The Bank of New York Mellon Health and Welfare Plan

and

Summary Plan Description

Originally effective April 1, 1988

Most recently amended and restated effective as of January 1, 2021

This Plan and summary plan description contains a summary in English of the rights, obligations, coverage and benefits afforded to eligible employees and participants under The Bank of New York Mellon Health and Welfare Plan. If you have difficulty understanding any part of this Plan and summary plan description, please contact Accolade at 1-833-640-0427 Monday through Friday, 8:00 a.m. to 11:00 p.m. ET for assistance.

If you have received this Plan and summary plan description in electronic form and you wish to receive a paper copy, please contact the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940, Monday through Friday, 8:30 a.m. to 8:00 p.m. ET and it will be provided to you at no charge.

BNY MELLON

Table of Contents

Page

THE BANK OF NEW YORK MELLON HEALTH AND WELFARE PLAN

AND SUMMARY PLAN DESCRIPTION

PART I: INTRODUCTION

The Bank of New York Mellon Corporation (the "Company") sponsors The Bank of New York Mellon Health and Welfare Plan (the "Plan") to provide health and welfare benefits to eligible employees of the Company and any of its affiliates or subsidiaries whose employees are authorized to participate in the Plan by the Company (individually and collectively, "BNY Mellon").

The Plan, originally effective as of April 1, 1988, and subsequently amended on a number of occasions, was most recently restated in its entirety, effective as of January 1, 2021. The Plan is designed to be an unfunded "employee welfare benefit plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended, and including any validly issued regulations thereunder ("ERISA"), and, accordingly, except for certain programs as described herein, the Plan is governed by ERISA. This document constitutes *both* the official plan document and the required summary plan description ("SPD") under ERISA. The evidence of coverage booklets, certificates and other descriptive materials under the Plan are incorporated by reference herein and constitute part of this combined plan document and SPD.

The Plan is offered in conjunction with a premium contribution arrangement, which is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended, and including any validly issued regulations thereunder (the "Code"). The cafeteria plan component allows you, as an eligible employee participating under the Plan, to pay certain health and welfare coverage premiums on a pre-tax basis. The cafeteria plan component also allows you to make pre-tax contributions to a Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account, and/or a Health Savings Account, which are made possible by Code Sections 105(h), 125, 129 and 223, respectively. By participating in the Plan, you are receiving in coverage a portion of what would otherwise be your wages. This reduces the amount of your taxable income and, therefore, could reduce your taxes and your eligible income for determining your Social Security benefits.

Please note that most of the benefit options under the Plan are self-insured, which generally means that BNY Mellon pays benefit claims rather than an insurance company. The national health benefit options under the Plan are self-insured, as described below.

Fully-Insured. When a plan option is fully-insured, the sponsor pays premiums (consisting of both sponsor and participant contributions) to an insurance carrier, which assumes the financial risk of paying for claims, as well as the responsibility for the administrative duties. Fully-insured benefit options under the Plan include Kaiser Permanente (Los Angeles and San Francisco only), HMSA Hawaii and Aetna International medical benefit options, the Aetna DMO dental benefit option, life insurance benefit options, long-term disability benefit options, and certain retiree medical benefit options. State insurance laws may require fully-insured plans to provide benefits that may not be offered under self-insured health plans.

Self-Insured. When a plan option is self-insured, the sponsor (in this case, BNY Mellon) generally assumes the financial risk of the claims incurred by eligible employees and their eligible dependents. Claims are paid from sponsor and participant contributions (premiums). A plan sponsor may also engage an administrator to process claims, manage provider networks and handle other administrative tasks. Self-insured benefit options under the Plan include those medical benefit options offered through Anthem Blue Cross Blue Shield, pharmacy benefit options offered through CVS/caremark, dental benefit options offered through MetLife, vision benefit options offered through VSP, Flexible Spending Accounts and the Flex Vacation Purchase. Self-insured health options give BNY Mellon the flexibility to create customized plan designs and benefits for our eligible employees and their eligible dependents and to help manage plan costs. Unlike fully-insured health plans, self-insured health plans are not subject to state insurance laws.

The laws relating to employee benefit plans frequently change. In any case in which a Plan provision (including, without limitation, an insurance policy or managed care contract provision) is inconsistent with any law, regulation or ruling, the Plan may be administered, at the sole and absolute discretion of the Company and the Administrator, as applicable, in accordance with the law, regulation or ruling, regardless of the terms and conditions of the Plan.

The Company reserves the right to amend or terminate the Plan or the participation of any participating affiliate in the Plan at any time for any reason, subject to applicable law.

No employee (active or inactive), dependent or beneficiary, or other person will have any right or claim to coverage and/or benefits under the Plan, other than as specified in the Plan. The coverage and benefits specified in the Plan are only available to eligible participants. All benefits are subject to the provisions of the Plan. No statement or omission in this combined plan document and SPD modify or affect the Reference Documents. No one speaking on behalf of the Plan, the Administrator or BNY Mellon can alter the terms of the Plan.

By participating in the Plan and/or accepting benefits provided through the Plan, you, as an employee, and on behalf of your covered dependent(s), acknowledge and agree to follow the terms and conditions set forth in the Plan. On behalf of yourself and your covered dependents, you also acknowledge and agree that any failure to comply with these terms and conditions may result in the denial of benefits, withholding of benefits, or termination of coverage under one or all of the benefits options offered under the Plan.

Please also refer to the Evidence of Coverage booklets (commonly referred to as "EOC") and/or other literature provided by the insurance carriers or contract administrators that outline specific benefit options in greater detail and that are incorporated herein by reference (each a "Reference Document" and collectively, the "Referenced Documents"). All Reference Documents should be read together for a complete understanding of the coverage and benefits offered under the Plan, as well as your legal rights and obligations, including the claims procedures for a particular benefit option. For example, Kaiser Permanente might require that you consent to binding arbitration in a specific venue at the time of enrollment. For further questions contact the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940.

Please note that in order for you to receive Plan communications in a timely manner, it is your responsibility to ensure that your contact information on file with BNY Mellon (or its designee) is accurate, complete, and kept up-to-date. If you have questions about how to update your contact information, active employees should refer to the Update Personal & Business Contact Information: Global page on MySource (https://mysource2.bnymellon.net/pages/hr/global/personal-data). Former employees should contact MyHR at 1-800-947-4748, option 3, and have their employee ID available for reference.

This document was not intended or written to be used, and it cannot be used, for the purpose of avoiding Federal tax penalties that may be imposed on you.

Furthermore, this Plan is not intended to, and does not provide state or local tax advice regarding the benefit options described herein.

You should consult with your own tax advisor regarding your particular tax circumstances.

PART II: GENERAL PLAN INFORMATION

Sponsor Name, Address and Phone Number:	The Bank of New York Mellon Corporation 240 Greenwich Street 19th Floor (101-1950) New York, NY 10286 212-495-1784
Sponsor Federal Identification Number:	13-2614959
Plan Name:	The Bank of New York Mellon Health and Welfare Plan
Participating Companies:	The Company and all members of the Company's U.S. controlled group of corporations, unless specifically excepted by the Company. For a complete list of Participating Companies, please contact the Administrator.
Plan Number:	510
Original Effective Date and Restatement Effective Date:	The Plan was originally effective as of April 1, 1988, and is restated in its entirety most recently effective as of January 1, 2021.
Plan Year:	Plan records are maintained on a 12-month period known as the Plan Year, which is the period from January 1 through December 31, inclusive.
Administrator:	Global Head of Compensation and Benefits c/o The Bank of New York Mellon Corporation 240 Greenwich Street 19th Floor (101-1950) New York, NY 10286 1-800-947-4748
Agent for Service of Process:	The Bank of New York Mellon Corporation c/o Legal Department 240 Greenwich Street, 18th Floor New York, NY 10286
Type of Plan:	A plan providing for medical, dental, vision, certain wellness program, long-term disability, life insurance, accidental death and dismemberment, employee assistance program, death benefits, and health and dependent care flexible spending accounts, and a legacy health reimbursement arrangement. The coverage and benefits under this Plan are provided in a manner intended to be consistent with the requirements of Code Sections 79, 105, 106, and 129, as applicable. The cafeteria plan component is a premium contribution vehicle permitting pre-tax payroll deductions to pay for qualified benefit option premiums pursuant to Code Section 125 and facilitating pre-tax contributions to a health savings account.

Type of Funding: Certain of the benefit options under the Plan are at least partially self-insured and certain others are fully-insured. See Part III for a specific list of the options and whether they are self- or fully-insured. Premium contribution costs are paid by both BNY Mellon and the employee (or applicable participant as required by applicable law).

Plan Document: Copies of the plan documents are available from the BNY Mellon Benefit Solutions Service Center for inspection and/or copying during normal business hours, Monday through Friday (excluding holidays). A reasonable charge may be made for copying.

Service Center: BNY Mellon Benefit Solutions Center, 1-855-354-6940, between 8:30am to 8:00pm ET Monday through Friday.

At Home: http://mybenefits.bnymellon.com.
At Work: MySource > HR & Personal > MyReward > Health > MyBenefit Solutions.

PART III: CONTACT INFORMATION AND RESOURCES

As of January 1, 2021

Type of Benefit Option	Contract Administrator/ Insurance Provider	Reference Document (Incorporated by Reference)	Claims Administrator: Address for Benefit Claims and Appeals of Denied Claims, Contact Information	Self-/ Fully- insured
Medical (Employees)	Anthem	*Medical Benefit Booklet for The Bank of New York Mellon Corporation Copay Plan; Lower Deductible HSA Plan, Higher Deductible HSA Plan*	www.anthem.com/bnymellon 1-833-640-0427	Self-insured
	Kaiser Permanente *(Los Angeles and San Francisco only)*	Group # 28081 Kaiser Permanente SF (Northern Group) *Kaiser Permanente Deductible HMO Plan Evidence of Coverage for The Bank of New York Mellon*	www.kaiserpermanente.org 1-800-464-4000	Fully-insured
		Group # 109359 Kaiser Permanente LA (Southern Group) *Kaiser Permanente Deductible HMO Plan Evidence of Coverage for The Bank of New York Mellon*		Fully-insured
	HMSA *(Hawaii only)*	Group # 17435-1 *Blue Cross Blue Shield of Hawaii, PNC Global Investment Servicing US, Inc.*	Hawaii Medical Service Association (HMSA) 818 Keeaumoku Street, P.O. Box 860 Honolulu, HA 96808-0860 1-808-948-5110	Fully-insured
	Aetna International *(International expatriates only)*	Group # 468814 *Group Insurance Plan Benefits for The Bank of New York Mellon Corporation, Administered by Aetna International*	www.aetnainternational.com 1-800-231-7729	Fully-insured

Retiree Medical (Retirees Ages 55 – 65)	*Non-Grandfathered Group Anthem - Lower Deductible HSA Plan*	*2021 Benefits Guide for Retirees Under Age 65*	www.anthem.com/bnymellon 1-833-640-0427	Self-Insured
	Grandfathered Group Anthem - Higher Deductible HSA Plan - Lower Deductible HSA Plan	*2021 Benefits Guide for Retirees Under Age 65*	www.anthem.com/bnymellon 1-833-640-0427	Self-Insured
	Kaiser Permanente (Los Angeles and San Francisco only)	Group # 28081 Kaiser Permanente SF (Northern Group) *Kaiser Permanente Deductible HMO Plan Evidence of Coverage for The Bank of New York Mellon*	www.kaiserpermanente.org 1-800-464-4000	Fully-Insured
		Group # 109359 Kaiser Permanente LA (Southern Group) *Kaiser Permanente Deductible HMO Plan Evidence of Coverage for The Bank of New York Mellon*		Fully-Insured
	HMSA (Hawaii only)	Group # 17435-1 *Blue Cross Blue Shield of Hawaii, PNC Global Investment Servicing US, Inc.*	Hawaii Medical Service Association (HMSA) 818 Keeaumoku Street, P.O. Box 860 Honolulu, HA 96808-0860 1-808-948-5110	Fully-Insured
	Aetna International *(International expatriates only)*	Group # 499908 *Group Insurance Plan Benefits for The Bank of New York Mellon Corporation, Administered by Aetna International*	www.aetnainternational.com 1-800-231-7729	Fully-Insured
Legacy Retiree Medical (Retirees Age 65+)	*Aetna Medicare Advantage ESA PPO with Drug Coverage Agreement (Grandfathered BNY Employees, Grandfathered Buck Consultants and Grandfathered Mellon Employees)*	*Summary of Benefits Provided by Aetna Life Insurance Company*	www.aetnaretireeplans.com 1-888-267-2637	Fully-Insured

	Aetna International (International expatriates only)	Group # 499908 *Group Insurance Plan Benefits for The Bank of New York Mellon Corporation, Administered by Aetna International*	www.aetnainternational.com 1-800-231-7729	Fully-Insured
	Aetna Transition Plan, including CVS Caremark Prescription Drug Program	GP-800210 *Aetna Medicare Integration – Traditional Choice Plan*	www.aetnaretireeplans.com 1-888-267-2637	Fully-Insured
		Pharmacy Benefit Services Agreement	www.caremark.com 1-800-685-4130	Self-Insured
Retiree Life Insurance (Certain Legacy Mellon employees, as described herein)	Metropolitan Life Insurance Company	This document *Certificate #3: Retired Named Employees, Basic, and Supplemental Life Insurance and Accidental Death and Dismemberment Insurance* *Certificate #4: Grandfathered Named Employees Supplemental Life and Dependent Life Insurance, and Supplemental Death and Dismemberment Insurance*	MetLife Group Life Claims Division 1-800-438-6388	Fully-insured
Prescription Drug	CVS Caremark *(For Anthem coverage)* CVS Caremark AccordantCare Health Services	Pharmacy Benefit Services Agreement	www.caremark.com 1-800-685-4130 www.accordant.com 1-800-948-2497	Self- insured
Dental	MetLife PDP Options 1 & 2	Group # 116273 *Your Metlife Summary Plan Description, The Bank of New York Mellon Corporation Dental Benefits Plan*	www.metlife.com/mybenefits 1-866-665-1494	Self- insured

	Aetna DMO	Group # 800210 *Benefit Plan, BNY Mellon,* *Dental Maintenance Organization (DMO)* Group # 800210 *Your Group Plan, BNY Mellon, Texas DMO*	Aetna Life Insurance Company www.aetna.com 1-855-855-8112	Fully- insured
Vision	VSP (Vision Service Plan)	Group # 12156679 *Group Vision Care Plan* *Evidence of Coverage (1/1/2012)*	www.vsp.com 1-800-877-7195	Self- insured
Long-term disability	Lincoln Life Assurance Company of Boston	Effective January 1, 2017 Group # GF3-830-510532-01 *The Bank of New York Mellon Corporation Long Term Disability Coverage*	Disability Claims PO Box 7206, London, KY 40742-9942 1-800-210-0268	Fully- insured
	Prudential Life Insurance	Claims for benefits incurred prior to January 1, 2017 will continue to be administered by Prudential. Group #G-24392-NY (refer to 2016 Plan) *The Bank of New York Mellon Corporation Long Term Disability Coverage*	The Prudential Insurance Company of America 761 Broad Street Newark, NJ 07102 1-800-842-1718	Fully- insured

Supplemental life insurance Spouse/ domestic partner life insurance Child life insurance Basic accidental death & dismemberment ("AD&D") Supplemental AD&D	Metropolitan Life Insurance Company	Group #116273-1-G *Certificate #1: All Full-Time Employees, Excluding Named Legacy Mellon Executives* *Basic, Supplemental and Dependent Life Insurance, Accidental Death and Dismemberment and Supplemental Accidental Death and Dismemberment Insurance* *Certificate #2: Full-Time Named Legacy Mellon Executives* *Basic, Supplemental and Dependent Life Insurance, Accidental Death and Dismemberment and Supplemental Accidental Death and Dismemberment Insurance*	MetLife Group Life Claims Division 1-800-438-6388	Fully- insured
Flexible Spending Accounts (Health Care, Dependent Care)	Alight	This document 2021 Benefit Guides for Active and Disabled Employees	Alight Single sign-on access through MyReward or http://mybenefits.bnymellon.com 1-855-354-6940	Self- insured
Wellbeing Program[1]		This document provides an overview of the Wellbeing Program. Additional information and details can be found on MyReward, and at the respective vendors' websites and ancillary documents (in each case, as may be listed below).		N/A

[1] BNY Mellon offers a wellness—Wellbeing—program in conjunction with the benefits offered under the Plan to promote health management among our eligible employees and their eligible dependents. Certain wellness components are tools and, accordingly, are not intended to be, and are not, benefits offered under the Plan. However, this is a comprehensive list of all components of the wellness program, regardless of whether such components are Plan benefits.

Accolade		Single sign-on access through MyReward or member.accolade.com 1-833-640-0427
Ayco		Single sign-on access through MyReward or www.ayco.com/login/bnymellon 1-800-334-6978
Beacon Health Options EAP Program	*Beacon Health Options EAP document*	www.achievesolutions.net/bnym 1-855-55ACCESS
Benefit Wallet		Single sign-on access through MyReward or mybenefitwallet.com 877-472-4200
CVS Health Pharmacy Advisor Counseling Program		www.caremark.com 1-800-685-4130
CVS MinuteClinics®		www.minuteclinic.com 1-866-389-2727
Onsite Health Centers operated by Premise Health	*Onsite Health Center brochure*	mypremisehealth.com/mychart/
meQuilibrium		Employees: getmeq.com/bnymellon Spouses, domestic partners, adult dependents: getmeq.com/bnymellonfamily
Sleepio		sleepio.com/bnymellon
Teladoc Medical Experts		teladoc.com/medicalexperts 1-833-640-0427
Transform Diabetes Care Program (Livongo)		join.livongo.com/BNYMellon/begin 1-800-945-4355
Virgin Pulse		Single sign-on access through MyReward or hr.bnymellon.com/wellbeing 1-888-671-9395

Flex Vacation Purchase	N/A	This document	Self-insured

For answers to questions about enrolling in or changing benefits:
Contact the BNY Mellon Benefit Solutions Service Center:
Call 1-855-354-6940 **between 8:30 am to 8:00 pm ET Monday through Friday,**
Or visit MyBenefit Solutions through **MyReward** at work. From home, visit **http://mybenefits.bnymellon.com**. (If you are a new employee or have not already registered, you will need to create a username and password.)

For answers to questions about your health and welfare benefits:
Contact Accolade: Call Your Personal Health Assistant at 1-833-640-0427 between 8:00 am to 11:00 pm ET Monday through Friday,
Or visit Accolade using single sign-on through MyReward or member.accolade.com.

PART IV: ELIGIBILITY AND PARTICIPATION

Who Is Eligible Under the Plan?

Eligibility under the Plan is limited to salaried employees of BNY Mellon, who are not otherwise excluded below.

You are considered to be an **eligible employee** if you are employed (or, as required by applicable law such as the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), formerly employed) by BNY Mellon in a salaried position, and you are regularly-scheduled to work at least twenty (20) hours per week, as determined by BNY Mellon. You will continue to be deemed an eligible employee while on short-term disability, long-term disability, military leave of absence or other leaves of absence, in each case, if such leave is approved by BNY Mellon.

You are also deemed to be an eligible employee while receiving separation pay from BNY Mellon under the terms of The Bank of New York Mellon Corporation Supplemental Unemployment Benefit Plan or under the terms of any other written transition/separation plan, policy, program or agreement with BNY Mellon unless otherwise provided in such plan, policy, program or agreement.

You are not eligible if:

- you are classified by BNY Mellon as a seasonal employee or are regularly-scheduled to work less than twenty (20) hours per week; or
- you are an agency worker or classified by BNY Mellon as a temporary employee, which means an employee, other than a summer associate as defined by BNY Mellon, who is employed for a short-term project assignment, generally of three (3) months or less duration; or
- you are a leased employee (within the meaning of Code Section 414(n) or as otherwise determined by BNY Mellon); or
- you are determined by BNY Mellon to be an independent contractor (even if you are subsequently determined by the Internal Revenue Service ("IRS"), the Department of Labor, a court of competent jurisdiction, or BNY Mellon to be a common law employee of BNY Mellon); or
- the terms and conditions of your employment are governed by a collective bargaining agreement under which health and welfare benefits were subject to good faith bargaining, unless such agreement provides for coverage under the Plan; or

- you are a non-resident alien (within the meaning of Code Section 7701(b)(1)(B)) who receives no earned income (within the meaning of Code Section 911(d)(2)) from BNY Mellon that constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)); or
- you become a Reclassified Employee and were not eligible to participate in the Plan prior to the effective date or period that you became a Reclassified Employee, regardless of whether such reclassification is intended to be retroactively effective, unless you are subsequently classified by BNY Mellon as an eligible employee for reasons other than becoming a Reclassified Employee; "Reclassified Employee" means an individual who was not classified by BNY Mellon as an employee, but who was subsequently reclassified as an employee by a Federal, state or local group, organization, agency or court; or
- you are a party to an agreement that provides that you will not be eligible to participate in the Plan, whether or not such agreement is upheld upon governmental or judicial review; or
- you are not on the United States payroll of BNY Mellon.

Please note that while all eligible employees (and their eligible dependents, if any) are automatically enrolled in certain default benefit options and, accordingly, become Plan participants, they will not necessarily be eligible for, or covered under, all benefit options then-available.

Some eligible employees (and their eligible dependents, if any) will be extended the opportunity to enroll in certain benefit options under the Plan, but may decline such coverage—either by specific election to opt-out or by failure to properly elect coverage when eligible to do so—which means that these employees are not covered under a particular benefit option under the Plan, as determined by the Company.

An eligible employee (or his or her eligible dependent(s)) may also be eligible to participate in the Plan, but not in all benefit options under the Plan. That is, specific eligibility rules may apply to eligibility for a particular benefit option, and a person has no right to coverage under a particular benefit option, unless he or she meets those specific eligibility rules. Employee eligibility and the eligibility of dependents for a specific benefit option, as well as the amount, type, and duration of coverage, are determined in accordance with the terms of the applicable insurance contract or policy, if applicable, and the terms of enrollment of the particular benefit option.

Notwithstanding the foregoing, separate eligibility requirements apply to retiree medical and life insurance coverage under the Plan (see "Who is Eligible for Retiree Medical Coverage?").

Who Is an Eligible Dependent?

Your **eligible dependent(s)** may participate in the Plan if you, as an eligible employee, are covered under the Plan. Please note that you may not be covered under the Plan as both an employee and a dependent. In no event will a dependent be covered as an eligible dependent of more than one eligible employee under the Plan. Additionally, each dependent must satisfy the eligibility requirements of the particular benefit option, policy or contract and terms of enrollment of the particular benefit option.

Your eligible dependent(s) include:

- 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 below;
- your child up to age twenty-six (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 physically or mentally disabled and is financially dependent on you for support, and who became disabled prior to age twenty-six (26); and
- 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 program benefit.

Special dependent eligibility provisions apply to the Beacon Health Options EAP. Specifically, Beacon Health Options EAP is available to all your household members (e.g., spouse, domestic partner, parents, grandparents, etc.) pursuant to the terms of the covered program benefit. In addition, special dependent eligibility provisions apply to Teladoc Medical Experts as described above.

A **spouse** is a person to whom you are currently legally-married, who is treated as your spouse or surviving spouse pursuant to the Code and ERISA, and for whom the marriage has not ended by such means as divorce, dissolution, annulment or death. A spouse of a covered employee is eligible for medical, dental, vision, spouse life insurance and certain portions of the Wellbeing Program.

A **child** is a natural child, stepchild, legally adopted child, child placed for adoption with you, 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), child for whom you are the legal guardian and the duty of sole financial support by court order, or a "child" of your qualified domestic partner. A child is not an eligible dependent if the child is also an eligible employee of BNY Mellon under the terms of the Plan. A child of a covered employee is eligible for medical, dental, vision, dependent life insurance and certain portions of the Wellbeing Program.

A **qualified domestic partner** is 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); and
- 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.

A domestic partner of a covered employee is eligible for medical, dental, vision, life insurance and certain portions of the Wellbeing Program.

When enrolling any dependent (i.e., spouse, qualified domestic partner, child, disabled dependent) and thereafter, you may be periodically required to provide satisfactory proof of applicable dependent status (e.g., marriage certificate, birth certificate or proof of incapacity and continued financial dependence on employee) as a condition of eligibility or continued eligibility under the Plan.

You and your qualified domestic partner may be required to demonstrate proof of the domestic partnership from time to time (e.g., at the time of enrollment, re-enrollment, change of status) by providing: (1) a notarized affidavit of domestic partnership (if residing in a state or locality that makes domestic partner registration available), and (2) 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, common leasehold interest in real property).

For purposes of this Plan, a qualified domestic partner shall have the same rights as the spouse of an eligible employee for all purposes under the Plan, except to the extent such rights would result in a violation of the Code or other applicable law, or a Reference Document.

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.

How Does Qualified Domestic Partner Coverage Work?

To the extent administratively practicable, as determined by the Company, and as permitted by applicable law, coverage for a qualified domestic partner under the Plan is similar to coverage provided for a spouse of any participant who is an eligible employee. If you lose health coverage due to a termination of employment, you may generally elect COBRA coverage and, under certain circumstances, elect to cover your qualified domestic partner as your dependent. As with coverage for spouses and other dependents, if your qualified domestic partner is covered by another health plan, coordination of benefits will apply.

A domestic partner who does not otherwise meet the requirements to be a qualified domestic partner under the Plan will nevertheless be deemed to be a qualified domestic partner to the extent that the Company determines that it is subject to an "equal benefits" ordinance or law requiring coverage of domestic partners, and only if all requirements for coverage under such ordinance or law have been met and no exemption or waiver applies.

Please note that although you may be able to enroll a qualified domestic partner and his or her children, unless they also meet applicable tax dependency requirements, premiums for their health coverage cannot be paid on a pre-tax basis through the cafeteria plan component. For this reason, an imputed income adjustment is included in each semi-monthly pay for Federal (and some state) tax purposes.

Generally, to meet the Federal tax dependency rules, the person must have the same principal place of abode as you and be a member of your household; you must provide over one-half (½) of his or her support for the calendar year; and the person must not be a dependent of any other taxpayer. If you claim your qualified domestic partner as your tax dependent, you may be required to complete a certification to this effect. State tax rules governing the taxation of benefits provided to qualified domestic partners and their children vary by state. You should contact your personal tax advisor for more information regarding the taxation of benefits provided to qualified domestic partners and their children.

When Does Participation Commence?

If you satisfy the eligibility requirements described in the Plan (see "Who Is Eligible Under the Plan?", "Who Is Not Eligible?" and "Who is Eligible for Retiree Medical Coverage?"), you will become a Plan participant when you are enrolled in, and become covered under, one or more of the benefit options, pursuant to the terms of the particular benefit option. Coverage for any dependents, who meet the dependent eligibility requirements described above, begins on the same date as does your participation.

With respect to the annual open enrollment, this means January 1 of the Plan Year for which you enrolled. With respect to mid-Plan Year enrollment, if you are a new hire or transition to a benefit-eligible status, your coverage will be effective on your date of hire or the date of your transition to benefit-eligible status, provided that you enroll within thirty-one (31) days of your benefit-eligibility date. See "What Is a (HIPAA)

Special Enrollment Event?" and "What Is a Change in Status Event (or Qualified Life Event)?" for information on when your coverage will be effective if you enroll mid-Plan Year during a special enrollment period following a special enrollment, change in status or other qualifying event.

Should you gain new dependents after beginning participation under the Plan, you may enroll your newly eligible dependent(s) by notifying the BNY Mellon Benefit Solutions Service Center within the applicable enrollment period (see "What Is a (HIPAA) Special Enrollment Event?" and "What Is a Change in Status Event (or Qualified Life Event)?"). Under such circumstances, the dependent's participation will generally begin on the first of the month following the date that the dependent becomes eligible. However, if you gain a child through birth, adoption, or placement for adoption, the child's participation in health coverage under the Plan begins as of the date of the birth, adoption or placement for adoption, provided the BNY Mellon Benefit Solutions Service Center receives your properly completed enrollment application in writing, on-line, or by phone within thirty-one (31) days of the birth, adoption or placement for adoption.

The eligibility rules applicable to you and your dependents may differ from one benefit option to another.

How Do You Elect to Participate?

You complete enrollment on-line through the MyBenefit Solutions website. Once completed, your participation is processed through the benefits enrollment system. If you do not have on-line access, please contact the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940 for assistance.

You will be able to elect your coverage from among the benefit options available. Your contributions towards the cost to pay for the coverage that you select can be made by payroll deductions if elected on a timely basis. Generally, you pay for your coverage (including medical, dental and vision premium payments, and flexible spending account contributions) on a pre-tax basis. Employee supplemental life insurance coverage and spouse/qualified domestic partner and child life insurance coverage is paid for on an after-tax basis.

Please note that you, as an eligible employee, will be automatically enrolled in, and provided coverage under, any default benefit options, whether or not you were a Plan participant in the preceding Plan Year. For the 2021 Plan Year, these default benefit options are long-term disability, life insurance, basic AD&D insurance and EAP. As an eligible active employee, you are also automatically eligible for the onsite Health Centers operated by Premise Health as long as you are enrolled in medical coverage, whether through the Plan or otherwise.

When Can You Make or Change Plan Elections?

Typically, if you do not make a timely election during the open enrollment period or when you or your dependents, if any, are first eligible, you and your dependents may only enroll during subsequent designated open enrollment periods or during the applicable election period following a special enrollment, change in status or other qualifying event, as explained below.

The Plan restricts changes to your payroll deductions made through the cafeteria plan component. As a result, your pre-tax payroll deduction election will continue in effect until the earliest of the following:

- you are no longer eligible to participate in the Plan for any reason; or
- you elect to discontinue participating in the Plan during the open enrollment period, or you do not make an election to participate in the Plan during the open enrollment period for a benefit option requiring active elections (even if you participated for the preceding Plan Year), in which case your related payroll deduction will stop at the end of the current Plan Year; or
- when you experience a special enrollment event and request a change within the required time frame *for changes other than with respect to your HSA contributions* (see "What Is a (HIPAA) Special Enrollment Event?") *or your Flexible Spending Account contributions for the 2021 Plan Year*; or

- when you experience a change in status or other qualifying event and request a change within the required time frame *for changes other than with respect to your HSA contributions* (see "What Is a Change in Status Event (or Qualified Life Event)?" and "What Election Changes Can Be Made Based on Other Change in Status Events?") *or as set forth below under* "Can I Make a Mid-Year Election Change without a Change in Status or Other Qualifying Event?"*.*

You can generally make changes to your Health Savings Account contributions at any time during the year on a prospective basis. For more information on when changes in Health Savings Account contributions may be made, see "What Is a Health Savings Account?"

You may be required to provide written certification or other documentation of a special enrollment, change in status or other qualifying event.

Can I Make a Mid-Year Election Change without a Change in Status or Other Qualifying Event?

For the 2021 Plan Year, the IRS published additional guidance allowing mid-year benefit election changes for certain 2021 health care coverage and flexible spending accounts, without the need for a change in status or other qualifying event.

You are permitted to adjust your 2021 elections for medical, dental and vision benefits, as well as your health care and dependent care flexible spending accounts under the Plan as described below. Election changes for medical, dental and vision coverage are permitted beginning January 1, 2021 through September 30, 2021 (the "Special Election Period"), for benefit coverage through December 31, 2021. You are permitted to make election changes for medical, dental and vision coverage pursuant to this 2021 special enrollment event one time (for each type of coverage) during the Special Election Period.

Election changes for your health care and dependent care flexible spending accounts are permitted beginning January 1, 2021 through November 30, 2021 for benefit coverage through December 31, 2021.

Who is eligible to make changes to their benefits?	All active employees or employees on a leave of absence are eligible to make a mid-year change through this special enrollment event.
What benefits can be changed?	You are able to add, drop or change the following benefits through this special enrollment event: • Medical • Dental • Vision • Health care flexible spending account • Dependent care flexible spending account
What are the allowable changes to each plan?	For medical, dental and vision coverage, you are able to: • Enroll yourself in coverage • Add your spouse or qualified domestic partner to coverage • Add any eligible dependent to coverage • Remove your spouse or qualified domestic partner

	• from coverage • Remove any eligible dependent from coverage • Cancel your own coverage* Please note that you are unable to change coverage options through this 2021 special enrollment event. For your flexible spending accounts, you are able to: • Enroll and start account contributions • Increase spending account contributions • Decrease spending account contributions • Cancel spending account contributions *Important note: Contributions that have already been made to your flexible spending accounts cannot be refunded but you can continue to receive reimbursements for qualifying eligible expenses incurred while actively participating in the applicable flexible spending account. You cannot receive reimbursements for expenses incurred prior to enrolling in the flexible spending account or after termination of your active participation in the flexible spending account.* *** If you choose to cancel BNY Mellon's medical plan coverage, you are required to attest online that you are enrolled, or immediately will enroll, in other comprehensive health coverage not sponsored by BNY Mellon.**

What Is the Open Enrollment Period?

Generally, the open enrollment period is a designated period during which you can make Plan elections for any reason. During the open enrollment period, you have the opportunity to make a new election, to change an existing election or to stop participating in the Plan altogether.

IMPORTANT! If you decide that you want to add, change or decline participation for any of the benefit options under the Plan, then you must make your election during the open enrollment period. If there are no coverage changes made by the Company that require your active enrollment or confirmation, then you may not need to do anything during the open enrollment period. In such a case, you will be, as applicable, enrolled in the default benefit option or your election from the prior Plan Year will remain in place. **You should, however, review your open enrollment materials carefully for details, including which benefit options do or do not require an active election and deadlines by which all elections must be made. For example, to the extent that you wish to participate in the Dependent Care Flexible Spending Account, or contribute to your Health Care Flexible Spending Account, or you wish to purchase vacation time through Flex Vacation Purchase, you will be required to make an active election each Plan Year.**

After the open enrollment period ends, typically you may start, stop or change participation in the Plan by submitting an election only during the next open enrollment period or within the required timeframe following the date that you experience a special enrollment, change in status or other qualifying event; provided, *however, for the 2021 Plan Year see "Can I Make a Mid-Year Election Change without a Change in Status or Other Qualifying Event?" for a description of mid-year election changes allowable under the Plan as a result of guidance from the IRS responding to the impact of COVID-19*.

What Is a (HIPAA) Special Enrollment Event?

The Plan permits certain mid-Plan Year election changes (i.e., outside of the open enrollment period) for certain special enrollment events under the Health Insurance Portability and Accountability Act ("HIPAA").

If you decline enrollment for yourself or your eligible dependents (including your spouse or qualified domestic partner) because of other health coverage, and such coverage is subsequently terminated, either because of loss of eligibility for that coverage (including, without limitation, as a result of legal separation, divorce, death, termination of employment or reduction in hours), employer contributions towards such coverage cease, or continuation coverage (under COBRA or similar coverage) is exhausted, you may be able to elect health coverage under this Plan for you and/or your eligible dependents who lost such existing coverage, provided that you request enrollment **within thirty-one (31) days** after such other coverage ends.

If you gain a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse, your domestic partner, and other eligible dependents, provided that you request enrollment **within thirty-one (31) days** after the marriage, birth, adoption or placement for adoption.

You or your eligible dependent may enroll for health coverage pursuant to two additional special enrollment events: (i) if you or your eligible dependent (who is not otherwise enrolled in group health coverage under the Plan) lose coverage under a Medicaid plan or state children's health insurance program ("CHIP") as a result of a loss of eligibility; or (ii) if you or your eligible dependent (who is not otherwise enrolled in group health coverage under the Plan) become eligible for assistance with respect to group health plan coverage subsidy under a Medicaid plan or CHIP. Coverage under the Plan must be requested **within sixty (60) days** after the date you or your dependent are terminated from such coverage or determined to be eligible for such coverage, as applicable.

The special enrollment provisions of HIPAA are not applicable to the Heath Care Flexible Spending Account. However, the particular life event may still qualify as a change in status event (see "What Is a Change in Status Event (or Qualified Life Event)?" below). For example, marriage is also a change in status event that would permit you to make a change in your Health Care Flexible Spending Account election.

An election change that corresponds with a special enrollment (other than a new dependent child) will be effective as soon as administratively practicable following the date the BNY Mellon Benefit Solutions Service Center receives proper notification **within thirty-one (31) days** of the special enrollment event.

A special enrollment attributable to the birth, adoption or placement for adoption of a child will be retroactively effective to the date of such birth, adoption or placement, provided that the My Benefit Solutions Team receives proper notification **within thirty-one (31) days** of the birth, adoption or placement.

A special enrollment attributable to marriage will be effective no later than first day of the month beginning after the enrollment request is received, also provided the BNY Mellon Benefit Solutions Service Center receives proper notification **within thirty-one (31) days** of the marriage.

To request special enrollment or to obtain more information, contact BNY Mellon Benefit Solutions Service Center or go online MyBenefit Solutions through **MyReward** at work. From home, visit **http://mybenefits.bnymellon.com**. (If you are a new employee or have not already registered, you will need to create a username and password).

What Is a Change in Status Event (or Qualified Life Event)?

Subject to any restrictions in the applicable benefit option, if you experience a change in status event, you may add, drop, or change the coverage election under the Plan for you and/or your dependent(s) by submitting a request online through MyReward/MyBenefit Solutions, or by calling the BNY Mellon Benefit Solutions Service Center **within thirty-one (31) days** of the event.

You should receive confirmation showing the change in your election and the effective date of that change. It is important that you carefully review this information to verify its accuracy and promptly notify the BNY Mellon Benefit Solutions Service Center if the confirmation notice does not accurately reflect the change and timing of that change, as you requested. If you do not receive a confirmation within seven (7) days after submitting a requested election change, contact BNY Mellon Benefit Solutions Service Center at 1-855-354-6940.

Change in status events include the following:

- a change in your marital or qualified domestic partnership status (e.g., marriage, new qualified domestic partnership, divorce, legal separation as determined by state laws, annulment, termination of domestic partnership, death of a spouse or domestic partner);
- a change in the number of your tax dependents because of the birth, adoption, placement for adoption, or death of a dependent;
- a change in your employment status or that of your dependent that affects eligibility under the Plan (e.g., employment ends, a change in employment status that affects eligibility under the relevant employer plan, start or return from an unpaid leave period);
- a dependent gaining or losing eligibility under the Plan;
- a change in the place of residence of you or your dependent that affects eligibility under the Plan; and
- if becoming enrolled in Medicare precludes you from participating in the health benefit option (e.g., a health savings account) you are enrolled in at such time.

If you experience one of these change in status events, you may change your pre-tax contributions to the Plan; provided, however, that the change meets the consistency requirement and other rules described below.

Please note! Election changes relating to the Health Care Flexible Spending Account on account of a change in status event are permitted only to elect or increase your contribution amount.

What Is the Consistency Requirement?

Generally, an election change is consistent with a change in status only if the change results in an increase or decrease in the number of dependents who are eligible for coverage under a benefit option, except with respect to Dependent Care Flexible Spending Accounts, as described below. The following rules apply in determining whether an election change is consistent with a change in status:

- *Losing or Gaining Eligibility for Coverage.* If you experience a change in status due to divorce, annulment or legal separation from your spouse, the death of your spouse/qualified domestic partner or dependent, or your dependent's ceasing to satisfy the eligibility requirements for coverage, then an election to cancel coverage for any person other than your spouse/qualified domestic partner or dependent who ceases to satisfy the eligibility requirements fails to

correspond with the change in status. Only coverage for the affected person may be cancelled. If a change in status involves you or your spouse/qualified domestic partner or other dependent gaining eligibility under another employer's plan because of a change in marital or employment status, an election to cease or decrease coverage for the affected person under this Plan is consistent with that change in status only if coverage for the affected person under the other employer's plan is obtained.

Example: Mike and Amy are married, and they have one child. BNY Mellon allows employees to elect employee-only medical coverage, employee-plus spouse/qualified domestic partner medical coverage, employee-plus-child(ren) medical coverage, employee-plus-family medical coverage or no medical coverage. During open enrollment, Mike elects family coverage for himself, Amy and his child. During the Plan Year, Mike and Amy divorce, and Amy ceases to be eligible for medical coverage under the Plan. Mike's child continues to be eligible. The divorce is a change in status. An election to cancel family coverage and to elect employee-plus-child(ren) coverage is consistent with that change in status. An election to cancel medical coverage for Mike or his child is not consistent with the change in status.

However, if Amy makes an election to cover the child under her employer's plan, a corresponding change by Mike to elect employee-only coverage under his Plan would be consistent with the change in status.

- *Dependent Care Flexible Spending Accounts.* Ordinarily, you may change or cancel your Dependent Care Flexible Spending Account election if such change is on account of, and corresponds with, a change in status that affects eligibility for coverage under another employer's plan, or if the change is on account of, and corresponds with, a change in status that affects eligible dependent care expenses. *However, for the 2021 Plan Year, you are permitted to change your future Flexible Spending Account contributions at any time prior to November 30, 2021.*

The Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a requested election change is consistent with the change in status.

What Election Changes Can Be Made Based on Other Change in Status Events?

Additionally, you may change your benefits election if you notify the BNY Mellon Benefit Solutions Service Center **within thirty-one (31) days** of certain other events. *Also see "Can I Make a Mid-Year Election Change without a Change in Status or Other Qualifying Event?" for additional permissible mid-year election changes for the 2021 Plan Year.*

- *Significant Cost and Coverage Changes*. If the cost of your health care coverage (or another benefit option) under the Plan significantly increases or decreases during the Plan Year, you may make certain election changes. If the cost of your benefit option significantly increases, you may choose to make a prospective corresponding increase in your contributions, revoke your election and receive coverage under another benefit option that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a benefit option significantly decreases, you may revoke your election and elect to receive coverage provided under the benefit option that decreased in cost. However, for insignificant increases or decreases in the cost of coverage, BNY Mellon may automatically adjust your election contributions to reflect the minor change in cost.

  If during the Plan Year BNY Mellon notifies you that your health care coverage is significantly curtailed, you may revoke your election and elect coverage under another benefit option that provides similar coverage for the Plan Year. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. If a benefit option is added or significantly improved during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly-added or

significantly-improved benefit option, so long as the newly-added or significantly-improved benefit option provides similar coverage.

- *Change in Coverage Under Another Employer Plan*. You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of BNY Mellon or a plan of your dependent's employer), so long as (a) the other plan permits its participants to make an election change permitted under the Code Section 125 regulations; or (b) the Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your spouse during his or her enrollment to drop coverage, you may add coverage under the Plan to replace the dropped coverage.
- *Loss of Coverage Under Other Group Health Coverage*. You may change your election to add group health coverage for you or your dependents if any of you loses coverage under any group health coverage sponsored by a government or educational institution (for example, a state CHIP or certain Indian tribal programs).
- *Judgment, Decree or Order*. If a judgment, decree or order from a divorce, separation, annulment or custody change requires you to provide health care coverage for your dependent child, (including a foster child who is your tax dependent) you may (or you may be required to) change your election to provide coverage for the dependent child. If the order requires that another individual (such as your former spouse) cover a child, and you are providing such coverage under the Plan at that time to the child, you may change your election to revoke coverage for the child.
- *Entitlement to Medicare or Medicaid*. If you, your spouse or other dependent becomes entitled to Medicare or Medicaid, you may cancel health care coverage for the person that became entitled, subject to the terms of the applicable benefit option. Similarly, if you, your spouse or other dependent has been entitled to Medicare or Medicaid, loses eligibility for Medicare or Medicaid, you may elect to begin or increase that person's health care coverage, subject to the terms of the applicable benefit option.

Please note! No employer or employee contributions to Health Savings Accounts are permitted if the employee is enrolled in any part of Medicare, Medicaid or TRICARE.

- *Eligibility for COBRA*. If you, your spouse (but not a former spouse) or other dependent becomes eligible for continuation coverage under COBRA, you may change your election in order to pay for such coverage for the remainder of the Plan Year.
- *Taking a Leave of Absence under the Family and Medical Leave Act of 1993, as amended ("FMLA") or the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").* If you take an FMLA or USERRA leave of absence, or leave of absence under state leave laws that require an employer to permit continuation of coverage, you may continue coverage or suspend your existing coverage elections. If you choose to suspend your coverage, it may be reinstated upon your return from such protected leave, as discussed in the Section of this Plan entitled "What Happens in the Event of a Family and Medical Leave or Other Protected Leaves?" below. If you continue coverage while on leave, you remain responsible for your portion of all premium payments.

Please note! For the 2021 Plan Year, as a result of recent legislation in connection with COVID-19, you are permitted to make changes to your future Flexible Spending Account contributions at any time prior to November 30, 2021. *See "Can I Make a Mid-Year Election Change Without a Change in Status or Other Qualifying Event?" for additional information.* However, it is anticipated that this flexibility will not continue into 2022 and the following rules will apply to election changes relating to Flexible Spending Accounts after November 30, 2021: (i) election changes relating to your Health Care Flexible Spending Account are not permitted on account of a change in cost or coverage under the Plan, a change in coverage under another employer's plan or a loss of coverage under other group health coverage; (ii) election changes relating to your Health Care Flexible Spending Account on account of a judgment, decree or order or due to changes in entitlement to Medicare or Medicaid are permitted only to elect or increase your contribution amount; (iii) election changes relating to your Dependent Care Flexible Spending Account are permitted on account of a change in cost (provided, however, that if the change is an increase in cost, a

corresponding election change is permitted only if such cost change is imposed by a dependent care provider who is not your relative), where one dependent care provider is replaced with another provider (even if the provider is related to you), or there is a reduction in the hours of care needed.

Whether any of the change in status or other events discussed above will give rise to an election change is governed by the Code, the terms of the Plan, and any applicable benefit option, as determined by the Company. For more information regarding permitted changes, contact the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940 right away. **You must notify the BNY Mellon Benefit Solutions Service Center within thirty-one (31) days of an event if you wish to make a corresponding election change, except as otherwise set forth in *"Can I Make a Mid-Year Election Change Without a Change in Status or Other Qualifying Event?"*.**

When Does Participation Cease?

You (as an eligible employee) will cease to participate in the Plan upon the earliest of any one of the following:

- the last day of the month in which your employment terminates, or the last day of the month in which you receive transition/separation pay pursuant to the Company's then existing applicable transition/separation pay policy, program or arrangement as determined by the Company, if later;
- the date that you are no longer an eligible employee for reasons other than termination of employment, or the date that you lose coverage under all benefit options as a result, if later (*for example*, see "When Does Coverage While on Leave Terminate?" and "Effect of Misrepresentation" below);
- a reasonable period of time after you fail to make required premium payments, as determined by the Administrator, not to exceed the last day of the month that is ninety (90) days after you fail to make payments;
- the date of your death;
- the date that you are no longer enrolled in and covered under at least one benefit option; or
- the date that the Plan terminates or is amended to provide that you are no longer eligible.

See Appendix D for a description of your right to continue coverage under COBRA.

In the event that you are absent from work because of a leave of absence approved by BNY Mellon, your participation and that of your dependents will continue during such approved leave, unless you are permitted to, and you elect to, suspend coverage during such leave. If you elect to suspend coverage, it will cease on the last day of the month in which the leave commences. If this should occur, coverage would be reinstated effective the first of the month following your return to active status as an eligible employee. If coverage is continued, arrangements must be made with the BNY Mellon Benefit Solutions Service Center for any required premium payments while you are on leave.

In addition, your eligible dependent will lose coverage under the Plan upon the earliest of any one of the following:

- the date you (as the eligible employee) cease to be enrolled in and covered by at least one benefit option covering the dependent; in the event of the eligible employee's death, dependent coverage extends through the end of the month in which the employee's death occurred;
- the date the dependent ceases to meet the dependent eligibility requirements;
- the date of the dependent's death;
- the date the dependent is no longer enrolled in and covered under at least one benefit option; or

- the date that the Plan terminates or is amended to provide that the dependent is no longer eligible.

You must notify the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940 within **thirty-one (31)** days of the date your dependent ceases to meet the dependent eligibility requirements. The dependent may be eligible for COBRA continuation coverage, or with respect to domestic partners, continuation coverage similar to COBRA, as determined at such time. Both you and your spouse or qualified domestic partner will be jointly and severally liable for any benefits the Plan pays after the dependent is no longer eligible if you fail to timely notify the BNY Mellon Benefit Solutions Service Center.

See Appendix D for a description of the dependent's right to continue coverage under COBRA.

What Happens in the Event of a Family and Medical Leave or Other Protected Leaves?

If you take a leave of absence that qualifies under FMLA, or certain local, county, state or other Federal protected leaves, then health (e.g., medical, dental, and vision) coverage for you and your then-covered dependent(s) will continue to be provided by BNY Mellon at the same contribution level during your protected leave through the "approved through date," subject to the payment terms outlined below.

You may, however, elect to suspend all coverage during the protected leave period. If you return to work at or before the end of your protected leave, your coverage will be reinstated to the same level in effect prior to that leave (to the extent such coverage continues to be offered under the Plan at the time of your return). If an open enrollment occurs during your protected leave, you will have the opportunity to make election changes to the same extent as then active employees. You may also be able to make a change if you experience a (HIPAA) special enrollment event, a change in status or other event.

The Plan is not intended to, and shall not, serve as a complete summary of your rights and obligations if you take a leave of absence. You should refer to Leave Management on MySource for general leave information or call BNY Mellon Leave Service Center at 1-844-804-2768 for specific information related to your leave.

What Happens in the Event of Personal Leave of Absence?

Generally, you cannot change elections for the duration of an unpaid personal leave unless you experience a valid (HIPAA) special enrollment event, change in status or other event as noted above. Because your leave of absence is unpaid, you are required to pay for your coverage monthly on an after-tax basis.

During an unpaid personal leave, your participation in the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account will be suspended until you return to active service, subject to any right to continue Health Care Flexible Spending Account coverage through COBRA. You will not be able to submit claims for reimbursement under your Health Care Flexible Spending Account or Dependent Care Flexible Spending Account for otherwise eligible expenses incurred during your leave period, while your account is suspended. If you do not cancel your coverage elections during an unpaid personal leave in connection with a (HIPAA) special enrollment event, change in status or other permissible event as noted above, your contributions to the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account will restart automatically when you return to active service, unless your leave spans two Plan Years, in which case you will have to make a new contribution election for the new Plan Year.

Please note, reinstatement of coverage following a leave of absence is only available for protected leaves qualifying under FMLA or certain state or other Federal protected leaves. If you request a leave of absence while not eligible for these protected leaves, and you request to cancel coverage, you may only reinstate coverage following your return to active status during the next annual open enrollment period or upon a special enrollment event, change in status or other event described herein that permits a mid-year election change.

The Plan is not intended to, and shall not, serve as a description of your rights and obligations if you take a leave of absence. You should refer to Leave Management on MySource for general leave information or call BNY Mellon Leave Service Center at 1-844-804-2768 for specific information related to your leave.

How to Pay for Coverage While on Leave?

If your leave of absence is a paid leave, regular payroll deductions will continue during the paid leave period. If your leave of absence is unpaid (or becomes unpaid during your leave), you are required to pay for your coverage monthly on an after-tax basis.

If you are on FMLA or other protected leave, as described above, and do not elect to suspend your coverage, you will be required to continue to pay your portion of the applicable premium.

For any approved unpaid personal leave of absence, you will be required to continue to pay your portion of the applicable premium during the first ninety (90) days of such leave of absence. After such ninety (90) day period, your coverage will be terminated, subject to your right to continue coverage under COBRA.

Alight, the Company's third-party administrator, will mail invoices and collect required funds. Payment must be made by the first of each month.

If you fail to timely pay invoices, your coverage will be retroactively terminated as of the end of the paid period of coverage. Any claims incurred after cancellation of coverage will be your responsibility.

Health Care Flexible Spending Account. If your coverage under the Health Care Flexible Spending Account terminates (e.g., by revocation or non-payment of your contribution) while on protected leave, as described above, you are not entitled to receive reimbursements for claims incurred during the period when coverage is terminated. If you subsequently elect to reinstate your Health Care Flexible Spending Account upon return from protected leave for the remainder of the Plan Year, you may not retroactively elect coverage under the Health Care Flexible Spending Account for claims incurred during the period when the coverage was terminated. Upon the reinstatement of your Health Care Flexible Spending Account, you may resume coverage at the level in effect before the protected leave and make up the unpaid contribution payments, or resume coverage at a level that is reduced and resume contribution payments at the level in effect before the protected leave. If you choose to resume your Health Care Flexible Spending Account coverage at a level that is reduced, the coverage is prorated for the period during the protected leave for which no contributions were paid. In both cases, your coverage level is reduced by prior reimbursements.

Dependent Care Flexible Spending Account. Please note that contributions to your Dependent Care Flexible Spending Account will generally not stop while you are on paid leave. While there are no restrictions on reimbursing eligible dependent care expenses incurred before your leave, dependent care expenses incurred during your leave (paid or unpaid) will not be reimbursable.

When Does Coverage While on Leave Terminate?

Generally, if you elect to continue your coverage while on leave but you do not return to work, Company provided coverage will end on the earlier of the last day of the month in which your approved leave period ends (not to exceed ninety (90) days for an unpaid personal leave), or the last day of the month in which your employment terminates. If you elect to continue your benefits, once this period ends, you may be able to continue your health care coverage under the provisions of COBRA (see "COBRA Rights Notice" in Appendix D). Please note, however, that certain benefit options (e.g., life insurance) as well as Health Savings Accounts are not COBRA covered benefits; however, even if some benefit options are not COBRA covered benefits, they may be portable at the time that you would otherwise lose coverage. Please contact the BNY Mellon Benefit Solutions Service Center for more information.

Continued Coverage When Short-Term Disability Ends if Eligible for Long-Term Disability

You continue to be deemed an eligible employee under the Plan while on short-term disability leave if such leave is approved by BNY Mellon. See "Who is Eligible Under the Plan?" above. If you were eligible for coverage while on short-term disability, once you have exhausted your short-term disability leave, if you meet the elimination period under the applicable Company Long Term Disability plan, you may remain eligible for coverage under the Plan if you apply, and are determined to be eligible, for coverage under BNY Mellon's long-term disability plan.

Continued Coverage When Long-Term Disability Ends

You are no longer eligible for coverage under the Plan when you are determined to be ineligible for, or exhaust, coverage under BNY Mellon's long-term disability plan. Coverage will terminate for you, and your dependents, at that time unless you return to active employment status. If you do not return to active employment, you and your dependents that lose coverage may be eligible to elect COBRA coverage. Please note, however, that certain benefit options (e.g., life insurance) as well as HSAs are not COBRA covered benefits; however, even if some benefit options are not COBRA-covered benefits, they may be portable at the time that you would otherwise lose coverage. Please contact the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940 for more information.

How does Medicare Impact Your Coverage While on Long-Term Disability Leave?

If an employee has medical coverage under the Plan while receiving benefits under BNY Mellon's long-term disability plan, they will generally become eligible for Medicare after receiving Social Security Disability Insurance for 24 months (30 months if eligible on the basis of end-stage renal disease), and Medicare will become their primary coverage at that time, regardless of whether they enroll in Medicare Part B. There are separate rules that apply to the employee's dependents who are at least age 65 or otherwise entitled to Medicare. For additional details, please contact Accolade at 1-833-640-0427.

PART V: COVERAGE AND BENEFIT OPTIONS

What Are the Benefit Options?

The following benefit options may be available under the Plan:

- Medical care, including the Anthem Lower Deductible HSA Plan, the Anthem Higher Deductible HSA Plan, the Anthem Copay Plan , the Kaiser Permanente Plan (Los Angeles and San Francisco only), the HMSA Hawaii Plan (Hawaii only), the Aetna International Plan (International Expats only), Aetna Medical Advantage PPO (retirees only), and Aetna Transition Plan (retirees only)
- Dental Care, including Aetna DMO and MetLife PDP Options 1 and 2
- VSP Vision Care
- Life Insurance (Basic, Supplemental, Spouse/Qualified Domestic Partner, and Child(ren))
- Accidental Death and Dismemberment (Basic and Supplemental)
- Short-Term Disability (as a payroll practice)
- Long-Term Disability
- Employee Assistance Program ("EAP")

- General Purpose or Limited Purpose Legacy Health Reimbursement Account ("HRA") for participants previously enrolled in the Health Reimbursement Plan option, prior to January 1, 2019, with outstanding balances as of January 1, 2021[2]
- Health Care Flexible Spending Account
- Limited-Purpose Health Care Flexible Spending Account for participants enrolled in the Lower Deductible or Higher Deductible HSA Plan
- Dependent Care Flexible Spending Account
- Flex Vacation Purchase
- Wellbeing Program

Please note that these benefits as listed above can generally be offered separately or together, and can be comprised of a number of components. For more information, refer to the Reference Documents provided by the various insurers or providers specifically listed in Part III. These specific Reference Documents are incorporated herein by reference. Hard copies may be provided to you upon request from the BNY Mellon Benefit Solutions Service Center. You may also request a schedule of benefits for each benefit option by contacting the BNY Mellon Benefit Solutions Service Center. Please also note that certain Wellbeing Programs and activities are tools and, accordingly, are not intended to be, and are not, benefits offered under the Plan.

If you and/or your dependents have Medicare or will become eligible for Medicare in the next twelve (12) months, a Federal law gives you more choices about your prescription drug coverage (please see Appendix B).

What Is the Cost for Coverage?

The Company generally pays the full cost of coverage for the following benefit options:

- Basic life insurance coverage equal to your base salary (up to a maximum of $500,000),
- Basic "AD&D" insurance coverage equal to your base salary (up to a maximum of $500,000),
- Short-term disability (STD),
- Long-term disability (LTD) coverage equal to 60% of your base salary (up to a maximum of $300,000),
- Wellbeing Program (except that charges may apply for certain services at the onsite Health Centers), and
- Employee Assistance Program

You and the Company share the cost of some of your other benefits, such as your medical (see below for further details regarding medical coverage pricing) and dental coverage.

[2] For those enrolled in the Lower Deductible or Higher Deductible HSA Plan for 2021, the legacy Health Reimbursement Account will be a limited purpose legacy Health Reimbursement Account. For those not enrolled in the Lower Deductible or Higher Deductible HSA Plan or enrolled in one of these HSA Plans but ineligible to contribute to a HSA because of enrollment in any part of Medicare or Tricare, the legacy Health Reimbursement Account will remain a general purpose legacy Health Reimbursement Account. Both the limited purpose and general purpose legacy Health Reimbursement Accounts will be automatically closed when the balance reaches zero. Any balance remaining in a limited purpose or general purpose legacy Health Reimbursement Account upon the death of an employee participant will remain eligible for reimbursement of qualified medical expenses of his or her eligible surviving spouse and dependents.

You may purchase all remaining benefit options – vision, life (supplemental, spouse/qualified domestic partner, child), supplemental AD&D and long-term disability insurance and flex vacation – at your own expense.

The portion of the cost of medical coverage that is subsidized by the Company is based on a combination of the following factors: your base salary, the benefit option you elect and the number of eligible dependents you choose to cover. Generally, the lower your base salary, the more BNY Mellon contributes toward the cost of your medical coverage. Prior to your enrollment you are notified of the amount of your premium cost for coverage, and such premium information is also available on-line at MyBenefit Solutions.

All premium costs will automatically be deducted from your paycheck, unless you are in a job classification that requires you to make payments directly to BNY Mellon. Except for child and spouse/qualified domestic partner life insurance, which is paid for on an after-tax basis, costs for coverage under all other benefit options will generally be paid for on a pre-tax basis. However, if your dependent does not satisfy certain Federal tax dependency requirements (as described under "How Does Qualified Domestic Partner Coverage Work?"), the costs must be paid for on an after-tax basis and the value of BNY Mellon-sponsored benefits will be imputed to your income.

What Are Flexible Spending Accounts?

There are two types of Flexible Spending Accounts: Health Care and Dependent Care. By using these Accounts, you will be able to set aside money on a pre-tax basis to use for eligible expenses. Money you spend on qualified health care expenses and child care is ordinarily only partially tax deductible through tax credits. However, if you set aside money in a Flexible Spending Account, these dollars are truly tax free.

You never pay Federal, state (in most states) or Social Security taxes on them. The Health Care Flexible Spending Account may be a general-purpose or a limited-purpose account. You do not have to be covered under a BNY Mellon sponsored health plan to enroll in the Health Care and/or the Dependent Care Flexible Spending Account. However, if you are covered by an HSA Plan, you may only enroll in a limited-purpose Health Care Flexible Spending Account, not the general-purpose Health Care Flexible Spending Account. Please note that no actual account is established; a Flexible Spending Account is merely a bookkeeping entry. No interest is credited or earnings accrued under the account.

IMPORTANT! Set aside only as much money in your Flexible Spending Accounts as you intend to use each Plan Year. IRS regulations typically require that all money contributed to your Health Care and Dependent Care Flexible Spending Accounts must be used by the applicable account to pay for eligible expenses incurred during the Plan Year (or covered period) only, otherwise, your money is forfeited. However, there are special carryover rules for the 2021 Plan Year; see the Section titled "Carryover of Flexible Spending Account Contributions" for possible carryover of unspent funds in your Flexible Spending Account. Please note that under the Heroes Earnings Assistance and Relief Tax Act of 2008, "qualified reservist distributions" are permitted from the Health Care Flexible Spending Account for employees who are called to active duty for 180 or more days, or for an indefinite period of time. A qualified reservist distribution is a distribution of all, or a portion of, the balance in an employee's Health Care Flexible Spending Account that is made during the period that begins on the date of the order or call up and ends on the last day of the Plan Year that includes the date of such order or call up.

By using a Health Care and/or Dependent Care Flexible Spending Account to pay for some of your health care and/or dependent care expenses, you may pay less in federal and, in most cases, state taxes.

For example, assume you are married, have one child and your spouse is a student with no earned income. You and your spouse file a joint tax return for 2021. Your annual income is $75,000. Your estimated qualified health care expenses for the Plan Year are $2,400. Using a Health Care Flexible Spending Account to pay for those expenses would affect your taxable income and net pay as follows.

	WITH A HEALTH CARE FLEXIBLE SPENDING ACCOUNT	WITHOUT A HEALTH CARE FLEXIBLE SPENDING ACCOUNT
Annual Income	$75,000	$75,000
Amount Contributed to Health Care Flexible Spending Account	($2,400)	0
W-2 Gross Wages	**$72,600**	**$75,000**
Standard Deduction	($25,100)	($25,100)
Taxable Income	**$47,500**	**$49,900**
W-2 Gross Wages	**$72,600**	**$75,000**
Federal Income Tax	($5,308)	($5,596)
FICA	($5,554)	($5,738)
After-Tax Health Care Expenses	$0	($2,400)
Take Home Pay After Taxes and Health Care Expenses	**$61,738**	**$61,266**

By using a Health Care Flexible Spending Account, in this example, you would pay $288 less in Federal income taxes and $184 less in FICA taxes.

Before establishing a Dependent Care Flexible Spending Account for a Plan Year, you should determine whether the Federal tax credit for dependent care assistance would result in greater tax savings because of your individual circumstances. Generally, the tax credit is available in lieu of a Dependent Care Flexible Spending Account. Individual tax situations vary. You should consult your personal tax advisor and IRS Publication 17 "*Your Federal Income Tax*" and Publication 503 "*Child and Dependent Care Expenses*" to determine whether the tax credit or a Dependent Care Flexible Spending Account is best for you.

Please note:

- If you decide to participate in the Health Care and/or the Dependent Care Flexible Spending Account, you may not use amounts in the Health Care Flexible Spending Account to pay dependent care expenses and vice versa. **Amounts cannot be transferred between a Health Care Flexible Spending Account and a Dependent Care Flexible Spending Account.**
- **You must submit claims no later than June 30 following the end of the Plan Year in which expenses were incurred.** For example: You have until June 30, 2022, to submit claims that you *incurred* in the 2021 Plan Year.
- If your employment with BNY Mellon ends, your participation in the Health Care and/or the Dependent Care Flexible Spending Account will end on the last day of the month in which your employment with BNY Mellon ends. You may, however, be able to continue your Health Care Flexible Spending Account under COBRA (see "COBRA Rights Notice" in Appendix D).
- **Any money not claimed within the applicable deadlines, as described above, may be forfeited, subject to a possible carryover of unspent funds as described in the Section titled "Carryover of Flexible Spending Account Contributions".**

When you enroll, you decide how much to set aside in one or both of the Flexible Spending Accounts. The amount you designate is deducted from your paycheck. As you incur eligible expenses, you request reimbursement from the money you have set aside. As a general rule, you must have received the service/product before you can be reimbursed. To receive reimbursement, you may submit claim

information on-line at MyBenefit Solutions or you can submit paper claims by mail or fax along with supporting documentation.

If your Health Care Flexible Spending Account is not a limited purpose account, and if the provider of services accepts, you may use the "Your Spending Account" debit card to pay for eligible expenses at the time of service. Debit card purchases are only permitted at merchants that comply with the Inventory Information Approval System ("IIAS"). A list of such merchants is available at www.sigis.com.

If payment is issued directly to the provider by means of the debit card, then you must retain documentation that verifies the charges were for eligible expenses. Annual audits are conducted to verify such expenses. If you receive a request to provide such verification of the charges and you cannot substantiate the charges as legitimate and eligible expenses, then you will be required to reimburse all unsubstantiated claims previously paid on your behalf.

If your Health Care Flexible Spending Account is a limited purpose account, a debit card will not be available for your use. Instead, you will be required to submit receipts for reimbursement to MyBenefit Solutions.

Claims will be processed as soon as administratively practicable and in the order in which they are received. For purposes of the Health Care Flexible Spending Account only, upon submission of a claim for eligible expenses, you will be reimbursed the full amount of your eligible expenses up to your elected Health Care Flexible Spending Account pre-tax deferral amount for that Plan Year, *plus* any carryover from the preceding Plan Year (see below), *less* prior reimbursements, regardless of whether you have made the full amount of pre-tax deferrals for the year. For example, assume that you establish a Health Care Flexible Spending Account of $1,200 for the Plan Year and submit a bill in the amount of $1,200 in the first month of the Plan Year. Even though you have only contributed $100 to your Health Care Flexible Spending Account, you will be reimbursed the full $1,200, subject to your $1,200 maximum Plan Year election. Future contributions to your Health Care Flexible Spending Account will continue to be made as usual for the remainder of the Plan Year.

Claims submitted to your Dependent Care Flexible Spending Account will only be reimbursed up to your Account balance as of the date the claim is received. You must have accumulated a sufficient credit balance in your Dependent Care Flexible Spending Account in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent weeks as more dollars are contributed from your pay to your Dependent Care Flexible Spending Account. For example, assume that you submit a bill in the amount of $300 in the first month of the Plan Year, and you have only contributed $250 to your Dependent Care Flexible Spending Account. You will be reimbursed $250, with the remaining $50 reimbursed after you have contributed an additional $50 to your Dependent Care Flexible Spending Account.

Expenses Eligible for Reimbursement from a General Purpose Health Care Flexible Spending Account

The Health Care Flexible Spending Account allows you to set aside money for reimbursement of qualified health care expenses, such as medical, dental or vision deductible, co-payments, or other out-of-pocket expenses incurred during the Plan Year. These out-of-pocket expenses may be for you or any of your eligible tax dependent(s). Drugs and medications, even if over-the-counter, and menstrual care products are also eligible for reimbursement.

For a complete list of eligible expenses, consult your personal tax advisor. You can also see IRS Publication 502 "Medical and Dental Expenses" for further guidance as to what expenses are eligible for reimbursement under a Health Care Flexible Spending Account. You can contact the IRS at (800) 829-FORM for the Publications or visit the IRS's web site at www.irs.gov/forms-pubs.

Limited-Purpose Health Care Flexible Spending Account and HSA Coordination

If you are covered by an HSA Plan, you may not enroll in the general-purpose Health Care Flexible Spending Account described above. You may, however, enroll in a limited-purpose Health Care Flexible Spending Account. If you do enroll in either the Lower Deductible HSA Plan or Higher Deductible HSA

Plan and a limited-purpose Health Care Flexible Spending Account, you must first meet the HSA Plan's applicable deductible before using your limited-purpose Health Care Flexible Spending Account for eligible medical expenses. In addition, you will be unable to use the FSA debit card for payment of eligible health care expenses and instead will be required to submit reimbursement requests. The limited-purpose Health Care Flexible Spending account may be used for the reimbursement of eligible vision, dental, preventive drugs and out-of-network preventive care benefits; and after meeting the applicable deductible for the HSA plan, other qualified health care expenses. If you choose to enroll in a limited-purpose Health Care Flexible Spending Account, you may not change your election to a general-purpose Flexible Spending Account, or vice versa, in the same Plan Year.

If you choose not to enroll in the Lower Deductible HSA Plan or Higher Deductible HSA Plan, your limited purpose Health Care Flexible Spending Account, if any, will automatically become a general-purpose Health Care Flexible Spending Account. In such case, you may continue to maintain your Health Savings Account, but you may not contribute to it.

Expenses Eligible for Reimbursement from a Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account allows you to set aside money for reimbursement of expenses you incur to obtain care for a child or other dependent. The care must be provided by a person or entity that can provide a name, address and taxpayer ID number – otherwise the expenses are not eligible.

You may only be reimbursed for expenses incurred for the care for qualifying individuals, as defined in accordance with Code Section 21(b)(1), to enable you (and your spouse, if you are married) to be gainfully employed, which generally means you are either working or looking for work. Eligible expenses may include:

- preschool or other day care for your children under age thirteen (13);
- preschool or other day care for your children under age fourteen (14) (rather than age thirteen (13)) with respect to any unspent funds carried over from the 2020 Plan Year to the 2021 Plan Year; provided, however, this change from age thirteen (13) to age fourteen (14) only applies for children who turn thirteen (13) in 2020 or 2021 and for expenses incurred while the child is under age fourteen (14);
- in-home or day care for dependents who are physically or mentally not able to care for themselves;
- care provided by a dependent care center (i.e., a facility that provides care for more than six (6) persons not residing there), provided the center complies with all applicable state and local laws and regulations; and
- care provided by a relative, however, amounts paid to the following are not eligible expenses: (1) an individual for whom you or your spouse are entitled to a personal tax exemption as a dependent, (2) your child who is under age nineteen (19) at the end of the year, even if the child is not your tax dependent, (3) a person who was your spouse any time during the year, or (4) the parent of your qualifying individual, if the qualifying individual is your child under the age of thirteen (13) (or fourteen (14), as applicable).

To be eligible for reimbursement, the expenses must be incurred for services rendered after the date you elect to establish the Dependent Care Flexible Spending Account and during the Plan Year to which your election applies.

Generally, a "qualifying individual" is:

- your child under age thirteen (13) (or fourteen (14), as applicable);
- your spouse or other Federal tax dependent who is physically or mentally incapable of caring for himself or herself and who shares your principal place of abode for more than half of the year.

A dependent child that turns age thirteen (13) (or fourteen (14), as applicable) will be covered through the end of that month. At that time, you may modify your election to account for the dependent who loses eligibility, or terminate enrollment in the Dependent Care Flexible Spending Account entirely, if that is the only child currently being covered.

You should consult your personal tax advisor and IRS Publication 17 "*Your Federal Income Tax*" and Publication 503 "*Child and Dependent Care Expenses*" for further guidance as to what expenses are eligible for reimbursement under a Dependent Care Flexible Spending Account. You can contact the IRS at (800) 829-FORM for the Publications or visit the IRS's web site at https://www.irs.gov/forms-instructions.

Dependent Care Flexible Spending Account Contribution Limits

You decide how much money you want to set aside each year. If you choose to elect coverage under a Dependent Care Flexible Spending Account, certain minimum and maximum contribution amounts apply.

If you choose to enroll in the Dependent Care Flexible Spending Account, you must elect to contribute a minimum of $60 annually. The maximum amount you may contribute to the Dependent Care Flexible Spending Account is normally the lesser of: (1) $5,000 annually ($2,500 if you are married and do not file a joint tax return with your spouse), or (2) your earned income or, if applicable, your spouse's earned income. However, please note the following:

- The American Rescue Plan Act increased the Dependent Care Flexible Spending Account contribution limit from $5,000 to $10,500 ($5,350 if you are married and do not file a joint tax return with your spouse) for 2021. It is not anticipated that this increase will remain in effect for the 2022 Plan Year.

- The IRS has requirements for Dependent Care Flexible Spending programs which place limits on the benefits highly compensated employees can receive under the Dependent Care FSA as compared to benefits non-highly compensated employees receive. If the benefits provided to highly compensated employees exceed this limit, benefits to highly compensated employees under the Dependent Care FSA may become taxable as imputed income. **According to the IRS, a highly compensated employee for the 2021 Plan Year is any employee whose total pay was greater than $130,000 in 2020. Total pay includes, by way of illustration and not limitation, items such as bonuses, commissions, overtime and shift differential. Highly compensated employees should consider the potential impact of 2021 imputed income before increasing contributions.**

Please note, with exception for the 2021 Plan Year as described above, the IRS limits the amount employers can exclude from an employee's income for dependent care assistance to $5,000. This limitation applies both to your contributions to BNY Mellon's Dependent Care Flexible Spending Account and to the value of childcare services, if any, provided by BNY Mellon. The value of childcare services you use through this program will be added to your contributions to the Dependent Care Flexible Spending Account to determine if you have exceeded the limit. If so, the excess will be reported as wages and will be subject to income and payroll taxes.

With the exception of the 2021 Plan Year (see the Section entitled "Carryover of Flexible Spending Account Contributions"), you will automatically forfeit any money left in your Dependent Care Flexible Spending Account at the end of the period for filing claims for the Plan Year (i.e., June 30th following the end of the Plan Year).

For additional information, call the IRS at 1-800-TAX-FORM (800-829-3676), or visit the IRS's web site at https://www.irs.gov/forms-instructions.

Health Care Flexible Spending Account Contribution Limits

You decide how much money you want to set aside each year. If you choose to elect coverage under a Health Care Flexible Spending Account, certain minimum and maximum contribution amounts apply.

If you choose to enroll in the Health Care Flexible Spending Account, you must elect to contribute a minimum of $60 annually or $5 monthly. The maximum amount you may contribute to the Health Care Flexible Spending Account (whether a general-purpose or limited-purpose account) is $2,750 annually or, if less, your earned income for the applicable Plan Year.

With the exception of the carryover described in the Section entitled "Carryover of Flexible Spending Account Contributions," you will automatically forfeit any money left in your Health Care Flexible Spending Account at the end of the period for filing claims for the Plan Year (i.e., June 30th following the end of the Plan Year).

For additional information, call the IRS at 1-800-TAX-FORM (800-829-3676), or visit the IRS's web site at https://www.irs.gov/forms-instructions.

Carryover of Flexible Spending Account Contributions

Ordinarily, you can carry over up to $550 in unspent amounts in your Health Care Flexible Spending Account from one Plan Year to the next Plan Year. However, for 2021, you can carry over your entire unspent amounts in your Health Care and Dependent Care Flexible Spending Accounts from the 2021 Plan Year to the 2022 Plan Year, subject to the following rules. If you have amounts remaining in your Health Care and/or Dependent Care Flexible Spending Accounts after the 2021 Plan Year ends (i.e., December 31, 2021) and are eligible to participate in the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account, as applicable, in the next Plan Year, then your Account(s) will automatically be credited with a carryover of the entire unspent amounts once the administrative processing period completes. It is anticipated that the 2022 Plan Year will return to the normal carryover limit of $550 for your Health Care Flexible Spending Account and $0 for your Dependent Care Flexible Spending Account. You will have until June 30, 2022 to claim reimbursement for eligible expenses incurred during 2021.

Current year contribution amounts will first be applied toward reimbursements of any eligible expenses, before carryover amounts are used.

Please note, if you enroll in the Lower Deductible HSA or Higher Deductible HSA Plan, any carry-over amounts in your general purpose Health Care Flexible Spending Account will be made available through a Limited-Purpose Health Care Flexible Spending Account.

General Purpose and Limited Purpose Legacy Health Reimbursement Account

If you had a legacy Health Reimbursement Account balance outstanding as of January 1, 2021, then that balance remains available for use based on the following rules:

YOUR STATUS	ON JANUARY 1, 2021 YOUR LEGACY HRA is
✓ You enrolled in either the Lower Deductible HSA Plan or Higher Deductible HSA Plan for 2021, and ✓ You are not enrolled in any part of Medicare or TRICARE	**A Limited Purpose Legacy Health Reimbursement Account** ✓ Remaining balances can be used to pay for eligible dental, vision, preventive drug, and out-of-network preventive care expenses, and (after the deductible is met) other qualified health care expenses
✓ You did not enroll in a BNY Mellon health care plan for 2021, or ✓ You enrolled in the Lower Deductible HSA Plan or Higher Deductible HSA Plan for 2021, but cannot contribute to a Health Savings Account because of enrollment in any part of Medicare or TRICARE	**General Purpose Legacy Health Reimbursement Account** ✓ Remaining balances can be used to pay for qualified health care expenses

You will be unable to use your Health Reimbursement Account debit card for payment of eligible health care expenses and instead you will be required to submit your receipts for reimbursement to MyBenefit Solutions. Please contact 1-855-354-6940 for information on submitting reimbursement claims.

Qualified long term care services are not eligible for reimbursement from the General Purpose or Limited Purpose legacy Health Reimbursement Account under any circumstance.

You may not be reimbursed for any expenses incurred before you became a participant in the legacy Health Reimbursement Account, or for any expenses incurred after your participation in the legacy Health Reimbursement Account terminates, except to the extent you are eligible for and elect to continue coverage under COBRA (in which case you may submit claims for expenses incurred though the date that your COBRA coverage ends), or are at or over the age of 55 when you leave BNY Mellon. If you lose coverage under the legacy Health Reimbursement Account and you are eligible to elect COBRA continuation coverage, you may have to pay the applicable COBRA premium including administrative expenses for the continued coverage.

When Does My Coverage Under the Limited Purpose or General Purpose Legacy Health Reimbursement Account End?

Generally, your coverage under the limited purpose and general purpose legacy Health Reimbursement Account will end upon the earliest of one of the following events:

- the date that your legacy Health Reimbursement Account balance has been exhausted; or
- if you leave BNY Mellon for any reason before the age of 55, the last day of the month in which your employment terminates, or the last day of the month in which you are receiving transition/separation pay pursuant to the Company's then existing applicable transition/separation pay policy, program or arrangement as determined by the Company for transition/separation pay, if later, even if you have a balance remaining in your legacy Health Reimbursement Account at such time, unless you or your eligible spouse or dependents elect COBRA; or
- the date of your death in which case your estate may be reimbursed for qualified medical expenses incurred prior to the date of your death regardless of whether you have a surviving spouse or other surviving dependent(s); in addition, if you have a benefits eligible surviving spouse and/or benefits eligible surviving dependent(s), they may be reimbursed for their qualified medical expenses for the remaining legacy Health Reimbursement Account balance until the earlier of the exhaustion of the legacy HRA balance, or they are all deceased.

An eligible dependent's coverage for the legacy Health Reimbursement Account will generally end upon the earliest of any one of the following:

- when your (as the eligible employee) coverage ends;
- the date your dependent ceases to meet the eligibility requirements; or
- the date of the dependent's death.

If you leave BNY Mellon for any reason before the age of 55, your legacy Health Reimbursement Account balance is forfeited, unless you continue the Lower Deductible HSA Plan, the Higher Deductible HSA or the Copay Plan coverage through BNY Mellon under COBRA in which case you may submit claims for expenses incurred though the date that your COBRA coverage ends. If you terminate employment with BNY Mellon before the age of 55 and do not elect COBRA continuation coverage, you may submit claims for expenses incurred through the end of the month in which you left. If you are at or over the age of 55 when you leave BNY Mellon, your legacy Health Reimbursement Account balance remains available for use as described in the chart above.

What Is a Health Savings Account (HSA)?

A Health Savings Account or "HSA" is a savings account established and maintained by BenefitWallet to allow you—if you elect (or have elected) to participate in the Lower Deductible HSA Plan or Higher Deductible HSA Plan--to save and pay for "qualified eligible medical expenses," as set forth in Code Section 223. The Health Savings Account is an independent component of the cafeteria portion of the Plan to allow for pre-tax contributions made on your behalf to the Health Savings Account. Notwithstanding the foregoing, the Health Savings Account is not intended to be, and is not, an ERISA-covered benefit and is not otherwise part of the Plan. BNY Mellon neither sponsors, nor maintains the Health Savings Account. You should contact BenefitWallet for further details regarding your Health Savings Account.

You must be enrolled in either the Lower Deductible HSA Plan or Higher Deductible HSA Plan to be eligible for Health Savings Account contributions on your behalf. Contribution limits differ depending on your coverage option election. Pre-tax contributions to your Health Savings Account cannot be made if you are on long-term disability, retired or on COBRA, and you will be ineligible to receive BNY Mellon's automatic contributions or earn Wellbeing Points Program contributions. You will, however, be able to make direct after-tax contributions to your Health Savings Account instead. You may then seek a Federal income tax deduction for these amounts.

Once you enroll in Medicare Part A, Part B and/or Part D coverage, you will no longer be eligible to contribute to a Health Savings Account. **To the extent that contributions are made to your Health Savings Account 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 Health Savings Account, then you should not apply for Medicare, Social Security, Tricare, or Railroad Retirement Board (RRB) benefits. However, if you are ineligible for BNY Mellon's automatic contribution or a Wellbeing Points Program contribution (see below) solely because of your enrollment in Medicare or Tricare, you will receive the amounts as a taxable payment and may still elect medical coverage under the Lower Deductible HSA Plan or the Higher Deductible HSA Plan. If your Medicare coverage has commenced at the time that you decide you would like to continue your Health Savings Account contributions, then you may be subject to an obligation to repay the Federal government for the costs of any benefits you have received in order to opt out of Medicare and remain Health Savings Account-eligible. It is important to note that premium-free Medicare Part A coverage takes effect retroactively up to six (6) months prior to the date that you apply for Medicare (or Social Security/RRB benefits), but no earlier than the first month that you become eligible for Medicare. To avoid complications such as the potential tax penalties and reimbursement obligations discussed above, you should consider discontinuing contributions to your Health Savings Account six (6) months in advance of your qualifying retirement age. For more information regarding Medicare eligibility and how it affects your Health Savings Account, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

Health Savings Account contributions are subject to annually-adjusted limits set by the IRS, and are prorated for the number of months in which you qualify as a Health Savings Account-eligible individual. BNY Mellon will make automatic contributions to your Health Savings Account in January up to the amounts specified in the chart below. You may elect to contribute the difference in lump-sum or through semimonthly payroll deductions. Lump-sum contributions are made on an after-tax basis directly through BenefitWallet. For eligible employees who enroll mid-Plan Year, BNY Mellon's annual allocation will be pro-rated for any partial year of participation.

Please refer to your BenefitWallet materials for further details.

Coverage Level	**Maximum Annual Contribution** (as determined under Code Section 223)	**BNY Mellon Annual Contribution** (automatic, tiered to base salary)		**Your Maximum Annual Contribution** (voluntary)
Employee Only	**$3,600**	Under $30,000	$700	$2,900
		$30,000-$39,999	$600	$3,000
		$40,000-$49,999	$500	$3,100
		$50,000-$79,999	$400	$3,200
		$80,000 and above	$200	$3,400
Employee + Spouse/Qualified Domestic Partner **Employee + Child(ren)** **Employee + Family**	**$7,200**	Under $30,000	$1,400	$5,800
		$30,00-$39,999	$1,200	$6,000
		$40,000-$49,999	$1,000	$6,200
		$50,000-$79,999	$800	$6,400
		$80,000 and above	$400	$6,800

In addition to the voluntary contribution amounts described above, you may make an additional "catch-up" contribution of up to $1,000 annually if you are age 55 or older in the applicable calendar year.

Please note: Health Savings Account maximum annual contribution limits include all contributions deposited to your account, including BNY Mellon contributions, Wellbeing Points Program contributions as described in the following paragraph and amounts you contribute through payroll and/or lump sum deposits to your account.

You and your covered spouse/qualified domestic partner may earn up to $600 each ($150 per calendar quarter) in additional contributions to your Health Savings Account by participating in a variety of activities as part of the Wellbeing Points Program during the period from January 1 through December 31, 2021. See "What is the 2021 Wellbeing Points Program (formerly the 2021 Wellbeing Rewards Program)" below for eligibility and details on each activity. These Wellbeing Points Program contributions also count toward your maximum annual contribution limits.

Wellbeing Points Program activities include:

FOR EMPLOYEES AND SPOUSES/DOMESTIC PARTNERS	FOR EMPLOYEES ONLY

• Get a biometric screening
• Complete a MyPulse survey
• Participate in these programs:
  ○ Accolade Condition/Disease Management
  ○ Journeys Digital Health Coaching
  ○ Health Coaching through an onsite Health Center
  ○ Healthy habit and activity tracking
  ○ Teladoc Expert Medical Opinion (formerly Best Doctors)
  ○ Accordant Health Services
  ○ Transform Care—Diabetes Management Program
  ○ Sleepio
  ○ meQuilibrium
	• Ayco financial education and planning
	• Set your 401(k) Plan contribution savings rate to automatically increase annually
	• Voya Retirement Advisor Online Advice, powered by Financial Engines, accessible on the 401(k) Plan website

For more information about each activity and how to earn contributions, please log in using single sign-on through MyReward or visit https://hr.bnymellon.com/wellbeing from home.

It is your responsibility to monitor your Health Savings Account contributions during the year to ensure that you do not exceed the maximum IRS contribution limit in a particular year. If your total Health Savings Account contributions (including your own post-tax contributions, pre-tax payroll contributions, Wellbeing Points Program contributions and BNY Mellon contributions) exceed the applicable IRS limit, you may withdraw the excess without penalty until the deadline (including extensions) for filing your Federal tax return for the tax year for which the excess contribution was made. After that time, the excess contributions are subject to both income taxes and an excise tax.

BNY Mellon currently pays the monthly BenefitWallet Health Savings Account checking account fee and, if you choose to use the BenefitWallet Health Savings Account investment platform, the monthly investment fee of $2.90 if (i) you are enrolled in Lower Deductible or Higher Deductible HSA Plan, and (ii) you are either actively employed, receiving transition/separation pay from BNY Mellon pursuant to The Bank of New York Mellon Corporation Supplemental Unemployment Benefit Plan or under the terms of any other written transition/separation plan, policy, program or agreement with BNY Mellon governing the separation of employment from BNY Mellon (unless otherwise provided in such plan, policy, program or agreement), or are covered by BNY Mellon's long-term disability benefits. However, if your employment with BNY Mellon is terminated and you are not covered by BNY Mellon's long-term disability benefits or receiving any such transition/separation pay (as determined by BNY Mellon), your Health Savings Account will be charged the monthly checking account fee of $3.25, as well as the additional monthly investment fee of $2.90 if you continue to use the investment option (such fees are subject to change by BenefitWallet). BNY Mellon may determine, in its sole discretion, to discontinue payment of these fees in future Plan years.

The cafeteria plan component provides for additional flexibility with respect to when you can change your

Health Savings Account contribution election. You may increase, decrease or revoke your Health Savings Account contribution election monthly throughout the year, provided all changes are made prospectively. Any election change will be effective as soon as administratively practicable, but normally no later than the first day of the next calendar month following the date you submit your election change request.

Wellbeing Program

The Wellbeing Program is a confidential, voluntary health management and benefits program comprised of a variety of voluntary options and activities, including the programs listed below and certain tools. The components that are tools are not intended to be, and are not, benefits offered under the Plan. Wellbeing resources are delivered by leading health care companies, including Anthem, Accolade (for Condition Management), CVS, Virgin Pulse, Teladoc Medical Experts, the Employee Assistance Program (EAP), Premise Health, Ayco, Sleepio, Transform Diabetes Care Program (Livongo), Voya and meQuilibrium (each a "Wellbeing Vendor," and collectively, the "Wellbeing Vendors").The Wellbeing Program is often offered at no additional cost to you (NOTE: if you are enrolled in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan, you will be responsible for the cost of most services at the onsite Health Centers, which are operated by Premise Health).

The following Wellbeing Programs are available to you in accordance with the terms of the applicable program:

- **Virgin Pulse** is available to all employees and covered spouses/domestic partners to track healthy activities (with a synced fitness device), engage in digital coaching, create and join challenges, get personalized tips and more.
- **Teladoc Medical Experts** is available to all benefits eligible employees and eligible family members (including parents and parents-in-law) to receive doctor and specialist recommendations, information, consultation, and a second opinion regarding diagnosis and treatment and referral services if you need help with a medical decision.
- **Beacon Health Options Employee Assistance Program (EAP)** is available to all employees and their eligible dependents (and other household members) to obtain free and confidential services intended to help manage work and personal responsibilities. Through Beacon Health Options EAP, you have access to telephone consultation, in-person counseling, customized research services and a broad array of educational resources. Each individual covered under the EAP, including you and your eligible dependents (and other household members), can meet with a professional near work or home for up to five free sessions per type of counseling service (as determined by Beacon) per calendar year.
- Onsite Health Centers operated by **Premise Health** ("Health Centers") are available for all employees enrolled in medical coverage, whether through the Plan or otherwise at BNY Mellon Center in Pittsburgh, 240 Greenwich Street in New York, and One Pershing Plaza in Jersey City. If you are enrolled in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan, IRS rules require that you pay the "fair market cost" of care at the Health Centers; however, all preventive services are free of charge. If you are a benefits eligible employee who is not enrolled in the Lower Deductible Plan or Higher Deductible HSA Plan, services at the Health Centers are generally available at no additional cost, with the exception of physical therapy and certain lab services. To schedule a Health Center appointment, please visit mypremisehealth.com.
- **Anthem's LiveHealth Online** is available to employees and their eligible dependents who are enrolled in the Anthem Higher Deductible HSA, Lower Deductible HSA or Copay Plan. This program offers 24-hour access to a national network of board-certified doctors and licensed professionals. Through HIPAA-compliant video consultations using your computer or mobile device with a front-facing camera, you can contact board-certified doctors who can diagnose your condition, treat it and write prescriptions to manage common health problems. In addition, behavioral health counseling is available by appointment with licensed professionals. You can register at livehealthonline.com. Your cost for LiveHealth Online services will be as provided under your medical plan.
- **Sleepio**. Getting a good night's sleep is essential to your health. Sleepio is a digital sleep improvement program you can access any time at your convenience, on your computer, tablet or phone. Available to all employees and, only if covered under the Plan, spouses/domestic partners.

- Start by taking a simple, online quiz, which provides a sleep score and tips you can try immediately.
- Over time, you will be taught techniques to improve your sleep using Cognitive Behavioral Therapy (CBT) to help quiet your mind and overcome negative emotions that can cause insomnia.
- You will receive access to a library of articles and guides to help you deal with common problems such as difficulty sleeping during pregnancy, jet lag, shift work and menopause.

- **meQuilibrium Stress Management and Resiliency Program.** meQuilibrium is a stress management app designed to help you feel more resilient and focused on what is most important to you. Available to all employees and dependents over the age of 18.
  - Start by enrolling and completing a 10- to 15-minute assessment that leads to immediate insights into stress patterns, thinking patterns and lifestyle habits that can cause you to feel overwhelmed.
  - You will then be guided step-by-step through an activities-based program of videos and activities to learn new skills.
  - When you download the free meQuilibrium app, you will receive daily stress-fighting tips, whenever and wherever you need them.
- **Additional Programs for Covered Employees and Covered Dependents Under the Anthem Lower or Higher Deductible HSA Plan or Copay Plan.** If you are enrolled in the Anthem Lower Deductible HSA Plan, Higher Deductible HSA Plan or Copay Plan through BNY Mellon, the following additional programs are available to you and your covered dependents as a part of that medical plan:

  CVS Caremark AccordantCare Health Services. This program is a voluntary, no-cost service that offers you and your covered dependents with one of nineteen complex and chronic conditions (as listed below) the opportunity to work with CVS Health Care Management Nurses to help obtain care and get answers to questions about health concerns. A team of nurses can answer your questions about special health concerns and help you notice health risks and concerns early, know when to call your doctor and understand your doctor's plan of care, get screenings, find reliable resources and keep you motivated to stay well. CVS Caremark Accordantcare™ Health Services covered conditions include the following: Amyotrophic lateral sclerosis (ALS) – Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) – Chronic Kidney Disease – Crohn's disease – Cystic fibrosis – Dermatomyositis – Epilepsy – Gaucher disease – Hemophilia – HIV – Multiple sclerosis – Myasthenia gravis – Parkinson's disease – Polymyositis – Rheumatoid arthritis – Scleroderma – Sickle cell disease – Systemic lupus erythematosus – Ulcerative colitis.

  The Transform Diabetes Care program (Livongo) offers those dealing with diabetes convenient ways to help manage their care and simplify living with the disease. Individuals and their covered family members age 18 or older who qualify for program services will be contacted directly by CVS Caremark. Minors age 13 and older can be enrolled by an adult parent or caregiver. Participants receive 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. Livongo's smart analytics program provides predictive and personalized insights. Participants receive real-time virtual coaching and help managing glucose levels from Livongo's Certified Diabetes Educators.

What is the 2021 Wellbeing Points Program (formerly the 2021 Wellbeing Rewards Program)?

The 2021 Wellbeing Points Program is a component of the Wellbeing Program comprised of a variety of completely voluntary options.

All benefits eligible employees are eligible to participate in most of the 2021 Wellbeing Points Program activities; however, only those active employees covered under the BNY Mellon sponsored Lower Deductible or Higher Deductible HSA Plan through Anthem, and their covered spouses/qualified domestic partners (in most cases), can earn incentives, generally in the form of Wellbeing Points Program contributions to their Health Savings Accounts.

Eligible employees and their covered spouses/qualified domestic partners can earn up to $600 ($150 per calendar quarter) each in contributions to their Health Savings Account by participating in a variety of program activities during the program period from January 1 through December 31, 2021. Generally, both you and your spouse/qualified domestic partner can separately earn the specified Wellbeing Points Program contributions, unless a participation exclusion is specified below or in the materials specific to that program option.

Pre-65 retirees, employees on long-term disability, former employees receiving transition/separation pay (but see below for additional provisions regarding timing of incentive distributions), COBRA participants and employees enrolled in the Anthem Copay Plan, Kaiser, HMSA Hawaii and Aetna International health plans along with their covered spouses/qualified domestic partners are not eligible to receive rewards/contributions, but may still participate in many of the Wellbeing Points Program activities.

IRS rules prevent active employees enrolled in any part of Medicare (including Part A, Part B, or Part D

Prescription Drug, etc.) or TRICARE from making or receiving contributions to a Health Savings Account. Wellbeing Points Program contributions for these groups will be paid through payroll on a taxable basis.

Wellbeing Points Program: How to Earn

The Wellbeing Points Program is an annual, year-long program. Employees and their covered spouses/domestic partners can earn up to $600 ($150 per calendar quarter maximum) each by earning points and achieving levels. You earn points for participating in a variety of everyday activities that support your wellbeing, such as being physically active and managing stress or one-time activities such as a biometric screening. All activities have an assigned point value that help you achieve different levels and a complete list of activities is available on Virgin Pulse (www.join.virginpulse.com/bnymellon).

- Level 1 (1,000 points) = $25
- Level 2 (5,000 points) = $35
- Level 3 (10,000 points) = $45
- Level 4 (15,000 points) = $45

If the full $150 is not earned for a particular quarter, it cannot be earned in a later quarter. Each quarter, the opportunity to earn $150 restarts.

Most points are earned in real-time, although some activities may take up to 4 weeks to be reflected.

For each level achieved in a month, the corresponding Health Savings Account Reward contribution will be deposited at the end of the following month, up to $150 each quarter.

All Wellbeing Points Program contributions are payable beginning in February 2021. Employees must be active or receiving transition/separation pay from BNY Mellon (and on BNY Mellon payroll), at the time of incentive distribution in order to receive the incentive, regardless of when the incentive was earned. Employees who are receiving transition/separation pay from BNY Mellon are not eligible to participate in the Wellbeing Points Program effective as of their separation date; however, any Wellbeing Points Program contributions for any activities completed before their separation date are eligible for contribution if they are receiving transition/separation pay from BNY Mellon at the time of incentive distribution.

Alternative Means to Earning Wellbeing Points Program Contributions

Incentives for participating in the 2021 Wellbeing Points Program are generally available to all employees and their Spouses/Qualified Domestic Partners (in most cases) who are covered under the BNY Mellon-Mellon sponsored Lower Deductible HSA Plan or Higher Deductible HSA Plan through Anthem. If you think you might be unable to meet a standard or activity for an incentive under this Wellbeing Points Program, you might, in many cases, qualify for an opportunity to earn the same incentive by different means. Contact Virgin Pulse at 1-888-671-9395 between 8 a.m. and 9 p.m. ET Monday – Friday and they will work with you (and, if you wish, with your physician) to find an alternative means for you to earn the same incentive in light of your health status.

Wellbeing Points Program Claim Procedures

If you believe that you have fully completed a rewardable activity, but did not earn the applicable incentive, you may file a claim after following these steps:

1. Be sure that your incentive points related to your activities have had enough time to be reflected in your account. Remember that completion of some activities takes up to four (4) weeks before points are posted to your account.
2. Check the 'myrewards' statement on Virgin Pulse and review your Benefit Wallet account to confirm whether your activities/incentives have been captured. Points earned in one month are payable at the end of the following month.
3. Contact Virgin Pulse customer support at support@virginpulse.com or 1-888-671-9395 and have Virgin Pulse review your account.

If, after you have gone through the above steps, you believe there is still an issue, contact wellbeing@bnymellon.com to request a "Claim Initiation Form." All rewardable activities/incentives for the 2021 Wellbeing Points Program must be filed by February 28, 2022.

Disclaimer: Wellbeing Program Not Endorsed By BNY Mellon

While BNY Mellon make the Wellbeing Program services, options and activities available to its eligible employees and eligible dependents, BNY Mellon does not endorse, review or recommend any program, provider, physician, specialist or facility, nor any advice, recommendation or treatment given or prescribed. Should you elect to utilize any of the services, options or activities provided by any of the Wellbeing Vendors, you are solely responsible for any outcomes, advice and/or treatment resulting therefrom. In addition, if you elect to utilize any of such services, options or activities, you may be asked by the Wellbeing Vendor to provide personal information. This information is collected by the Wellbeing Vendor and is not shared with BNY Mellon. The Wellbeing Vendors are responsible for the safekeeping and use of your information in accordance with their privacy policies. BNY Mellon does not assume any liability for your utilization of any of the Wellbeing Vendor's services, options or activities, and by using such services, options or activities you agree not to hold BNY Mellon liable for such utilization. BNY Mellon is not affiliated with any of the Vendors and BNY Mellon receives no consideration (monetary or otherwise) from the Wellbeing Vendors in connection with their services, options or activities (other than Premise Health that pays rent in certain locations).

Disclaimer: Privacy Policy of Wellbeing Vendors

Our Wellbeing Vendors have agreed to preserve the privacy of your personal health information in compliance with HIPAA. To the extent that any personal health information is disclosed to BNY Mellon, BNY Mellon will take appropriate measures to protect the privacy of your health information consistent with the policies described in our 2021 HIPAA Notice of Privacy Practices and the Health Wellbeing Program Privacy Notice (found in Appendices B and C).

Under the Wellbeing Points Program and other Wellbeing Programs, we offer services and activities of selected third-party vendors. Each of these vendors is independent of BNY Mellon and the Plan. BNY Mellon does not control, and is not responsible for, their privacy practices. If you choose to interact with any of these vendors, you may be asked to provide personal information directly to them. Your information will be governed by the vendor's privacy policy. Please read their privacy policies before submitting information.

What Is Flex Vacation Purchase?

If you were hired by BNY Mellon prior to November 30, 2020, you may purchase additional vacation time for 2021 through this component of the cafeteria portion of the Plan during open enrollment. Notwithstanding the foregoing, the Flex vacation purchase is a voluntary benefit and is not intended to be, and is not, an ERISA-covered benefit and is not otherwise part of the Plan. Should you choose to participate, the cost of each purchased vacation day (up to 5 days) will depend on your base salary or, if you work part-time, the standard number of hours that you work each week.

You may elect to purchase Flex vacation time during open enrollment. Elections, once made, cannot be changed during the Plan Year. Flex vacation may only be used once you have exhausted your full annual vacation, including carry-over days from the prior calendar year.

Flex vacation will continue to accrue and the cost will be deducted (when possible) from your paycheck during a leave of absence. If you are on an unpaid leave of absence, deductions for Flex will stop while you are not receiving a paycheck and the unpaid amount will be deducted from future pay upon your return to work.

Flex vacation cannot be returned, carried over to the next year, or paid in lieu of time off except as otherwise specifically provided below. You will automatically forfeit any Flex vacation days that are unused at the end of the Plan Year (i.e., December 31, 2021). In the event your employment terminates during the year, the costs for your regular vacation time and your flex vacation time will be calculated together for final pay purposes.

Who is Eligible for Retiree Medical Coverage?

Except as otherwise provided to the contrary herein, all provisions of the Plan will apply to the retiree medical coverage, to the extent applicable.

Eligible employees who terminate employment with BNY Mellon after attaining age 55 with at least ten (10) years of total years of employment with BNY Mellon, disregarding any breaks in service, are eligible for a pre-age 65 "access only" medical coverage benefit. The medical coverage will mirror the Lower Deductible HSA Plan, but the retiree is required to pay the full cost of coverage at retiree group rates and retirees are not eligible to receive Wellbeing Points Program contributions.

If you were an employee of Mellon Financial Corporation ("Mellon") or a subsidiary of Mellon on July 1, 2007 and, on December 31, 2008, you were at least age 50 or your age plus years of credited service totaled 65 or more, BNY Mellon will continue to pay a portion of the cost of your pre-65 retiree medical coverage if you terminate employment with BNY Mellon at or after age 55 with at least 15 years of credited service, have medical coverage through BNY Mellon on your last day of employment with BNY Mellon and begin distribution from The Bank of New York Mellon Corporation Pension Plan (the "Pension Plan") immediately upon termination of employment (a "Grandfathered Mellon Employee"). The amount of the premium that BNY Mellon will pay is based on your years of credited service under the Pension Plan. You are responsible for paying the balance.

If you are a former employee of The Bank of New York Company, Inc. ("BNY") or a subsidiary of BNY and were hired before January 1, 1993, you may be eligible for pre-age 65 retiree medical coverage and post-age 65 Medicare Advantage (MAPD) Plan if you have had continuous (uninterrupted) service since your original date of hire, are at least age 55 as of your termination of employment with BNY Mellon, and have

medical coverage through BNY Mellon on your last day of employment with BNY Mellon (a "Grandfathered BNY Employee"). You will be responsible for paying the full cost for the coverage if, as of January 1, 1993, you were younger than 45 and your combined age and years of service was less than 60. BNY Mellon will pay a portion of your retiree medical coverage cost if, as of January 1, 1993, you were at least age 45 or your combined age and years of service equaled at least 60. The amount paid by BNY Mellon varies based on your age and years of service as of January 1, 1993.

If you were an employee of Buck Consultants on December 31, 2000 and on December 31, 2005 and were at least age 50 and had a minimum of 15 years of service or who were at least age 55 and had a minimum of 10 years of service ("Grandfathered Buck Consultants"), you will be eligible for pre-age 65 retiree medical coverage and post-age 65 Medicare Advantage Prescription Drug (MAPD) Plan. The portion of the premium paid by BNY Mellon varies based on your years of service as of December 31, 2000.

Certain other grandfathered employees may be eligible for retiree medical coverage as set forth in individual employment or separation agreements or certain BNY Mellon transaction agreements.

When Does Retiree Medical Coverage Commence and Cease?

Active employees who are eligible for retiree medical coverage may elect to enroll beginning the first month after their termination of employment and may choose whether to cover eligible dependents. Former employees may elect to enroll beginning the first month after they meet the eligibility requirements and may choose whether to cover eligible dependents at such time. If you are eligible. you can continue pre-age 65 retiree medical coverage until you reach age 65 or become eligible for Medicare and post-age 65 MAPD plan until death, provided coverage will cease upon the earlier of:

- a reasonable period of time after you fail to make required premium payments, as determined by the Administrator, not to exceed the last day of the month that is ninety (90) days after you fail to make payments;
- the date of your death;
- the date that you are no longer enrolled in and covered under at least one benefit option;
- rescission of coverage under "Effect of Misrepresentation" below or
- the date that the Plan terminates or is amended to provide that you are no longer eligible.

The Company reserves the right to terminate the Plan, or any portion of the Plan, including but not limited to retiree medical coverage, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided or received prior to the date of amendment, termination or partial termination.

Please contact the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940, Monday through Friday, 8:30 a.m. to 8:00 p.m. ET to enroll.

How Much Will Retiree Medical Coverage Cost?

If you believe you are eligible for retiree medical coverage under the Plan, please contact the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940, Monday through Friday, 8:30 a.m. to 8:00 p.m. ET for further information regarding your options.

Who is Eligible for Retiree Life Insurance?

Except as otherwise provided to the contrary herein, all provisions of the Plan will apply to the retiree life insurance coverage, to the extent applicable.

Legacy Mellon employees who terminate employment with BNY Mellon with 15 years of credited service (as calculated under the Pension Plan), were age 50 or older or had age plus service of at least 65 as of December 31, 2008, were participants in the Legacy Mellon Pension Plan on December 31, 2008, and immediately commence distribution of their benefit under the Pension Plan are given $5,000 of retiree life insurance.

PART VI: GENERAL PROVISIONS

Plan Interpretation

The Administrator and the contract administrator or insurance provider will use this Plan and the Reference Documents in interpreting, applying, and making all determinations pertaining to benefits under the Plan. The actual administrative contracts and evidence of coverage booklets take precedence, to the extent they apply to covered benefits, if there should be any conflict between those documents and this document that pertains to the terms for benefits under the Plan. Only the Administrator (or the contract administrator, insurance provider or another authorized delegate) and the Plan, as applicable, in each of their sole and absolute discretion, may make decisions or administrative interpretations of the provisions of the Plan. Furthermore, the Plan is intended to be a cafeteria plan meeting the requirements under Code Section 125, as well as to comply with ERISA with respect to all ERISA benefits. This document will be construed as necessary to comply with those laws, as applicable.

Communications

All communications (including, without limitation, all notices, consents, requests, elections and enrollment forms) claiming rights, coverage or benefits under this Plan must be made in the form, contain the content, be delivered within the deadlines, be given by the means and manner, satisfy all requirements, and will become effective following receipt, in each case as prescribed by BNY Mellon, the Administrator, or the claims administrator, or their authorized delegates, as applicable (or, to the extent not prescribed, as may be acceptable to them). BNY Mellon, the Administrator, or the claims administrator, or their authorized delegates, without liability, may disregard any communication made otherwise. Reference in this Plan to "written" communications will also be deemed to be a reference to written substitutes (e.g., electronic communications) acceptable to the Company, the Administrator or the claims administrator, or their authorized delegates, as applicable, for the type of communication involved.

Administrator

Within the meaning of ERISA, the Administrator and "named fiduciary" is the Global Head of Compensation and Benefits. The Administrator's business address and business telephone number are provided under Part II entitled "General Plan Information". In general, the Administrator is the judge of the application and interpretation of the Plan, and has the full discretionary authority to administer and interpret the Plan, to resolve disputed issues of fact, and to make determinations regarding benefits under the Plan (other than any specific provisions addressing the Plan's discretion).

The Administrator has the authority to delegate certain of his powers and duties to a third party. The Administrator has delegated certain administrative functions under the Plan to various service providers. Based on the scope of the Administrator's delegation, these service providers may have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply. Any determination by the Administrator or his authorized delegate in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) are final and binding on all persons and entities and generally will not be overturned by a court of law. The Administrator also may employ, and authorize any of his delegates to employ persons to render advice regarding any fiduciary responsibility hereunder. All delegations will be terminable by the Administrator upon such notice as he deems appropriate.

Upon designation and acceptance of such delegation, retention, or authorization, the Administrator will have no liability for the losses or costs for the acts or omissions of any such designee as long as the

Administrator does not and has not violated his fiduciary responsibility in making, or continuing, such designation.

Notwithstanding the foregoing, nothing in this Plan is intended to, or shall, alter the authority, rights and obligations of any third party with respect to this Plan as specifically agreed to separately by the Administrator in written contractual arrangements.

Sponsor

The Company has full discretionary authority to administer and interpret the Plan as the Sponsor (i.e., serving in its settlor capacity). Any authorized delegate acting on behalf of the Sponsor may, depending on the delegation, have full discretionary authority to carry out the Sponsor's duties. Any determination by the Sponsor or its authorized delegate in all matters relating to the Plan (including, but not limited to, eligibility for coverage under its benefit options, Plan interpretations, and disputed issues of fact) are final and binding on all persons and entities and generally will not be overturned by a court of law.

Notwithstanding the foregoing, nothing in this Plan is intended to, or shall, alter the authority, rights and obligations of any third party with respect to this Plan as specifically agreed to separately by the Company in written contractual arrangements.

Amendment or Termination of the Plan

The Company reserves the right to amend or modify the Plan at any time, for any reason, subject to applicable law. Such changes may include, but are not limited to, the right to: (1) change or eliminate benefit options/coverages, (2) increase or decrease employee contributions and/or Wellbeing financial incentives, (3) increase or decrease deductibles and/or copayments and/or any applicable maximums, (4) change the eligibility terms, including the class(es) of employees, and/or dependents covered by the Plan, and (5) change insurers, HMOs, third party administrators, claims administrators or other providers, as applicable.

The Company also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided or received prior to the date of amendment, termination or partial termination.

Effect of Misrepresentation

If you (and/or your dependents) commit an act or omission that constitutes fraud or make an intentional misrepresentation of material information against the Plan (for example, in enrollment materials, a claim or appeal of benefits, or in response to a question from the Company or the Plan Administrator), the Company, as applicable, may: (1) immediately rescind your coverage and benefits under the Plan, (2) make you liable for, and require you to reimburse BNY Mellon for the contributions and benefits that were improperly obtained and any and all losses, expenses, claims, and costs incurred relating to, resulting from or arising out of such fraud or misrepresentation, and (3) if applicable, terminate your employment with BNY Mellon.

Without limiting the foregoing, enrolling an individual who is not eligible under the Plan, failing to inform the Company or the Plan Administrator that you or your dependent are covered under another group health plan, failing to provide requested evidence or falsifying evidence of eligibility for coverage and/or benefits under the Plan, or otherwise failing to comply with the Plan's eligibility requirements will be considered evidence of fraud or intentional misrepresentation of material information.

BNY Mellon reserves the right to periodically audit participant eligibility under the Plan.

BNY Mellon will provide you with a thirty (30) calendar day notice prior to any rescission of coverage.

No Right to Employment

This Plan does not give you any right with respect to continuation of your employment by BNY Mellon, nor will it interfere in any way with your right, or BNY Mellon's right, to terminate your employment at any time for any reason, which right is hereby expressly reserved.

Administration

Benefits under the Plan are administered by various providers in accordance with contracts the Company has entered into with various insurance companies and other providers or administrators of health and welfare benefits, or directly by the Company. A list of providers and their roles under the Plan is included in Part III.

General Assets

Premium costs for the Plan are paid for in part by BNY Mellon out of its general assets and in part by participant contributions. BNY Mellon is neither required to, nor has it, established a trust to fund the Plan.

No Guarantee of Tax Consequences

Certain coverage and benefits hereunder are not intended to be subject to Federal taxation; provided, however, that taxable income will be imputed for benefits provided to qualified domestic partners or other eligible dependents who do not otherwise constitute tax dependents under Code Section 152. Notwithstanding the foregoing, no guarantee of the Federal, state, or local tax consequences of such coverage or benefits is provided herein, and any failure by the Plan to meet any discrimination standards under the Code may result in taxable income to the participants.

No Assignability

Unless specifically permitted by, and in accordance with, the applicable Reference Document, the interest of any participant in the coverage and benefits described in this Plan may not be sold, assigned, transferred or otherwise disposed of in any way, and any attempted sale, assignment, transfer or other disposition will be null and void. If a participant attempts to sell, assign, transfer or otherwise encumber his or her rights or interest under the Plan, then such act will be treated as an election by the individual not to participate in the Plan. The payment of benefits directly to a health care provider, if any, will be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

Address and Notice

You, as an eligible employee in the Plan, and your eligible dependents, if any, must file in writing with the Administrator and BNY Mellon a valid and current mailing address when requested to do so. A communication, statement, or notice addressed to you at your last known address as filed with the Administrator and/or Company will be binding on you for all purposes under the Plan, and neither BNY Mellon, nor the Administrator will be obligated to conduct any further search to determine how you may be contacted. In the event that BNY Mellon is unable to locate you regarding a payment due to you, that amount will be forfeited.

Nondiscrimination Testing

If the Company determines for any Plan Year that the Plan may fail any nondiscrimination requirement imposed on the Plan by law or may exceed any limitation on benefits provided to highly compensated individuals or such other individuals for whom benefits may not be discriminatory under the law, the Company will have the authority to take such action either prospectively or retroactively as it deems necessary or appropriate to assure compliance with such nondiscrimination requirement or limitation. Such action may include, without limitation, a modification or limit on benefits reimbursable for any individual for whom benefits cannot be discriminatory under the Code.

Base Salary

Contributions towards the cost of coverage will be calculated by BNY Mellon on the employee-participant's behalf from the employee-participant's "base salary", which is defined as annualized base salary, rate of pay (based on a normal workweek not exceeding 40 hours), in effect as of September 1 prior to the Plan Year, except as specified further. For those newly benefits eligible during the Plan Year, the base salary will be the annualized base salary, rate of pay (based on a normal workweek not exceeding 40 hours), in effect at the time of benefit eligibility. For those changing from full-time to part-time or part-time to full-time, base salary will be determined as of that change in status. A person's base salary, as in effect prior to COBRA coverage will be used for purposes of COBRA premiums, to the extent an employer offset is available. Eligible employees on long-term disability and eligible pre-65 retirees will receive a separate communication providing the contribution amounts required for coverage.

Base salary generally excludes all other forms of compensation, such as, without limitation: commissions (unless specifically included in BNY Mellon's method of compensation or pay), overtime pay, bonuses, payments in lieu of vacation, all non-regular payments, any special purposes payments such as car or expenses allowances, moving expenses or reimbursement or contributions by BNY Mellon to this or any other plan or plans for the benefit of its employees, except that salary reduction contributions to this Plan, a Code Section 132(f) transportation plan and similar salary reduction, as well as any deferred compensation contributions will be included.

For eligible employees who have been designated by BNY Mellon as having a "benefit base", for purposes of the benefit options under the Plan, such employees' base salary will be equal to their benefit base. For purposes of this Plan, benefit base mean the mid-point of the salary range established from time to time by BNY Mellon for the job classification of such employees for the Plan Year, as determined under BNY Mellon's salary administration policy without regard to any adjustments specified in the preceding paragraph.

Insurance Carrier Rebates

In the event that the Company receives a return of premiums ("Rebate") as a result of the insurers of the Plan's health benefit options (identified in Part III) failing to meet the medical loss ratio requirements under the Patient Protection and Affordable Care Act and including any validly issued regulations thereunder ("ACA"), the Company, at its option, will:

- Reimburse participating employees through a payroll adjustment in the amount determined in accordance with ACA;
- Reduce participating employees' contributions by an amount determined in accordance with ACA to reflect the employees' share of the Rebate; or
- Use the Rebate to enhance benefits under the Plan by an amount determined in accordance with ACA.

Correction of Coverage or Enrollment Error

If the Company determines that an error has occurred with respect to enrollment or coverage under the Plan, the Company may correct any such error in any manner it deems appropriate; provided, however, that, to the extent any such correction is not a permissible mid-Plan Year election change in accordance with Code Section 125 and results in a cost increase or decrease to the affected participant-employee, such participant-employee will not be permitted to make a corresponding change to the amount of his or her pre-tax contributions elected for the Plan Year, and any increase in cost to such participant-employee resulting from such correction must be paid by the participant-employee on an after-tax basis.

Controlling Law and Severability

The Plan will be governed by, and construed in accordance with, ERISA and, to the extent not preempted by ERISA or where ERISA is inapplicable, the laws of the State of New York (other than the choice of law principles). If any provision of this Plan or application thereof to any individual or circumstance, is deemed invalid or unenforceable by a court of competent jurisdiction, then the remainder of the Plan or the application of such term or provision to individuals or circumstances will be valid and enforceable to the fullest extent permitted by law. No right hereunder will inure to any third party beneficiary.

PART VII: THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Applicability

This Part VII only applies to those benefit options subject to the HIPAA Privacy Regulations, and only for so long as such plans are subject to the Privacy Regulations.

Organized Health Care Arrangement

The benefit options subject to the HIPAA Privacy Regulations are hereby designated as an Organized Health Care Arrangement. For purposes of this Part VII and compliance with the HIPAA Privacy Regulations, such benefit options may collectively be referred to as the "Plan".

When Disclosure of Protected Health Information to the Company Is Permitted

Disclosure of Protected Health Information by the Plan to the Company is permitted only upon receipt by the Plan of a certification from the Company, in accordance with 45 C.F.R. § 164.504(f)(2)(ii) of the HIPAA Privacy Regulations, that the Plan incorporates the required provisions specified in 45 C.F.R. § 164.504(f) and that the Company agrees to certain restrictions as provided in this Part VII.

Permitted Uses and Disclosures of Protected Health Information by the Company

The Company may use and disclose Protected Health Information about a Plan participant for purposes of payment and health care operations under the Plan. Payment activities shall include all of the activities undertaken by the Plan to determine or fulfill the Plan's responsibility for coverage and the provision of benefits or to obtain or provide reimbursement for the provision of health care and include, but are not limited to, (a) determinations of eligibility or coverage and adjudication of health benefit claims; and (b) billing, claims management, coverage under a health plan, or justification of charges as described in 45 C.F.R. § 164.501 defining "Payment". Activities for health care operations shall include all of the activities described in 45 C.F.R. § 164.501, defining "Health Care Operations," to the extent the activities are related to Plan administration functions and specifically include, but are not limited to, (a) business planning and development; (b) managing and administering the Plan; and (c) customer service. Notwithstanding the foregoing, the Company shall not use or disclose Protected Health Information that is genetic information, as defined in 45 C.F.R. § 160.103, for underwriting purposes, as defined in 45 C.F.R. § 164.501, in accordance with Title I of the Genetic Information Nondiscrimination Act of 2008 and regulations issued thereunder. The Company shall not use or further disclose Protected Health Information other than as permitted or required in this Part VII or as required by law.

Agents of BNY Mellon

The Company shall ensure that any agents or independent contractors to whom it provides Protected

Health Information received from the Plan agree to the same restrictions and conditions that apply to the Company.

No Use for Employment-Related Decisions or Other Plans

The Company shall not use or disclose Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan.

Reporting Inconsistent Uses to the Plan

The Company shall report to the Privacy Officer for the Plan any use or disclosure of Protected Health Information that is inconsistent with the permitted or required uses of which the Company becomes aware, including, but not limited to, any use or disclosure that may constitute a breach of Unsecured Protected Health Information under the HITECH Act, as defined in 42 U.S.C. § 17921 and 45 C.F.R. § 164.402.

Rights of Plan Participants and Covered Dependents

The Company shall make available to you and your covered dependents, Protected Health Information in accordance with 45 C.F.R. § 164.524. The Company shall make available Protected Health Information for amendment by you or your covered dependents, as applicable, and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526. The Company shall make available to you and your covered dependents the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

Disclosure to the Secretary

The Company shall make available its internal practices, books and records relating to the use and disclosure of Protected Health Information to the Secretary of Health and Human Services for purposes of determining compliance by the Plan.

Returning Protected Health Information

If feasible, the Company shall return to the Plan or destroy any Protected Health Information once it is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, the Company shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Protected Health Information Firewall

The Company shall ensure that only the employees or classes of employees that it has designated in writing have access to Protected Health Information. The Company shall restrict the access to and use by such employees to those Plan administration functions listed in the Section entitled “Permitted Uses and Disclosures of Protected Health Information by the Company” above performed on behalf of the Plan.

Noncompliance by Employees of BNY Mellon

The Company shall implement appropriate mechanisms for resolving issues of noncompliance. Any issue of noncompliance with the Company’s obligations under the Section entitled “Protected Health Information Firewall” shall be referred to the Privacy Officer for the Plan. The Privacy Officer is authorized to make findings with respect to whether the adequate separation requirement described in the Section entitled

“Protected Health Information Firewall” has been violated or whether a particular disclosure or use is consistent with the Section entitled “Protected Health Information Firewall”. If the Privacy Officer determines that the Section entitled “Protected Health Information Firewall” has been or would be violated, the Privacy Officer may take such actions as the Privacy Officer deems appropriate, including forbidding any further disclosure of Protected Health Information to the Company, requesting the Company to correct any action taken based on the improper use of the Protected Health Information, and notifying the Secretary of Health and Human Services.

Compliance with State Health Privacy Laws

To the extent that such laws do not conflict with, or are more restrictive than, the HIPAA Privacy Regulations, the Company shall comply with applicable state health privacy laws. Notwithstanding the foregoing, no such state health privacy law shall apply to the extent such law is preempted by ERISA.

Electronic Data Security

The Company shall:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan.

(b) ensure that the separation requirements applicable to the Plan set out in the Section entitled "Protected Health Information Firewall" of this Part VII and 45 C.F.R. § 164.504(f)(2)(iii) shall be supported by reasonable and appropriate security measures.

(c) ensure that any agent to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information.

(d) report to the Plan, the Privacy Officer and the Security Officer any Security Incident of which it becomes aware.

Definitions

As used in this Part VII, each of the following capitalized terms shall have the respective meaning given below:

"Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI as defined in 45 C.F.R. § 164.402.

"Electronic Protected Health Information" means information that comes within subparagraphs 1(k) or 1(ii) of the definition of Protected Health Information as defined in 45 C.F.R. § 160.103.

"Organized Health Care Arrangement" means the relationship of separate legal entities as defined in 45 C.F.R. § 160.103.

"Privacy Regulations" means the regulations issued under HIPAA at Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

"Protected Health Information" or "PHI" means individually identifiable health information as defined in 45 C.F.R. § 160.103.

"Unsecured Protected Health Information" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons as defined in 45 C.F.R. § 164.402.

PART VIII: COORDINATION OF BENEFITS AND SUBROGATION

A. Coordination of Benefits

There are some Plan participants who are covered by more than one health plan. Coordination of benefits is a provision that makes sure that if you are covered by more than one plan, you are not reimbursed for more than what you are entitled to under the Plan.

Under this provision, the plan that pays first is called primary. The plan that pays second is called secondary. When the Plan is secondary, it will limit its benefits so that the total amount that you will be

reimbursed from all plans will not be more than the amount that the Plan would have paid if it had been primary.

The following rules are generally used to determine which plan is primary. This could vary, based on individual carrier contracts.

- A plan without a coordination of benefits provision is considered primary.
- The plan in which you are enrolled as an active employee is primary.
- When both plans have a coordination of benefits rule, the plan in which you are enrolled as an employee rather than as a dependent is primary. Usually, the plan that covers you other than as a dependent, for example as an employee, member, or subscriber, is primary and the plan that covers you as a dependent is secondary.

Please contact Accolade at 1-833-640-0427 more information.

B. Subrogation of Claims and Reimbursement

The subrogation provisions contained in this Subpart shall apply unless a particular benefit option is fully insured and the applicable insurance carrier has included a valid subrogation provision in the booklet for that benefit option.

If benefits are paid or payable to you or your covered dependent, that is, your spouse or qualified domestic partner and/or child (each a "Covered Individual") from this Plan or a benefit option, and there is any third party, insurer or guarantor, or any other alternate source that is or may be liable or legally responsible to pay the Covered Individual on account of the illness, disease, injury or condition that resulted in the payment of benefits (a "Responsible Person"), then, as a condition of participating in the Plan and accepting such benefits, each Covered Individual agrees to the following, both for the Covered Individual and for any person claiming through the Covered Individual or on account of the Covered Individual's rights under the Plan:

(1) The Plan shall automatically have a first priority lien upon the proceeds of any recovery that the Covered Individual may receive, may be entitled to receive, or may have paid on his or her account, from a Responsible Person, directly or indirectly, whether by lawsuit, settlement, or otherwise (a "Recovery"). A Recovery includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how a Covered Individual or Covered Individual's representative or any agreements characterize a Recovery the Covered Individual receives, it shall be subject to these provisions. The lien shall constitute an equitable lien by agreement and shall be in the amount of benefits provided through or paid by the Plan for the treatment of any illness, disease, injury or condition with respect to which the Responsible Person may be liable to the Covered Individual. The Covered Individual consents to the Plan's lien, and agrees to cooperate with the Plan and its agents and assignees to enforce any rights that the Plan may have with respect to any Recovery. The Covered Individual's failure to acknowledge the Plan's lien shall be a sufficient ground for termination of the Covered Individual's future participation in a benefit option or the entire Plan, as well as discontinuance of payment of some or all of the Covered Individual's future benefits under a benefit option or the Plan.

(2) The Plan shall have an automatic, specific and first priority right of reimbursement, up to the amount of the Plan's lien, out of the proceeds of any Recovery that a Covered Individual may receive, or may be entitled to receive. The Covered Individual shall reimburse the Plan, in full and as a first priority, for benefits provided by or through the Plan or a benefit option, immediately upon collecting any Recovery from a Responsible Person or receiving the benefit of such Recovery. If the Covered Individual is a minor, then any amount recovered by the minor or the minor's representative shall also be subject to the subrogation and reimbursement provisions in

this Subpart VIII.B, regardless of state law and regardless of whether the minor's representative has access to or control over such funds. Likewise, if the Covered Individual's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision. The Covered Individual agrees to segregate any Recovery (up to the amount of the Plan's lien) in a separate account, and shall preserve such Recovery so that the Plan can enforce its lien and so that any disputes as to entitlement can be resolved. Any Recovery or Overpayment (as defined below) must be segregated as described in this Subsection until the Plan has confirmed in writing that no dispute exists. If the Covered Individual dissipates or transfers the Recovery or Overpayment when the Plan has a lien upon or claim to such funds, that shall constitute inequitable conduct and a breach of the Plan by the Covered Individual. The Covered Individual agrees that the Plan may, without limitation, trace the transferred or dissipated Recovery or Overpayment and recover the disputed amount from assets paid over to a third person (including, without limitation, the Covered Individual's attorney), all of which for this purpose shall be subject to an equitable lien by agreement in the amount of the Plan's claim. Should timely reimbursement not be made to the Plan, or if the Covered Individual and/or his or her legal counsel fails to comply with any of the requirements of the Plan regarding the Plan's right of reimbursement, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Individual's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Individual in an amount equivalent to any outstanding amounts owed by the Covered Individual to the Plan. This provision applies even if the Covered Individual has disbursed settlement funds.

(3) The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

(4) A Covered Individual shall not, without the Plan's written consent, assign any right, claim or cause of action against a Responsible Person to recover for any illness, disease, injury or condition on account of which benefits were paid by the Plan. The Covered Individual assigns to the Plan any benefits that the Covered Individual may have under any automobile policy or other coverage on account of any illness, disease, injury or condition for which the Plan pays or provides benefits, to the extent of the Plan's lien.

(5) If a claim is asserted against any Responsible Person by or on behalf of a Covered Individual, the Covered Individual must advise the Plan in writing of that fact within thirty (30) days of the date when the Covered Individual (or his or her authorized representative) first acts to assert a claim against the Responsible Person (for example, by sending notice of the claim or by submitting or filing a claim). The Plan shall be entitled to intervene and participate in such action, and the Plan's lien shall apply to any resulting Recovery.

(6) Should a Covered Individual himself or herself directly receive any Recovery, whether by judgment, settlement, or otherwise, upon his or her receipt of any such Recovery, the Covered Individual shall provide the Plan with written notice of the receipt of such Recovery, including the amount and source(s) of such Recovery, and shall not distribute any or all of such Recovery to any person or entity other the Plan until at least sixty (60) days have passed after the date of the notice provided to, and received by, the Plan. Should the Covered Individual's legal counsel (rather than the Covered Individual) come into possession of any Recovery, upon his or her receipt of any such Recovery, the Covered Individual's legal counsel shall provide the Plan with written notice of the receipt of such Recovery, including the amount and source(s) of such Recovery, and shall not distribute any or all of such Recovery to any person or entity other the Plan (including to the Covered Individual) until at least sixty (60) days have passed after the date of the notice provided

to, and received by, the Plan. For the purpose of the notices required under this paragraph, notice provided by means of a nationally recognized overnight carrier by one-day overnight delivery shall be deemed received on the next business day subject to proof of delivery.

(7) If a Covered Individual (or the estate of a Covered Individual) fails, refuses or is unable to institute legal action against a Responsible Person, then the Plan shall have the right, at its option and at any time, to become subrogated to, and thereby assume and prosecute, the Covered Individual's claim (or the claim of the Covered Individual's estate) against any Responsible Person in order to secure the Plan's right of recovery of its payments and expenses regarding services provided under a benefit option. The Plan shall be entitled to prosecute such a claim in the name of the Covered Individual (or the Covered Individual's estate), with or without specific consent. The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan. The Plan may commence a subrogation action by sending a written notice to the Covered Individual and/or the Covered Individual's counsel or other representative. The Plan shall be entitled to retain from any judgment or settlement with a Responsible Person the amount of benefits paid or to be paid to the Covered Individual (or to the Covered Individual's estate), together with the Plan's costs and attorneys' fees.

(8) The Covered Individual shall furnish such information and assistance, execute and deliver such instruments and papers, and take such other actions as the Plan or its agents or assignees may reasonably request to secure the rights of the Plan under this Subpart VIII.B and/or facilitate the exercise or enforcement of the Plan's rights or interests. The instruments and papers that the Covered Individual shall be required to execute may include a separate subrogation agreement that does not conflict with the provisions of this Subpart VIII.B, if the Administrator or its counsel deem such an agreement to be necessary or appropriate. The Covered Individual shall not do anything to hinder the Plan's assertion of its rights to a Recovery. The Covered Individual shall not, without the prior written consent of the Plan or its agents or assignees (as may be applicable), take any action that may prejudice the Plan's rights or interests respecting subrogation or reimbursement, including without limitation disbursing, transferring or dissipating all or any part of a Recovery in which the Plan may have an interest, assigning all or part of any claim against a Responsible Person in which the Plan may have an interest, or settling, releasing or compromising any claim against a Responsible Person in which the Plan may have an interest. Failing to advise the Plan of the assertion of a claim against a Responsible Person, failing to cooperate with the Plan or its agents or assignees, disbursing, transferring or dissipating any Recovery to which the Plan has a claim or upon which the Plan has a lien, or taking any action that prejudices the Plan's rights or interests relating to subrogation or reimbursement, would be a material breach of the Covered

Individual's responsibilities under the Plan, shall entitle the Plan to the imposition of a constructive trust in its favor and may result in the Covered Individual's being equitably responsible for reimbursing the Plan.

(9) Each Covered Individual shall cooperate fully with and abide by the terms of this Plan, including the provisions of this Subpart VIII.B. The Plan shall have the right to withhold payment of claims and/or benefits pending the resolution of disputes relating to subrogation or reimbursement.

(10) The Plan's lien and its rights of subrogation and reimbursement shall have first priority and may not be reduced for any reason without the Plan's prior written consent. Without limiting the generality of the foregoing, the Plan's lien and its rights of subrogation and reimbursement shall not be reduced on account of the doctrine of unjust enrichment, the make-whole doctrine, the double recovery rule, principles of comparative or contributory fault, the common fund doctrine, the defense that another party is liable only in part, the defense that the Recovery is less than the actual loss suffered by the Covered Individual, the defense that the other party's resources or insurance may be limited, the argument that the Plan should share in a pro rata allocation of a Covered Individual's fees and costs (including attorneys' fees) incurred in pursuit of a claim, or any similar theory whether based on Federal common law, state law or some other source. To the extent that such a theory would otherwise have provided equitable or other defenses against the Plan's lien, each Covered Individual disclaims all such defenses and recognizes that the Plan is permitting the Covered Individual to receive benefits in reliance upon that disclaimer. The Plan shall not be responsible for paying any part of a Covered Individual's legal fees or costs in

connection with obtaining a Recovery from a Responsible Person. The Plan shall be entitled to recover from the Covered Individual the value of all services provided and paid for by, through or on behalf of the Plan, when the Covered Individual is reimbursed or paid for the cost of care by a Responsible Person. The Plan shall not be required to apportion recoveries and shall remain entitled to one hundred percent (100%) reimbursement from any Recovery for all benefits provided to the Covered Individual, regardless of whether the Covered Individual obtains a full or partial recovery (i.e., is "made whole"), regardless of whether the Recovery is a settlement, judgment or award, and regardless of the attorneys' fees and costs incurred by the Covered Individual in seeking the Recovery from the Responsible Person. Any Recovery received by or on behalf of a Covered Individual shall first be used to reimburse the benefits and expenses paid by the Plan (including attorneys' fees and court costs if the Plan brings suit in the name of the Covered Individual).

(11) A Covered Individual might receive payments through the Plan that exceed the payments to which the Covered Individual is legally entitled under the Plan. Such payments, to the extent that they exceed the amount to which the Covered Individual is legally entitled under the Plan, are hereinafter referred to as "Overpayment". In the event that a Covered Individual receives an Overpayment, (i) the Overpayment shall belong to the Plan; (ii) the Plan shall have a first priority equitable lien by agreement upon the Overpayment; (iii) the Plan shall have a right to reimbursement of the full amount of any Overpayment; (iv) the Covered Individual shall not have any right to retain the Overpayment; (v) the Covered Individual shall segregate and shall not disburse or dissipate the Overpayment, so that the Overpayment can be returned to the Plan and any dispute over entitlement to the Overpayment can be resolved; (vi) the Covered Individual shall be required to return the Overpayment to the Plan; (vii) the Covered Individual shall cooperate fully with efforts to recover the Overpayment; (viii) the Plan shall automatically have a first priority equitable lien by agreement upon any monies paid to the Covered Individual by the Plan in the amount of the Overpayment; (ix) if an Overpayment is the subject of a declaratory judgment action, no costs or expenses, including attorneys' fees, may be recovered out of the Overpayment; and (x) the Plan shall be entitled, at its option, to recoupment by withholding and retaining any benefits or other monies payable to the Covered Individual, up to the amount of the Overpayment.

(12) To the extent that any portion of this Subpart VIII.B is inconsistent with applicable law in whole or in part, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of this Subpart VIII.B shall remain in full force and effect. Thus, for example, if an applicable law were to limit the amount of the lien provided for in Subpart VIII.B(1) above, then the lien would be enforceable in the greatest amount allowable consistent with such law. Any law that is preempted by the terms of this Plan under applicable federal precedent or statute is not deemed an "applicable law" for purposes of the application of this paragraph (12).

(13) If the Plan takes legal action against a Covered Individual to enforce its recovery rights under this Subpart VIII.B, the Plan shall be entitled to recover its attorneys' fees and expenses from the Covered Individual.

(14) The Administrator may waive the Plan's right of recovery. To be enforceable, such a waiver must be in writing and signed by a duly authorized representative of the Administrator. The Plan's waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to another claim; and the Plan's waiver of its right of recovery with respect to one Covered Person shall not constitute a waiver of its right of recovery with respect to another Covered Person.

(15) The Covered Individual acknowledges and agrees that this Subpart VIII.B is intended to restore and preserve the *status quo ante* and to avoid duplicative or undeserved recovery by the Covered Individual. The Covered Individual acknowledges his or her responsibility to give full force and effect to the Plan's liens and its rights of subrogation and reimbursement under this Subpart.

(16) For purposes of this Subpart VIII.B, any action, right, or entitlement of the Plan may be taken, asserted, or enforced by the Administrator. Any ambiguity in this Subpart VIII.B, and any dispute arising out of or in connection with this Subpart, shall be resolved by the Administrator pursuant to the Plan's dispute resolution procedures, and the interpretation and application of this Subsection shall be committed to the Administrator's discretion.

PLEASE REFER TO THE BOOKLET PROVIDED BY YOUR INSURER FOR MORE INFORMATION ON SUBROGATION AND REIMBURSEMENT.

PART IX: STATEMENT OF ERISA RIGHTS

If you have any questions about your rights or your benefits as a participant, please contact the BNY Mellon Benefit Solutions Service Center at 1-855-354-6940.

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. Among these rights, you are entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse/qualified domestic partner or dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, but only if you complete all of the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court, but only if you complete all of the Plan's claims and appeals procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of

Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical

Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or accessing its website at https://www.dol.gov/agencies/ebsa.

INDEX OF DEFINED TERMS

The following is a list of terms as first defined in the Plan.

APPENDIX A
CLAIMS AND APPEALS INFORMATION

For inquiries about denials in eligibility, coverage, or benefits under the Plan, please contact Accolade at 1-833-640-0427. You may also file a formal claim by following the procedures described below. For purposes of this Appendix A, the entity to which the Administrator has delegated the authority to review and evaluate claims (e.g., an insurance company) shall be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeals level, if applicable. You can also contact Accolade at 1-833-640-0427 for guidance and support in navigating the appeal process.

What is a claim? A request is a formal "claim" subject to these procedures only if it is filed in accordance with the Plan's claim filing guidelines. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about coverage or benefits or the circumstances under which benefits might be payable under the Plan is not a "claim" under these rules, unless the Claims Administrator determines that your inquiry is an attempt to file a claim, in which case you will be informed. If a claim is received, but the Claims Administrator determines that there is not enough information to process the claim, you will be given an opportunity to provide the missing information. Any response to an inquiry or request that is not a "claim" is not intended to be, and it is not, an approval or guarantee of a benefit.

Using an authorized representative. If you want to bring a claim under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice. If you (or your beneficiary) appoint a representative to act on your behalf, then the Claims and Appeals Administrators will communicate all matters to your authorized representative.

Insurer, vendor, or other third party procedures may apply. The certificates of coverage or other documents that describe a particular benefit option under the Plan (see Part III of the main body of the Plan) generally will contain a specific set of claims and appeals procedures that you must follow to make a claim or appeal a claim denial with respect to that particular benefit option. Such third party procedures may include binding arbitration. Although procedures for the various benefit options may be similar in most respects, there may be important differences. Please note that special rules apply to disability claims, and you should refer to your certificate of coverage under the BNY Mellon disability benefit options for details. **If the certificate of coverage or other document that describes a particular benefit (see Part III of the main body of the Plan) does not contain a specific set of claims and appeals procedures, then the Plan's default procedures, as described below, will apply.** *If you have any questions about which set of claims and appeals procedures to follow or any other questions about making or appealing a claim, you should contact BNY Mellon Benefit Solutions immediately.*

DEFAULT CLAIMS PROCEDURES

The applicable procedures differ depending on whether a claim is a request for a determination of eligibility under the Plan ("Eligibility Claim") or for benefits provided under the Plan ("Benefit Claim"). Generally, if an Eligibility Claim is being made in combination with a Benefit Claim, then the Eligibility Claim will be handled separately in accordance with the procedures/times applicable to Eligibility Claims, and the Benefit Claim procedures and times will apply to the Benefit Claim. However, when an Eligibility Claim cannot be handled separately from a related Benefit Claim, the Benefit Claim procedures and times will apply to both. Claims for rescission of coverage are treated as Benefit Claims for purposes of these procedures.

IMPORTANT! You should follow all applicable claims and appeals procedures carefully. Failure to comply with applicable timing and notice requirements will result in forfeiture of your right to any further review of an adverse decision.

I. ELIGIBILITY CLAIMS

IMPORTANT! Unlike Benefit Claims, Eligibility Claims are not "claim[s] for benefits" as defined under ERISA. Accordingly, your claim for eligibility, to the extent it is not combined with a Benefit Claim, is exempt from the procedural requirements of ERISA and applicable regulations, as detailed in Sections II and III below. If the Eligibility Claim is combined with a Benefit Claim, the rules in Section II (below) will apply.

An Eligibility Claim, or a claim that relates solely to your eligibility for participation under the Plan (for example, a claim with respect to a missed open, or mid-year, enrollment deadline, or meeting the hours of service requirements) must be filed with the BNY Mellon Benefit Solutions Service Center (1-855-354-6940).

You must submit your Eligibility Claim no later than the last day of the Plan Year for which you are making your claim. However, eligibility claims under the Wellbeing Points Program must be submitted no later than February 28, 2022 for the 2021 Plan Year. Claims received after December 10, 2021 but before February 28, 2022 may, if granted, result in a credit to your account in early 2022.

The initial decision on an Eligibility Claim will be provided within ninety (90) days after the BNY Mellon Benefit Solutions Service Center confirms receipt of your claim, unless special circumstances require an extension of time. If an extension is needed, you will be notified in writing before the end of the initial ninety (90)-day period of the special circumstances for the extension and when you can expect a decision. A decision will be given as soon as possible, but not later than 180 days from the date the BNY Mellon Benefit Solutions Service Center confirms receipt of your claim.

Generally, unless the Eligibility Claim also involves a Benefit Claim or an adverse benefit determination, the decision by the BNY Mellon Benefit Solutions Service Center will be deemed final and will be conclusive and binding on all parties.

II. BENEFIT CLAIMS

Benefit Claims are claims with respect to receiving a particular benefit under the Plan. Depending on the type of Benefit Claim involved, different procedures may apply. Benefit Claims may be:

- Urgent care claims,
- Non-urgent required pre-service claims,
- Post-service claims,
- Concurrent claims (Urgent and Non-urgent), or
- Disability benefits claims.

How do I file an initial claim for benefits?

A. Benefit Claims other than Flexible Spending Account Claims and Wellbeing Points Program Claims

Benefit Claims (except urgent care claims, which may be made orally) must be submitted in writing to the Claims Administrator specified in Part III of the main body of the Plan above.

Initial Claim Submission Deadline. Benefit Claims must be made within one (1) year of your receipt of service or onset of illness or injury, whichever is later, or your claim will be denied.

B. Flexible Spending Account Claims

To request a Flexible Spending Account reimbursement, go to My Benefit Solutions to submit a claim online or download a copy of the required forms.

Initial Claim Submission Deadline. You must submit a claim for reimbursement by **June 30, 2022** for the Plan Year ending **December 31, 2021** (and **June 30** for each year thereafter) following the end of the Plan Year in which you incurred the expense (for which you seek reimbursement). The claim must have been incurred while you were still eligible.

Please note that Flexible Spending Account claims are post-service claims. They are also not eligible for external review or Deemed Exhaustion (described below).

C. Wellbeing Points Program Claim Procedure

If you believe that you have fully completed a rewardable activity for that quarter, but you have not earned the applicable incentive, you may file a claim after following these steps:

1. Be sure that your incentive points related to your activities have had enough time to be reflected in your account. Remember that completion of some activities takes up to four (4) weeks before points are posted to your account.

2. Check the 'myrewards' statement on Virgin Pulse and review your Benefit Wallet account to confirm whether your activities/incentives have been captured. Points earned in one month are payable at the end of the following month.

3. Contact Virgin Pulse customer support at support@virginpulse.com or 1-888-671-9395 and have Virgin Pulse review your account.

If, after you have completed the above steps, you believe there is still an issue, contact wellbeing@bnymellon.com to request a "Claim Initiation Form."

Claim Submission Deadline. Claims for the 2021 Wellbeing Points Program must be submitted by February 28, 2022.

Please note that Wellbeing Points Program claims are post-service claims. These claims are not eligible for external review or Deemed Exhaustion (as described below).

What is an adverse benefit determination?

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically

necessary or appropriate. An adverse benefit determination also includes a rescission of coverage (i.e., the cancellation or discontinuance of coverage that has a retroactive effect), unless the cancellation of coverage is due to a failure to timely pay required premiums or contributions.

What happens if my initial claim for benefits is denied?

If you receive an adverse benefit determination, you will be provided a notice of the determination within the time periods described in the Claims Review Timing Chart. ***Please review your notice carefully.***

*The **notice of an initial adverse benefit determination** will include (to the extent not subject to attorney-client privilege):*

- information sufficient to identify the claim, including the date of service, health care provider, claim amount (if applicable), and notification of the right to request the diagnosis and treatment codes (and their meaning), if any, upon request, and that such request will not be considered an appeal of the adverse benefit determination; the specific reason(s) for the adverse benefit determination, including the denial code and corresponding meaning, the Plan's standard, if any, that was used in making the adverse benefit determination, and a reference to the specific Plan provision(s) on which the adverse benefit determination is based;
- a description of the Plan's voluntary internal and external appeal procedures, including information on how to initiate an appeal;
- a statement of your rights to bring a civil action under Section 502(a) of ERISA, following an adverse benefit determination on review;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and
- contact information for an applicable office of health insurance consumer assistance or ombudsman.

Additionally…

- ***If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination,*** either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.
- ***If the adverse benefit determination is based on medical necessity or experimental treatment,*** the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical condition, or a statement that such explanation will be provided free of charge upon request.
- ***If the adverse benefit determination is for an urgent care claim,*** the notice will include a description of the expedited review process applicable to such claim. This adverse benefit determination may be conveyed to you orally, provided that a written or electronic notice is furnished to you no later than three (3) days after the oral notice.
- ***If the recipient of the adverse benefit determination notice resides in a county identified by the Census Bureau as having 10% or more of its population literate only in the same non-English language,*** a one-sentence notice in the applicable non-English language about the availability of language assistance will be included.

How do I appeal an adverse benefit determination?

If you receive an adverse benefit determination from the Claims Administrator, then you have the right to appeal. Information about the appeals procedures applicable to your particular claim, including how to initiate such an appeal, will be included in the notice of adverse benefit determination you receive. Please follow those instructions carefully. Please note: you can contact Accolade at 1-833-640-0427 for guidance and support in navigating the appeal process.

Generally, you must submit your appeal in writing to the Appeals Administrator as specified in the initial notice of adverse benefit determination.

Your request for an appeal of adverse benefit determination should describe all of the grounds upon which it is based, all facts in support of your request and any other matters that you consider pertinent to your appeal. The Appeals Administrator may also require you to submit such additional facts, documents or other material, as it considers necessary or appropriate in making its decision. The review of the adverse benefit determination will take into account all new information, whether or not that information was presented or available for your initial claim, and will not be influenced by the decision on your initial claim.

If your appeal involves urgent care, then you may submit a request for an expedited appeal orally or in writing, and all necessary information will be transmitted between the Plan and you by telephone, fax, or other similar available method.

If you appeal, you have the right to review pertinent documents (other than legally-privileged documents) and to submit issues and comments in writing.

Appeals Submission Deadline. Generally, you must submit your appeal within 180 days of receiving the adverse benefit determination. If the appeal is of the Plan's determination to reduce or terminate an initially approved course of treatment, the appeal must be filed within thirty (30) days of receipt of the Plan's decision. **If you do not timely appeal, then you will generally lose your right to file suit in a state or Federal court, as you will not have exhausted your internal administrative appeal rights.**

*The **final adverse benefit determination** will include (to the extent not subject to attorney-client privilege):*

- information sufficient to identify the claim, including the date of service, health care provider, claim amount (if applicable), and notification of the right to request the diagnosis and treatment codes (and their meaning), if any;
- the specific reason(s) for the adverse benefit determination, including the denial code and corresponding meaning, the Plan's standard, if any, that was used in making the adverse benefit determination, and a reference to the specific Plan provision(s) on which the adverse benefit determination is based;
- a statement indicating that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information (other than legally-privileged documents) relevant to the determination, and that such request will not be considered a request for external review;
- a description of the Plan's voluntary internal and external appeal procedures, including information on how to initiate an external appeal, if applicable;
- a statement of your rights to bring a civil action under Section 502(a) of ERISA, following the adverse benefit determination of a claim on review;
- a statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency"; and
- contact information for an applicable office of health insurance consumer assistance or ombudsman.

Additionally…

- ***If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination,*** either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.
- ***If the adverse benefit determination is based on medical necessity or experimental treatment,*** the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical condition, or a statement that such explanation will be provided free of charge upon request.
- ***If the adverse benefit determination is for an urgent care claim,*** the notice will include a description of the expedited review process applicable to such claims. This adverse benefit determination may be conveyed to you orally, provided that a written or electronic notice is furnished to you no later than three (3) days after the oral notice.
- ***If, in reaching the final decision, the Appeals Administrator considered, relied upon, or generated new or additional evidence*** in connection with the claim, such evidence will be provided, as well as any new or additional rationale for the adverse benefit determination. The Appeals Administrator will also provide you with a reasonable opportunity to respond to such new evidence or rationale.
- ***If the recipient of the final determination resides in a county identified by the Census Bureau as having 10% or more of its population literate only in the same non-English language,*** a one-sentence notice in the applicable non-English language about the availability of language assistance will be included.

What other options are available to me if I receive an adverse benefit determination on appeal?

Generally, no legal action against or relating to this Plan may be brought until, in accordance with the procedures specified, you:

- have submitted a written claim;
- have been notified by the Claims Administrator that such claim is denied (i.e., you receive an initial adverse benefit determination);
- have filed a written request for review of the claim; and
- have been notified by the Appeals Administrator that it has affirmed the adverse benefit determination.

Unless you qualify for an external review (see below), the decision on appeal by the Appeals Administrator will be deemed final and will be conclusive and binding on all parties. If you (or your authorized representative) challenge the decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above.

III. BENEFIT CLAIMS ELIGIBLE FOR EXTERNAL REVIEW

Standard External Review. For Benefit Claims involving medical judgment and rescissions of coverage (other than due to failure to timely pay required premiums or contributions) you may request an independent, external review within four (4) months of having received your adverse benefit determination on appeal. If there is no corresponding date of the calendar month that is four (4) months after receipt of the adverse benefit determination on appeal, the request must be made by the first day of the fifth (5th) month after receipt of the adverse benefit determination on appeal. For example, if you received the adverse benefit determination on appeal on May 31, the deadline for you to submit a request for external review would be October 1, since September 31 does not exist. The types of claims that may qualify for external review are claims with respect to:

- medical necessity, as determined by an external reviewer, e.g., appropriateness of health care setting or treatment by a specialist, level of care or effectiveness of a covered benefit, determination of emergency care; or
- rescission of coverage.

Flexible Spending Account and Wellbeing Program (including the Wellbeing Points Program) claims are not eligible for external review.

If your final internal appeal is denied (i.e., you receive a final internal adverse benefit determination), you will be notified in writing that your claim is eligible for external review and you will be informed of next steps.

Deemed Exhaustion. You may also qualify for external review (or, alternatively, judicial review (see Section IV. below)) if the Plan fails to strictly adhere to all claims determination and appeal requirements under Federal law – other than minor violations that do not cause, and are not likely to cause, prejudice or harm, so long as the violations were for good cause or due to matters beyond the Plan's control, and that occurred in the context of an on-going, good-faith exchange of information, and do not reflect a pattern or practice of non-compliance – based on so-called "Deemed Exhaustion". Please note, Flexible Spending Account and Wellbeing Program (including the Wellbeing Points Program) claims are not eligible for external review.

You may request that the Plan provide a written explanation of the violation, including a specific description of the bases, if any, for asserting that a particular violation should not cause Deemed Exhaustion of the internal claims and appeals processes. The Plan must provide such an explanation within ten (10) days.

If an external reviewer rejects your request for an immediate external review based on Deemed Exhaustion, the Plan will notify you within ten (10) days of your opportunity to resubmit your appeal in accordance with the internal appeal processes. Time periods for such re-filing of your Benefit Claim will begin to run from the date of your receipt of such notice.

Expedited External Review. You may immediately request an expedited external review when you receive:

- an initial internal adverse benefit determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines;
- a second and final internal adverse benefit determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines; or
- a second and final internal adverse benefit determination involving admission, availability of care, continued stay, or a health care item or service for which you received emergency services, but have not been discharged from a facility.

To submit a claim for external review, please contact the People Solutions HR Contact Center.

If your claim for external review is accepted, it will be assigned to an Independent Review Organization ("IRO") that will review your claim de novo, that is, as if it had not been previously reviewed. The Plan must comply with the IRO's ultimate decision without delay, regardless of whether the Plan intends to seek judicial review (i.e., go to court). Please note that the process of an IRO review may require a nominal filing fee of you as the claimant, not to exceed $25 that will be refunded to you if the adverse benefit determination is reversed through the external review.

IV. LIMITS ON LEGAL ACTION

Notwithstanding any other provision in this Plan, or any of the documents incorporated by reference herein, no lawsuit may generally be brought with respect to the Plan until the foregoing administrative procedures (other than your right, if any, to external review) have been exhausted or Deemed Exhaustion applies and you choose not to pursue an external review.

As described above, you may request a written explanation of the violation from the Plan, including a specific description of the bases, if any, for asserting that a particular violation should not cause Deemed Exhaustion of the internal claims and appeals processes. The Plan must then provide such an explanation within ten (10) days.

If a court rejects your request for an immediate judicial review based on Deemed Exhaustion, the Plan will notify you within ten (10) days of your opportunity to resubmit your appeal in accordance with the internal appeal processes. Time periods for such re-filing of your Benefit Claim will begin to run from the date of your receipt of such notice.

Additionally, no lawsuit may be brought more than one (1) year following the final adverse determination under the Plan or, if earlier, more than four (4) years after the facts or events giving rise to the allegation(s) in the claim or when the claim(s) first occurred.

CLAIMS REVIEW TIME LIMITS

The following chart sets forth the time limits that will apply for initial review of Benefit Claims and appeal of adverse benefit determinations under the Plan, unless a shorter period is prescribed by the applicable administrative contract.

Urgent Health Care Claim

Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain. The Plan must defer to the attending health care provider with respect to whether a claim is urgent.

YOUR INITIAL CLAIM

Step 1:	The Claims Administrator must approve or deny your initial claim life, health, or as soon as possible, taking into account the medical exigencies ability to regain involved, but no later than 72 hours after receiving it.

IF YOUR CLAIM IS IMPROPER OR INCOMPLETE

Step 1:	The Claims Administrator has 24 hours after receiving your initial claim to notify you that your claim is improper or incomplete.
Step 2:	You have 48 hours after receiving notice from the Claims Administrator to correct or complete your claim.
Step 3:	The Claims Administrator must notify you if your claim is approved or denied within the earlier of 48 hours of (i) the Claims Administrator's receipt of your completed claim, or (ii) the end of the period given for you to correct or complete your claim.

APPEAL OF AN ADVERSE BENEFIT DETERMINATION

Step 1:	If you receive an adverse benefit determination, you have 180 days after receiving it to appeal the Claims Administrator's determination.
Step 2:	The Appeals Administrator has 72 hours after receiving your appeal to notify you of its appeal determination.

Pre-Service Health Claim

Group health claims where treatment must be pre-approved before it is performed.

YOUR INITIAL CLAIM	
Step 1:	The Claims Administrator has up to 15 days after receiving your initial claim to notify you if your claim is approved or denied.
Step 2:	If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and provides an extension notice during the initial 15-day period, the Claims Administrator has 30 days after receiving the claim to notify you of its determination.

IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
Step 1:	The Claims Administrator has 5 days after receiving your initial claim to notify you (i) that your claim is an improper claim (that is, you have failed to follow the applicable procedures for filing a preservice claim) and (ii) of what the proper procedures for filing a claim are. Such notification may be oral, unless written notifications is requested.
Step 2:	You have 45 days after receiving the extension notice to provide additional information or complete the claim. (The time the Claims Administrator has for approving/denying your claim is tolled until you have responded to the Claims Administrator's request for additional information.)

APPEAL OF AN ADVERSE BENEFIT DETERMINATION	
Step 1:	If you receive an adverse benefit determination, you have 180 days after receiving it to appeal the Claims Administrator's determination.
Step 2:	The Appeals Administrator has 60 days after receiving your appeal to notify you of its appeal determination.

Pre-Service Health Claim

Group health claims that are neither urgent nor pre-service health claims.

YOUR INITIAL CLAIM	
Step 1:	The Claims Administrator has 30 days after receiving your initial claim to notify you of an adverse benefit determination.

IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	
Step 1:	If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and provides an extension notice during the initial 30-day period, the Claims Administrator has 45 days after receiving the claim to notify you of an adverse benefit determination.
Step 2:	You have 45 days after receiving the extension notice to provide additional information or complete your claim. (The time the Claims Administrator has for approving/denying your claim is tolled until you have responded to the Claims Administrator's request for additional information.)

APPEAL OF AN ADVERSE BENEFIT DETERMINATION	
Step 1:	If you receive an adverse benefit determination, you have 180 days after receiving it to appeal the Claims Administrator's determination.
Step 2:	The Appeals Administrator has 60 days after receiving your appeal to notify you of its appeal determination.

Concurrent Care Claim

For a concurrent care claim where a course of health care treatment is reduced or terminated before the end of the period or the number of treatments previously approved then the Claims Administrator will notify you sufficiently in advance of the reduction or termination to permit you to appeal the determination, and have your appeal decided before the benefit is reduced or terminated.

Urgent Concurrent Care Claim

If you request an extension of the treatment beyond the approved period of time or number of treatments and the claim is an urgent care claim, then the Claims Administrator will notify you of its determination on the claim within 24 hours after receipt of the claim, as long as the claim is made at least 24 hours before the expiration of the prescribed period of time or number of treatments.

IMPORTANT! For a concurrent care claim where a course of health care treatment is reduced or terminated before the end of the period or the number of treatments previously approved then the Claims Administrator will notify you sufficiently in advance of the reduction or termination to permit you to appeal the adverse benefit determination, and have your appeal decided before the benefit is reduced or terminated.

If you request an extension of the treatment beyond the approved period of time or number of treatments and the claim is an urgent care claim, then the Claims Administrator will notify you of its determination on the claim within 24 hours after receipt of the claim, as long as the claim is made at least 24 hours before the expiration of the prescribed period of time or number of treatments.

Standard External Review Claim

Claims related to medical judgment or rescission.

PRELIMINARY REVIEW OF REQUEST	
Step 1:	The Plan has 5 business days to make a preliminary assessment of your request, and must notify you within 1 business day of completing such assessment, whether your claim is accepted for external review.

IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	
Step 1:	You have the remainder of the original 4-month period, or 48 hours if the original period has expired, to provide additional information or complete your claim.

REFERRAL OF CLAIM TO IRO	
Step 1:	If your claim is approved for external review, it will be assigned to an IRO, which will timely notify you, in writing, to (i) confirm your claim's eligibility and acceptance for external review, and (ii) provide you with an opportunity to submit in writing, within 10 business days, additional information that the IRO should consider in its external review.
Step 2:	The IRO has 45 days after receiving your claim to notify you if the adverse benefit determination is upheld.

Expedited External Review Claim

Claims related to medical judgment or rescission.

PRELIMINARY REVIEW OF REQUEST	
Step 1:	Immediately upon receipt of your request, the Plan must determine whether your claim is eligible for expedited external review.

REFERRAL OF CLAIM TO IRO	
Step 1:	If your claim is approved for expedited external review, it will be assigned to an IRO, which will render its determination as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the IRO will provide written confirmation of its determination within 48 hours of initially notifying you of its determination.

APPENDIX B
PLAN NOTICES

These notices are being provided to you in conjunction with your and your beneficiaries' or dependents', participation in the BNY Mellon Health and Welfare Plan (the "Plan") in 2021. Each of the following notices (and related information) is intended to be, and is, interpreted consistent with and not as an expansion of the applicable referenced law:

– **Summary of Benefits and Coverage**—Group health plans are required to provide participants and beneficiaries with uniform summaries of benefits and coverage (SBCs) during annual and special enrollments. This SBC will help you better understand your coverage by summarizing the key features of the health plans under the Plan such as the covered benefits, cost-sharing provisions, coverage limitations and exceptions. You can access the SBC through the MyBenefit Solutions website accessible via MyReward or at mybenefits.bnymellon.com/ > Knowledge Center > Plan Information. You may request a free paper copy by calling the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940, Monday through Friday between 8:30 a.m. and 8:00 p.m. ET.

– **Value of Health Benefits**—The value of your health benefits received in the immediately preceding year will be reported in Box 12 on your 2021 W-2 statement. This reporting requirement is for informational purposes only and will not affect your taxable income. The value of health benefits reported in Box 12 on the W-2 statement that you receive in January 2021 should not be included in your taxable income when you file your taxes. Accordingly, you will also not be subject to, or required to pay any FICA taxes on this amount.

– **General Questions**—If you would like more information about these notices or the underlying Plan, please refer to the summary plan description or call the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940 Monday through Friday, 8:30 a.m. to 8:00 p.m. ET.

Women's Health and Cancer Rights Act of 1998 ("WHCRA") Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Newborns' and Mothers' Notice

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act

This law generally requires that coverage limits on mental health and substance use disorder benefits will not be less favorable than any comparable coverage limits for medical and surgical benefits offered under a group health plan.

Military Leave Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are on an approved military leave under USERRA, whether for active duty or for training, you are entitled to continue coverage under the Plan during the USERRA leave for up to twenty-four (24) months as long as you give BNY Mellon advance notice (with certain exceptions) of the leave. If the entire length of the leave is less than thirty-one (31) days, your contributions will remain the same as before the leave (to the extent such coverage continues to be offered under the Plan at the time of your return). If the entire length of the leave is thirty-one (31) days or longer, you may be required to pay up to 102 percent of the entire amount necessary to cover you, and your eligible dependent(s). Coverage under USERRA will run concurrently with any right to continue coverage under COBRA.

If your military leave lasts thirty-one (31) days or longer and you do not elect to continue coverage during the leave, your coverage will be reinstated upon reemployment on the same terms and conditions as existed prior to your military leave (to the extent such coverage continues to be available at the time of your reemployment). However, no exclusion or waiting period will be imposed upon you or your covered dependents upon reemployment except to the extent it would have been imposed if your coverage had not been terminated as a result of the military leave. This rule does not apply to the coverage of any illness or injury determined by the Secretary of Veterans' Affairs to have been incurred in, or aggravated during, performance of service in the uniformed service.

For more information on your rights under USERRA and military leave, a VETS directory and additional information is available at http://www.dol.gov/vets/**.** In the event that you have notified BNY Mellon that you intend to commence an approved military leave, you will be provided with more specific details regarding your contributions and benefits during your leave which may be greater than what is outlined above.

Qualified Medical Child Support Orders

Upon receipt of an order purporting to be a Qualified Medical Child Support Order, the Administrator will follow the procedures established for reviewing and implementing such orders with respect to coverage under the Plan. You may request, at no charge, a copy of such procedures from the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://www.myalhipp.com/ Phone: 1-888-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidplrecovery.com/flmedicaidplrecovery.com/hipp.index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

OR

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services **www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

Medicare Prescription Drug Notice

Please read this Notice carefully, and keep it where you can find it. This Notice has information about your current prescription drug coverage under BNY Mellon-sponsored health plans and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. In general, you are eligible for a Medicare drug plan if you are entitled to Medicare Part A and/or enrolled in Part B (i.e., are age 65 or older; have a qualifying disability for which you have been receiving Social Security Disability Insurance (SSDI) for more than 24 months; or have been diagnosed with End-Stage Renal Disease). If you are eligible for and considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area, information about where to get help to make decisions about your prescription drug coverage is at the end of this Notice. If you are not currently eligible for a Medicare drug plan, the Notice may be helpful to you when you become eligible.

BNY Mellon Creditable Coverage Plans

If you are Medicare eligible and participate in one of the plans listed under this section (referred to as "Creditable Coverage Plans"), the information contained in this section applies to you. BNY Mellon Creditable Coverage Plans include:

- Anthem Copay Plan
- Anthem Higher Deductible HSA Plan
- Anthem Lower Deductible HSA Plan
- Kaiser Permanente California (Los Angeles)
- Kaiser Permanente California (San Francisco)
- HMSA (Hawaii only)
- Aetna International

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also may offer more coverage for a higher monthly premium.
2. BNY Mellon has determined that the prescription drug coverage offered under the Creditable Coverage

Plans listed above is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you are a participant in one of the Creditable Coverage Plans, because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this BNY Mellon plan coverage and not pay extra if you later decide to enroll in Medicare coverage.

Medicare-eligible individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year during the Medicare annual enrollment period (October 15 – December 7 in 2020). If you lose coverage under a BNY Mellon Creditable Coverage Plan, through no fault of your own, you may be eligible for a special enrollment period in which to sign up for a Medicare prescription drug plan.

Your current BNY Mellon coverage pays for other health expenses in addition to prescription drugs. You cannot drop only the prescription portion of BNY Mellon coverage. If you keep your BNY Mellon coverage and enroll in a Medicare prescription drug plan, your BNY Mellon coverage will not change. If you drop your BNY Mellon coverage (which includes medical and prescription benefits) and enroll in a Medicare prescription drug plan, you may not be able to get BNY Mellon coverage back later.

If you drop or lose your coverage under a BNY Mellon Creditable Coverage Plan and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. Similarly, if you do not enroll in Medicare prescription drug coverage when eligible, and change your mind later, you may pay more.

If you drop or lose coverage under a BNY Mellon Creditable Coverage Plan or if you don't enroll in Medicare prescription drug coverage when eligible, and you go 63 days or longer after your applicable Medicare enrollment period ends without a Medicare drug plan or other creditable prescription drug coverage, your Medicare prescription drug plan monthly premium will go up at least 1 percent per month for every month that you did not have creditable coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19 percent higher than the Medicare base beneficiary premium. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Medicare Open Enrollment to enroll in Part D. This may mean the number of months you have to wait for coverage will be longer, which could make your premium higher.

General Information

When you make your decision, you also should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

For more information about this Notice or your current prescription drug coverage, contact the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940, Monday through Friday, 8:30 a.m. to 8:00 p.m., ET.

Note: You may receive this Notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail from Medicare. You also may be contacted directly by Medicare prescription drug plans. You also can get more information about Medicare prescription drug plans by:

- visiting **www.medicare.gov**;
- calling your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for its telephone number) for personalized help; or
- calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration at **www.ssa.gov** or call 1-800-772-1213 (TTY: 1-800-325-0778).

Remember: Keep this guide because it contains your Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

January 2021

BNY Mellon
Benefits Department
500 Grant Street, Room 3118
Pittsburgh, PA 15258
1-800-947-4748, option 1, sub-option 2

Health Insurance Marketplace Coverage Options and Your Health Coverage

Key Things to Know About the Health Insurance Marketplace

- Anyone can shop in the public health insurance marketplace. While some low-income individuals qualify for subsidized coverage, BNY Mellon employees generally will not qualify because of the cost and benefit value of our health plans.

- If you shop in the health insurance marketplace, you may find the options offered to be more expensive than BNY Mellon coverage because BNY Mellon pays a part of the cost for your medical coverage. Generally, in the public marketplace, you will pay the entire cost of your coverage.

Health Insurance Marketplace Coverage Options

PART A: General Information

The Affordable Care Act offers a new way to buy private individual health insurance: the **Health Insurance Marketplace**. To help you evaluate health care options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by BNY Mellon.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find private, individual health insurance if you need it. The Marketplace offers "one-stop shopping" to find and compare private health insurance options.
Can I Save Money on my Health Insurance Premiums in the Marketplace?

If you purchase health insurance through the Marketplace and your income is within certain limits, you may be eligible for a premium tax credit from the IRS that reduces your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards.
Does the Health Coverage Offered by BNY Mellon Affect My Eligibility for Premium Savings through the Marketplace?

Yes. Each of the medical plans offered by BNY Mellon meets or exceeds the standards for comprehensive and affordable coverage as required under the law. As a result, you will not be eligible for a tax credit through the Marketplace if you are eligible to enroll in a BNY Mellon sponsored medical plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if you are not eligible for the BNY Mellon medical coverage. If the cost of individual coverage is more than 9.83 percent of your household income for 2021, or if the coverage provided by BNY Mellon does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by BNY Mellon, then you will lose BNY Mellon's contribution to the cost of your medical coverage, as well as the tax benefits of those before-tax contributions. The BNY

Mellon contributions — as well as your own contributions — are often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by BNY Mellon, please check your summary plan description or contact the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940.
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.healthcare.gov** for more information, including an

online application for health insurance coverage and contact information for a Health Insurance Marketplace agent or broker in your area.

PART B: Information About Employer-Provided Health Coverage

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide information about the medical coverage offered by BNY Mellon. The information below can help you complete your application for Marketplace coverage.

General Employer Information	
Employer Name	The Bank of New York Mellon Corporation
Employer Identification Number (EIN)	13-2614959
Employer phone number	1-800-947-4748
Employer street address	500 Grant Street, Room 3118
Employer city	Pittsburgh
Employer state	PA
Employer ZIP code	15258
Contact about employee health coverage at this job	BNY Mellon Benefit Solutions Service Center
Phone number	1-855-354-6940

Here is some basic information about health coverage offered by BNY Mellon:

- In general, we offer a health plan to all benefits-eligible full-time and part-time employees who are regularly scheduled to work at least 20 hours per week.

- With respect to dependents, we do offer coverage. Eligible dependents are: your spouse, your qualified domestic partner, your children up to age 26, your unmarried, dependent children older than age 26 who are mentally or physically disabled and incapable of self-support and who became disabled before age 26. Please see the summary plan description for a complete definition of eligible dependents.

- You may be required to check a box indicating whether the BNY Mellon medical plan meets the minimum value standard. All of the BNY Mellon medical plan options meet the minimum value standard.

Privacy Notice for Wellbeing Program

Your privacy is important.

Your participation in the BNY Mellon Wellbeing Program (the "Wellbeing Program") is voluntary. The Wellbeing Program is available to all eligible employees and their eligible family members. The Wellbeing Program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the Wellbeing Program, you have the option to complete a voluntary Health Risk Assessment that asks a series of questions about your health-related activities, behaviors and history. You may also complete a voluntary biometric screening, which will include a blood test for cholesterol and blood glucose levels. You are not required to complete the Health Risk Assessment or to participate in the biometric screening or any other medical examinations.

Active employees and their spouses/qualified domestic partners who participate in the Wellbeing Program may have the opportunity to earn certain incentives on a quarterly basis. If you think you might be unable to meet a standard or activity for an incentive under this Wellbeing Program, you might qualify for an opportunity to earn the same incentive by different means. Contact Virgin Pulse at 1-888-671-9395 between 8:00 a.m. and 9:00 p.m. EST Monday through Friday and they will work with you (and, if you wish, with your physician) to find an alternative means for you to earn the same incentive.

None of the Wellbeing Program providers will provide your personal health data, including Health Risk Assessment and biometric screening input or results, or other personal information, to BNY Mellon, except as permitted by law or except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellbeing Program. BNY Mellon will receive only anonymous, aggregate data to be used for the purpose of evaluating the success of the Wellbeing Program and for designing programs with the goal to meet your health and wellness needs.

Individual participation will be reported to BNY Mellon and Wellbeing Program providers for purposes of Wellbeing Program incentive administration, when applicable. Wellbeing Program providers (but not BNY Mellon) may receive individual medical and pharmacy information in order to provide you with tools and services under this Wellbeing Program. Although BNY Mellon may receive aggregated data from Wellbeing Program providers for estimating overall plan costs, it will not receive any of your personal health data under any circumstance.

The programs and services provided by Wellbeing Program providers are completely confidential. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the programs and services, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellbeing Program or receiving any incentive.

In addition, all medical information obtained through the Wellbeing Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Wellbeing Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellbeing Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellbeing Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the BNY Mellon Health Information Privacy Officer at:

BNY Mellon
Employee Benefits Department
500 Grant Street, AIM: 151-3118
Pittsburgh, PA 15258

APPENDIX C
2021 HIPAA NOTICE

To: Employees (both active and inactive), retirees, dependents and COBRA beneficiaries who are eligible to participate in any of the health plans offered by BNY Mellon

Date: January 1, 2021

Subject: HIPAA Notice of Privacy Practices

The privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) became effective April 14, 2003. These federal regulations require covered entities, such as health plans, to provide plan participants with a notice of privacy practices describing the health-related information that is collected, how it is used and the ways in which the regulations permit it to be disclosed. These privacy notices also provide information on a participant's right to access, review and, if necessary, to have this information amended.

The following HIPAA Notice of Privacy Practices details the uses and disclosures that the BNY Mellon health plans may make of your health information, along with your rights and BNY Mellon's health plan's obligations with respect to that information.

BNY Mellon's benefits program includes both self-insured and insured plans. If you are enrolled in an insured plan, as listed below, the applicable insurance company or HMO is obligated to provide its HIPAA Notice of Privacy Practices to you.

BNY Mellon and its health plans strive to take all appropriate measures to protect the privacy of your health information. We take this responsibility very seriously and consider it our obligation to you and to your family, not simply a legal requirement that we must fulfill. Not only do the BNY Mellon health plans place limits on disclosing your health information to outside parties, but we also take precautions regarding who can access that information internally. Your health information is not disclosed to outside parties for the purpose of marketing products and services.

If you have questions, please contact the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940 or 1-800-947-4748, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

BNY Mellon-Sponsored Insured Health Plans/Programs for U.S.-Based Employees

- Aetna DMO
- Aetna International (international expatriates only)
- HMSA (Hawaii only)
- Kaiser Permanente California (Los Angeles)
- Kaiser Permanente California (San Francisco)

BNY Mellon Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the medical information practices of BNY Mellon's health plans and programs and of any third party (called a "business associate") in connection with functions or services that party provides in the administration of those plans and programs.

"We," "us," and "Plan" refer to all the health plans and programs, except for the insured plans listed above. "Plan Sponsor" refers to BNY Mellon. ''You" or "yours" refers to individual participants in the Plans.

If you participate in one of the insured health plans sponsored by BNY Mellon, you will receive a notice from the appropriate insurance company or HMO regarding the policies and procedures it will follow related to the use and disclosure of your Protected Health Information (PHI).

PHI is information that may identify you and that relates to past, present or future health care services provided to you, payment for health care services provided to you, or your physical or mental health or condition. This Notice of Privacy Practices describes how we may use and disclose your PHI. It also describes your rights to access and control your PHI. We are required to abide by the terms of this Notice of Privacy Practices as it is currently in effect.

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to:

- maintain the privacy of your PHI;
- provide you with certain rights with respect to your PHI, including the right to be notified of a breach of unsecured PHI as further described below;
- provide you with this Notice of our legal duties and privacy practices regarding your PHI; and
- abide by the terms of this Notice as it may be updated from time to time.

We protect your PHI from inappropriate use or disclosure. Our employees and those of our business associates are required to protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to determine coordination of benefits or services.

We will not disclose your PHI to anyone for marketing purposes. We will not sell your PHI to anyone in violation of HIPAA.

Uses and Disclosures of PHI

Primary Uses and Disclosures of PHI

The main reasons for which we may use and may disclose your PHI are in order to administer our health benefit programs effectively and to evaluate and process requests for coverage and claims for benefits. The following describe these and other uses and disclosures, together with some examples.

Treatment, Payment and Health Care Operations Purposes

For Treatment: Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. We may disclose your PHI to health care providers to provide you with treatment. For example, we might respond to an inquiry from a hospital about your eligibility for a particular surgical procedure.

For Payment: Payment refers to our activities in collecting premiums and paying claims for health care services you receive. We may use your PHI or disclose it to others for these purposes. For example, if you had insurance coverage from a spouse's employer, we might disclose your PHI to the other insurer to determine coordination of benefits or services. Payment also refers to the activities of a health care provider in obtaining reimbursement for services. We may disclose your PHI to a provider for this purpose.

For Health Care Operations Purposes: Health care operations purposes refer to the following:

- We may use your PHI or disclose it to others for quality assessment and improvement activities.
- We may use your PHI or disclose it to others for activities relating to improving health or reducing health care costs, development of health care protocols, case management and care coordination.
- We may use your PHI or disclose it to others for the purpose of informing you or a health care provider about treatment alternatives.

- We may use your PHI or disclose it to others for the purpose of reviewing the competence, qualifications or performance of health care providers, or conducting training programs.
- We may use your PHI or disclose it to others for accreditation, certification, licensing or credentialing activities.
- We may use your PHI or disclose it to others in the process of contracting for health benefits or insurance covering health care costs.
- We may use your PHI or disclose it to others for purposes of reviewing your medical treatment, obtaining legal services, performing audits or obtaining auditing services, and detecting fraud and abuse.
- We may use your PHI or disclose it to others in our business management, planning and administrative activities. As an example, we might use your PHI in the process of analyzing data about treatment of certain conditions to develop a list of preferred medications.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules.

- **Business Associates:** We contract with various individuals and entities (business associates) to perform functions on behalf of the Plans or to provide certain services. To perform these functions our business associates may receive, create, maintain, use or disclose PHI, but only after we require the business associates to agree in writing to contract terms designed to safeguard your PHI.
- **Plan Sponsor:** We and our business associates may also disclose PHI to the Plan Sponsor in connection with payment, treatment or health care operations purposes or pursuant to a written request signed by you. Such disclosures may only be made to the individuals authorized to receive such information.
- **Other Covered Entities:** The Bank of New York Mellon Corporation's Plans (including the insured plans) together are called an "organized health care arrangement." The Plans may share PHI with each other for the health care operations purposes of the organized health care arrangement.

Other Possible Uses and Disclosures of PHI

In addition to using and disclosing your PHI for treatment, payment and health care operations purposes, we may (and are permitted to) use or disclose it in the following circumstances:

- **To Persons Involved in Care and for Notification Purposes:** We may disclose PHI to a family member, relative, close personal friend or any other person identified by you, provided that the PHI is directly relevant to that person's involvement with your care or payment related to your care. In addition, we may use or disclose PHI to notify a member of your family, your personal representative or another person responsible for your care of your location, general condition or death.
- **In Regard to Abuse, Neglect or Domestic Violence:** In certain circumstances, we may disclose your PHI to a government authority that is authorized to receive reports of cases of abuse, neglect or domestic violence.
- **To Coroners, Medical Examiners and Funeral Directors:** We may disclose PHI to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death or other purposes authorized by law. We may disclose PHI to funeral directors to enable them to carry out their duties.
- **For Public Health Activities:** We may disclose PHI to public authorities for the purpose of preventing or controlling disease, injury or disability. Under some circumstances, when authorized by law, we may disclose PHI to an individual who is at risk of contracting or spreading a contagious disease or condition. We also may disclose PHI to appropriate parties for the purpose of activities related to the quality, safety or effectiveness of products regulated by the U.S. Food and Drug Administration.
- **To Avert a Threat to Health or Safety:** We may, under certain circumstances, disclose PHI to avert a serious threat to the health or safety of a person or the general public.

- **Organ and Tissue Donations:** We may, under certain circumstances, disclose PHI for purposes of organ, eye or other medical transplants or tissue donation purposes.
- **To Comply with Workers' Compensation Laws:** We may disclose your PHI to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs.
- **For Law Enforcement and National Security Purposes:** In certain circumstances, we may disclose PHI to appropriate officials for law enforcement purposes—for example, as required by law or legal process. In addition, we may disclose your PHI if you are or were armed forces personnel or to authorized federal officials for conducting national security and intelligence activities.
- **In Connection with Legal Proceedings:** In certain cases, we may disclose PHI in connection with the legal proceedings of courts or governmental agencies. For example, we may disclose your PHI in response to a subpoena for such information, but only after certain conditions required by HIPAA are met.
- **For Health Oversight Activities:** We may disclose PHI to a governmental agency authorized by law to oversee the health care system, compliance with civil rights laws or government benefit. Health oversight activities include audits, inspections, investigations or legal proceedings.
- **Military Personnel:** If you are in the armed forces, we may disclose your PHI for activities that military authorities consider necessary to the accomplishment of a mission.
- **Inmates:** If you are incarcerated, we may disclose your PHI to appropriate authorities as needed for your health care, your safety, the health or safety of other persons, or general administrative purposes.
- **Research:** Under certain circumstances, we may disclose PHI for research purposes, provided certain measures have been taken to protect your privacy.
- **Health Information:** We may contact you with information about treatment alternatives and other health-related benefits and services.
- **As Required by Law:** We may disclose your PHI when required to do so by federal, state or local law.

Required Disclosures of PHI

The following is a description of disclosures we are required by law to make:

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services:** We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with HIPAA.
- **Disclosure to You:** We are required to disclose to you most of your PHI. We will also disclose your PHI to an individual whom you have designated as your personal representative. However, before we can disclose your PHI to such person, you must submit a written notice of his/her designation, along with documents supporting his/her qualification (such as a power of attorney). In limited situations HIPAA permits us to elect not to treat the person as your personal representative if we have reasonable belief that it could endanger you.

Other Uses and Disclosures of Your PHI with Authorization

We generally may use or disclose psychotherapy notes about you or use or disclose your PHI for marketing purposes only with your written authorization, unless a specific exception to those rules applies. We may not sell your PHI without your written authorization.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. You may revoke an authorization at any time by providing written notice to us. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in reliance on the authorization. To obtain an Authorization for Release of Information, call the BNY Mellon Benefit Solutions Service Center directly at 1-855-354-6940 (Monday through Friday, 8:30 a.m. to 8:00 p.m. ET). You may revoke an authorization by contacting the Health Information Privacy Officer identified at the end of this Notice.

Genetic Information

The Privacy Regulations prohibit us from using or disclosing your family members' genetic information for underwriting purposes.

Your Rights

Right to Request Restrictions on Uses and Disclosure

You may ask us to restrict uses and disclosures of your PHI for treatment, payment or health care operations purposes, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care, or to restrict disclosures for notification purposes. However, we are not generally required to comply with your request for restrictions, except in those situations where the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment) and the PHI pertains solely to a health care item or service for which the individual, or a person other than the Plan on behalf of the individual has paid in full. You may exercise this right by contacting the Health Information Privacy Officer identified at the end of this Notice, who will provide you with additional information including what information is required to make a restriction request.

Right to Inspect, Copy and Amend Your PHI

As long as we maintain records containing your PHI, you have a right to inspect and copy such information. If you request an electronic copy of this information, we will provide you with the information in the electronic form and format you request, if it is readily reproducible in that form or format or, if not, in a readable form and format to which we and you agree. These rights are subject to certain limitations and exceptions. For example, if the requested information contains psychotherapy notes or may endanger someone, it may not be available. You may request a review of any denial to access. If you believe your PHI held and created by us is incorrect or incomplete, you may request that we amend your PHI. You will be required to provide the reason the amendment is necessary. Requests for access to your PHI or amendment of your records should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to a List of Disclosures

You have a right to an accounting of certain disclosures of your PHI by us. The accounting will not include those items which are not required to be provided such as disclosures made at your request or disclosures made for treatment, payment or health care operations. A request for a list of disclosures should be directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to Request Confidential Communications

We will accommodate a reasonable request by you to receive communications from us by alternative means or at an alternative location if you believe that disclosure of your PHI could pose a danger to you. For example, you may request that we only contact you by mail or at work. Requests for confidential communications should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to be Notified of a Breach

You have the right to be notified in the event that we (or a business associate) discover a breach of unsecured PHI.

Right to Receive Paper Copy

You have the right to receive a paper copy of this Notice from the Plan upon request, even if you have previously agreed to receive copies of this Notice electronically. Requests for a paper copy should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Changes to This Notice

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI we maintain. If we change this Notice, you will receive a new Notice. Active employees will receive the Notice by distribution in the workplace; inactive employees (including retirees) will receive the Notice by mail.

Complaints

If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below under "Health Information Privacy Officer" or with the office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Health Information Privacy Officer

You may exercise the rights described in this Notice by contacting the office identified below, which will provide you with additional information.

BNY Mellon
Employee Benefits Department
500 Grant Street
Suite 3118
BNY Mellon Center
Pittsburgh, PA 15258
ATTN: Health Information Privacy Officer

Any Employee Assistance Program (EAP)-related questions or issues should be directed to:
BNY Mellon
EAP Manager
500 Grant Street
Suite 3118
Pittsburgh, PA 15258

Effective Date of Notice

This Notice is effective as of January 1, 2021.

DocuSign Envelope ID: 2F984277-C924-4C73-87A2-F5A661726173

APPENDIX D
COBRA RIGHTS NOTICE – HEALTH AND WELFARE BENEFITS

You are receiving this notice because you are currently covered under a group health plan under the BNY Mellon Group Health and Welfare Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (see the Marketplace notice in this packet for further details). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when you would otherwise lose your group health coverage under the Plan. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review your Summary Plan Description or contact the BNY Mellon Benefit Solutions Service Center.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;

- Your entitlement to Medicare benefits (under Part A, Part B, or both);
- Your divorce or legal separation; or
- The dependent stops being eligible for coverage under the Plan as a “dependent child”.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to BNY Mellon, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

BNY Mellon will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified that a qualifying event occurred. For the following qualifying events, BNY Mellon will notify the BNY Mellon Benefit Solutions Service Center of the qualifying event:

- Your hours of employment are reduced;
- Your employment ends;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B, or both); or
- BNY Mellon commences Chapter 11 bankruptcy proceedings.

You Must Give Notice For All Other Qualifying Events

For all other qualifying events (divorce or legal separation from your spouse, or your dependent child’s losing eligibility for coverage as a dependent child), you or a family member must notify the BNY Mellon Benefit Solutions Service Center within 60 days after the qualifying event occurs.

You must notify the BNY Mellon Benefit Solutions Service Center of the qualifying event by accessing the MyBenefit Solutions website at **mybenefits.bnymellon.com** or calling 1-855-354-6940.

How Is COBRA Continuation Coverage Provided?

Once the BNY Mellon Benefit Solutions Service Center receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your spouse and dependent children. Your spouse may also elect continuation coverage on behalf of your dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are two ways in which an 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

COBRA coverage may be available for you and your family for up to a total of 29 months at a higher premium if:

- You, your covered spouse, or your covered dependents (including newborn and newly adopted children) are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage;
- The Social Security Administration’s disability determination is received within the disabled individual’s initial 18 months of COBRA coverage;
- The disability remains in effect at the end of the 18-month period of continuation coverage; and

- The BNY Mellon Benefit Solutions Service Center is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security Disability award. If the disability determination occurred before COBRA coverage started, you're required to notify the BNY Mellon Benefit Solutions Service Center within the first 60 days of COBRA coverage.

You, your covered spouse, or your covered dependents must notify the BNY Mellon Benefit Solutions Service Center within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period in order to receive the coverage extension. To notify the BNY Mellon Benefit Solutions Service Center of the disability determination event, call 1-855-354-6940.

You, your covered spouse, or your covered dependents must notify the BNY Mellon Benefit Solutions Service Center within 30 days of the date the disability ends by calling 1-855-354-6940.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if the BNY Mellon Benefit Solutions Service Center is properly notified about the second qualifying event. Additional continuation coverage is available only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. These events include:

- Your death;
- Your entitlement to Medicare (under Part A, Part B, or both);
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the Plan as a "dependent child".

You, your covered spouse, or your covered dependents must notify the BNY Mellon Benefit Solutions Service Center within 60 days after the event occurs in order to receive this additional coverage. To notify the BNY Mellon Benefit Solutions Service Center of the additional qualifying event, call 1-855-354-6940.

Events That May Change Continued Coverage

Once your COBRA coverage begins, you may be able to change your COBRA coverage elections based on plan rules if you experience a qualified change in status. You, your covered spouse, or your covered dependents must notify the BNY Mellon Benefit Solutions Service Center by calling 1-855-354-6940 within 31 days of the qualified change in status to change your COBRA coverage. See your Summary Plan Description for detailed information on allowable changes in status. Adding family members to COBRA coverage may result in a higher premium for this additional coverage.

You may also change COBRA coverage if a child is born to the covered employee or placed for adoption with the covered employee during the 18-, 29-, or 36 -month continuation period. In such case, you must notify the BNY Mellon Benefit Solutions Service Center by calling 1-855-354-6940, Monday through Friday, 8:30 a.m. to 8:00 p.m. ET, within 31 days of the birth or placement to cover the new dependent as a qualified beneficiary under COBRA. There may be a higher premium for this additional coverage.

Events That End Continued Coverage

COBRA coverage will end automatically upon the expiration of the 18-, 29-, or 36-month continuation periods previously described. In addition, COBRA coverage will end automatically if any of the following situations occur:

- BNY Mellon stops providing group health benefits;
- Premiums are not paid within 60 days of the due date (with the exception of the initial premium which is due within 45 days of your election date); or
- A person eligible for continued benefits becomes covered under any other group health plan or becomes entitled to Medicare.

If your coverage ends because of expiration of the 18-, 29-, or 36-month limit, you may be able to convert coverage to an individual policy if this right currently exists in the Plan.

Other Coverage Options

When you lose group health coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You can learn more about many of these options at **www.healthcare.gov**.

Enrolling in Medicare Instead of COBRA Continuation Coverage

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. The Plan will pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit www.medicare.gov/medicare-and-you.

Address Information

Be sure to keep your current address information up to date with BNY Mellon. Doing so is the only way to ensure that important benefit information will reach you. You should also keep a copy, for your records, of any notices you send to BNY Mellon.

Your Rights Under ERISA

For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

For More Information

BNY Mellon Benefit Solutions is providing COBRA administration services. Questions concerning the Plan or your COBRA continuation coverage should be directed to BNY Mellon Benefit Solutions. You can contact the BNY Mellon Benefit Solutions Service Center as follows:

- Web: MyBenefitSolutions at **mybenefits.bnymellon.com**
- Phone: 1-855-354-6940 or 1-800-947-4748, Monday through Friday 8:30 a.m. to 8:00 p.m ET.

Please address any written correspondence to:

BNY Mellon Benefit Solutions
PO Box 563931
Charlotte, NC 28256-3931