Ayco	1-800-334-6978 Coaches available Mon – Thu, 9 a.m. – 8 p.m. ET, and Fri, 9 a.m. – 5 p.m. ET	From work: Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Wealth > Ayco Financial Planning) From home: **ayco.com/login/bnymellon**; login using the username and password you created during registration through MyReward, or register as a new user	• One-on-one telephonic coaching and digital resources to help you achieve your financial goals • Help with everyday financial decision and planning for major life events
RETIREMENT			
Voya	1-877-269-8758 Voya Customer Service Representatives available Mon – Fri, 8 a.m. – 8 p.m. ET	From work: Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > My External Links > Wealth > 401(k) Account) From home: **bnymellon401k.com**; login using the username and password you created during registration, or register as a new user.	