2019 Benefits Guide for Active Employees

Make Informed Choices When You Enroll

Revised July 2019

BNY MELLON

About this Guide

This document is a Summary of Material Modifications to the 2018 version, intended to notify you of important changes made to BNY Mellon's benefit plans for the plan year beginning on January 1, 2019. The information set forth in this Guide is in summary form. It is not intended to, and does not, provide tax or investment advice and is not a guarantee of employment of any nature. In the event of any discrepancy between this information and the applicable plan documents, the terms of the applicable plan documents control. BNY Mellon reserves the right to change or eliminate any of its benefit plans at any time for any reason, subject to applicable law.

If you have questions, call the BNY Mellon Benefit Solutions Service Center at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

Welcome to BNY Mellon

BNY Mellon is committed to sponsoring health care benefits in an environment where health and wellbeing are aligned to drive superior results and outcomes, both personally and professionally. We strongly encourage you to actively enroll in 2019 benefits to help ensure you have coverage that meets the needs of you and your dependents. Your enrollment deadline will be included with your enrollment information.

Please use this 2019 Benefits Guide to find the information you need to make informed decisions about your 2019 BNY Mellon Benefits.

Please note: The choices you make when you enroll will remain in effect from the date of your eligibility through the earlier of December 31, 2019, or the last day of the month you transition to a status that is ineligible for coverage, including termination.

After your enrollment period, you will be able to make changes to your benefit elections ONLY if you have a "qualified life event" during the year (see "Changing Coverage" on page 14 for more information). Your next opportunity to make changes will be during Open Enrollment for the next plan year.

Be sure to read this Guide carefully. It is designed to:

– help you understand your benefit options and their costs to assist with making informed health care choices;

– support your overall wellbeing and encourage simple steps to living a healthier lifestyle;

– explain to you eligibility and other important benefit program provisions;

– show you where to find additional information that may help you make informed decisions; and

– provide instructions on how to enroll in 2019 benefits.

If you have questions, call the BNY Mellon Benefit Solutions Service Center at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see "BNY Mellon Creditable Coverage Plans" on page 75 for more details. Also, note that Medicare eligibility may impact your medical plan choices for 2019. Carefully review this document to ensure you make the right decision for 2019.

Eligibility and Enrollment

Benefits Eligibility

The Bank of New York Mellon Health and Welfare Plan (BNY Mellon's Flexible Benefits Program) is available to all active full-time and part-time salaried employees, who are regularly scheduled to work at least 20 hours per week as determined by BNY Mellon.

In addition to yourself, you can also enroll your dependents for medical, dental, vision and dependent life insurance coverage.

You may enroll yourself and your eligible dependents for benefits within 31 days after the later of your date of hire or your eligibility date.

Eligible dependents include (subject to the terms of the covered benefits):

– your opposite-sex or same-sex spouse (unless you are divorced or legally separated);

– your qualified domestic partner—a partner, of the opposite or same sex, with whom you share a committed and mutually dependent relationship, evidenced by a shared residence and record of financial interdependence (review "Qualified Domestic Partner Definition" below for more information);

– your children up to age 26, regardless of full-time student status, residency, financial support, marital status or access to other employer-sponsored coverage;

– your unmarried, dependent children older than age 26 who are mentally or physically disabled and incapable of self-support and who became disabled before age 19;

– your parents and parents-in-law (even if not members of your household) for Best Doctors only; and

– all of your household members (e.g., spouse, qualified domestic partner, parents, grandparents) for the Employee Assistance Program (EAP).

For this definition, "child" means your natural child, stepchild, legally adopted child (including those placed with you for adoption), foster child placed with you, a child for whom you have legal guardianship and the duty of sole financial support by an order of the court (you must provide documentation verifying that a court order gives you both legal custody and the duty of sole financial support before you can enroll the child), or a "child" of your qualified domestic partner.

You may add or remove a child from medical coverage at any time if a Qualified Medical Child Support Order (QMCSO) requires (or previously required) you or your former spouse to cover the child. You may be asked for documentation of eligibility at the time of enrollment or during any audit checks.

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

Qualified Domestic Partner Definition

BNY Mellon defines qualified domestic partners as two same- or opposite-sex people in a spouse-like relationship who have each met each of the following requirements:

– are each other's sole qualified domestic partner and intend to remain so indefinitely;

– are at least age 18 and competent to enter into a legal contract;

– are not related in a way that would prevent them from being legally married;

– are not legally married to anyone else, and any prior marriages have been dissolved through death or divorce;

– are not qualified domestic partners with anyone else, and any prior qualified domestic partnerships have been terminated;

– have 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, health care, work or military service); and
– are registered qualified domestic partners with any state or local government domestic partnership registry, if residing in a state or locality that provides qualified domestic partner registration.

You may be required to demonstrate proof of this relationship by submitting:

– a notarized Affidavit of Domestic Partnership (if residing in a state or locality that makes qualified domestic partner registration available); or
– two proofs of joint ownership in effect for at least the prior six months (including, but not limited to, joint bank account statements, joint credit card accounts, or joint ownership or a common leasehold interest in real property).

Go Paperless

Start paperless delivery to receive benefits documents electronically.

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

If you consent to electronic delivery, please update your delivery preference through the MyBenefit Solutions website by selecting “Email” as your delivery preference. Each time a new document is available, you will receive an email notifying you it is ready for viewing. If no preference is selected, you will receive paper communications. You may revoke your consent to electronic delivery and request paper form copies at no charge by changing your preferences online or by contacting the BNY Mellon Benefit Solutions Service Center at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

Benefit Options at a Glance

BNY Mellon offers a comprehensive, competitive benefits program with the flexibility to help meet the needs of our diverse workforce. Review the benefits available to you, and then choose the options that best meet the needs of you and your family.

YOUR 2019 BENEFIT OPTIONS AT A GLANCE	

Medical	– No coverage
	– Both Aetna and UnitedHealthcare offer two plans:
	  – Lower Deductible HSA Plan (Health Savings Account)
	  – Higher Deductible HSA Plan (Health Savings Account)
	– Kaiser Permanente (Los Angeles and San Francisco only)
	– HMSA (Hawaii only)
	– Aetna International (international expatriates only)

Dental	– No coverage – MetLife PDP Option 1 – MetLife PDP Option 2 – Aetna DMO (Dental Maintenance Organization)—only pays a benefit when you use participating providers
Vision	– No coverage – Vision Service Plan
Long-Term Disability	– 50% of base pay benefit (buy-down option for credit) – 60% of base pay benefit (BNY-Mellon-paid coverage) – 70% of base pay benefit (buy-up option)

YOUR 2019 BENEFIT OPTIONS AT A GLANCE	
Basic Life Insurance	– BNY Mellon-paid benefit equal to your base pay, up to $500,000 – Elect to buy down to coverage of $50,000 for credit (for employees with salaries greater than $50,000)
Supplemental Life Insurance	– No coverage – Elect additional coverage of one to eight times your base pay ($3 million maximum), subject to Evidence of Insurability (EOI)
Basic Accidental Death & Dismemberment (AD&D) Insurance	– BNY Mellon-paid benefit equal to your base pay, up to $500,000
Supplemental AD&D Insurance	– No coverage – Elect additional coverage of one to eight times your base pay ($3 million maximum)
Spouse/Qualified Domestic Partner Life Insurance	– No coverage – $25,000 benefit – $50,000 benefit
Child Life Insurance	– No coverage – $10,000 benefit – $15,000 benefit
Health Savings Account (HSA)	– No contribution – Elect to contribute up to $3,500* (individual) or $7,000* (family), including BNY Mellon contributions, annually * If you are age 55 or older, you may make an additional catch-up contribution up to $1,000 annually.
Health Care Flexible Spending Account (FSA)	– No contribution – Elect to contribute up to $2,650 annually – Not available if you contribute to a Health Savings Account (see Limited Purpose Flexible Spending Account (FSA))
Limited Purpose Flexible Spending Account (FSA)	– No contribution – Elect to contribute up to $2,650 annually to a Limited Purpose FSA (if you enroll in Plan HSA)
Dependent Care Flexible Spending Account (FSA)	– No contribution – Elect to contribute up to $5,000 annually
Flex Vacation Purchase	– No purchase – Elect to purchase up to five additional vacation days for 2019 if you were hired on or prior to November 30, 2018

Enrollment

How to Enroll

Visit MyBenefit Solutions to enroll in health plans and other insurance coverages:

– **At Work:** Single sign-on access through **MyReward** (MySource > MyReward > Log on to MyReward > Proceed to My Personal Total Reward Data > MyBenefit Solutions).

– **At Home: mybenefits.bnymellon.com**. (If you are a new employee or have not already registered, you will need to create a username and password.)

If you have questions, call the BNY Mellon Benefit Solutions Service Center at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

Your Path to a Successful Enrollment

Be informed:

– Read this Decision Guide to learn about 2019 health plan details and instructions for enrolling.

– Visit **www.healthhub.bnymellon.com** to access information, tools, and resources that provide information on the 2019 health plans.

– Learn more about health savings accounts by visiting the BenefitWallet microsite (**www.mybenefitwalletsite.com/bnymellon).**

Review and compare health plans. Visit MyBenefit Solutions to use these health plan decision support tools:

– **Medical Expense Estimator:** Estimate your 2019 health care expenses under both health plan options.

– **Decision Direct:** Obtain specific, personalized enrollment suggestions with this easy-to-use tool. By answering a few simple questions about your health care needs and preferences, Decision Direct helps you compare the plans and determine the best option for you.

– **"People Like Me":** Review hypothetical enrollment decisions others have made and the reasons behind their decisions.

– **Health Savings Account (HSA) Estimator:** Estimate how much to contribute to your Health Savings Account based on anticipated yearly expenses.

– **Flexible Spending Account (FSA) Estimator:** Estimate how much to contribute to your health care and dependent care Flexible Spending Accounts based on anticipated yearly expenses.

Choosing Your Health Plan

In addition to the information in this guide, BNY Mellon offers a variety of online resources and tools to help you choose your health plan and help you make informed decisions when using your benefits.

– Find more information about enrollment and your benefits on the HealthHub website at **www.healthhub.bnymellon.com.**

– Be sure to use the health plan comparison tools on the MyBenefit Solutions website at **mybenefits.bnymellon.com**.

Enrollment Reminders

Keep the following in mind as you prepare to enroll:

– Check your personal information, such as address and phone number, to ensure that all information is accurate.

– Think about your coverage needs, including how much health care you and your family may use and whether basic life and disability insurance provides enough protection.

Enrollment Deadline

You must enroll by the deadline provided in your enrollment materials, generally within 31 days after the later of your date of hire or your eligibility date.

If You Do Not Enroll by the Enrollment Deadline

The following chart shows the default coverage you will receive for 2019 if you do not enroll by the deadline provided with your enrollment information.

COVERAGE YOU WILL RECEIVE	
	Newly Benefited Employees
Medical	No coverage
Health Savings Account Contributions (available only if you enroll in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan and establish an HSA account with BenefitWallet)	No employee contributions; you may change your Health Savings Account contribution amount monthly throughout the year
Dental	No coverage
Vision	No coverage
Long-Term Disability Insurance	BNY Mellon-paid coverage equal to 60% of base pay
Life Insurance/Supplemental Life Insurance	BNY-Mellon-paid coverage equal to your base pay, up to $500,000
Spouse/Qualified Domestic Partner Life Insurance	No coverage
Child Life Insurance	No coverage
AD&D Insurance/Supplemental AD&D Insurance	BNY Mellon-paid coverage equal to your base pay, up to $500,000
Health Care Flexible Spending Account	No participation
Limited Purpose Flexible Spending Account	No participation
Dependent Care Flexible Spending Account	No participation
Flex Vacation	No participation

When Coverage Becomes Effective and Terminates

If you are newly eligible for benefits during 2019 and you enroll within 31 days of your benefit-eligibility date, the choices you make when you enroll remain in effect from the date of your eligibility through the earliest of December 31, 2019, or the last day of the month you transition to a status that is ineligible for benefit coverage, including termination.

Once you are covered, coverage for a new spouse or children born, adopted or placed with you for adoption during the year begins on the date of marriage, birth, adoption or placement. In all cases involving newly eligible dependents, you must notify the BNY Mellon Benefit Solutions Service Center within 31 days of the date the dependent became eligible for coverage.

After you enroll, except for changes in Health Savings Account contributions, you will be able to make changes to your benefit selections ONLY if you have a qualified life event during the year or one of the special enrollment rights applies. For more details, review the “Changing Coverage” section starting on page 14. Your next opportunity to make changes will be during Open Enrollment for the 2020 plan year.

Paying for Coverage

BNY Mellon pays the full cost of some of your benefits. These include:

– Life insurance coverage equal to your base pay (up to a maximum of $500,000)

– Basic accidental death and dismemberment (AD&D) insurance coverage equal to your base pay (up to a maximum of $500,000)

– Travel accident insurance coverage

– Long-term disability coverage equal to 60 percent of your base pay

– Short-term disability

– Wellbeing program
– Castlight (for those enrolled in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan through Aetna or UnitedHealthcare)
– Employee Assistance Program
– CVS Caremark AccordantCare™ Health Services
– CVS Health Pharmacy Advisor Counseling Program
– Best Doctors

You and BNY Mellon share the cost of some of your other benefit options, such as your medical and dental coverage. You pay the full cost of other benefits—vision, life (supplemental, spouse/qualified domestic partner, child) insurance, supplemental AD&D insurance, supplemental long-term disability insurance, and flex vacation.

Your Per-Pay Cost

Your share of the cost of coverage will be made through convenient payroll deductions, unless you are in a job classification that requires you to make benefits payments directly to BNY Mellon. All of your contributions, except for spouse/qualified domestic partner and child life insurance and supplemental life insurance premiums, are deducted from your pay before taxes are deducted (unless your dependent does not meet tax dependents requirements). By contributing on a pre-tax basis, you lower your current taxable income.

The per-pay premiums for each benefit option and coverage level are shown online when you enroll. If you elect certain life insurance coverage or the 50 percent long-term disability option, you may receive a credit from BNY Mellon, as shown when you enroll online—the system will calculate your per-pay costs automatically.

For federal tax purposes, the full value of the health care benefits provided to your dependents (e.g., your qualified domestic partner and his or her children) is taxable, unless such dependents qualify as your federal tax dependent(s) for health plan purposes or you claim a federal tax exemption for them.

Note: Certain coverage choices will result in imputed taxable income in addition to your regular coverage premiums. For more information on imputed income, see “Cost of Coverage” on page 64.

Pricing Structure for Medical Coverage

Health plan premiums are based on four criteria:

– your base pay;
– the plan option you choose;
– the carrier you choose; and
– the number of eligible dependents you choose to cover.

The per-pay contributions are shown in “2019 Medical Premiums” on page 27. Generally, the lower your base pay, the more BNY Mellon contributes toward the cost of your coverage.

When You Have Other Medical Coverage Available

If you enroll in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan, which includes a Health Savings Account, you cannot make or receive any contributions to your Health Savings Account if you have coverage under any other plan, such as your spouse’s/qualified domestic partner’s or any part of Medicare Part A, Part B, etc. or TRICARE, unless it also meets the IRS definition of a “high-deductible health plan.”

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

When your spouse or qualified domestic partner has other coverage, this is how BNY Mellon determines which plan is primary:

– If you are the patient, BNY Mellon coverage is primary.

– If your spouse or qualified domestic partner is the patient, your spouse's or qualified domestic partner's coverage is primary.

– If your child is the patient and is covered by both parents' plans, the birthday rule applies. This means that the plan of the parent with the earlier birthday in the calendar year (using month and date only, not year) will be considered primary.

When a child is claimed as a dependent by parents who are separated or divorced, the primary plan is the plan of the parent who has court-ordered financial responsibility for the dependent child's health care expenses. When a child's parents are separated or divorced and there is no court decree, then the primary plan will be determined in the following order:

– the plan of the parent with custody of the child;

– the plan of the spouse of the parent with custody of the child; and

– the plan of the parent not having custody of the child.

The birthday rule described above applies if a court decree awarding joint custody does not stipulate that one parent is responsible for the child's health care.

Please note: if you enroll in other medical coverage, such as through your spouse's or qualified domestic partner's plan, including a general-purpose health care flexible spending account or health reimbursement account, or are covered by Medicare or TRICARE, by federal law, you are not eligible for the Health Savings Account. (While you can still enroll in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan, you will not be eligible to open or contribute to the Health Savings Account.)

Coordination of Medicare and BNY Mellon Medical Coverage

If *you or your covered spouse* is enrolled in both Medicare and a BNY Mellon health plan, whether the BNY Mellon health plan or Medicare is the primary claims payer will generally depend upon your employment status. For a *disabled employee* enrolled in both Medicare and a BNY Mellon plan, Medicare would be primary.

Medicare's rules for qualified domestic partners with group health insurance coverage are:

– Medicare pays first if a qualified domestic partner is entitled to Medicare on the basis of age and has group health plan coverage based on the current employment status of his/her qualified domestic partner.

– Medicare generally pays second:

  – When the qualified domestic partner is entitled to Medicare on the basis of disability and is covered by a large group health plan on the basis of *his/her own current employment status* or the status of a family member.

  – For the 30-month coordination period when the qualified domestic partner is eligible on the basis of end-stage renal disease, and is covered by a group health plan on any basis.

  – When the qualified domestic partner is entitled to Medicare on the basis of age and has group health plan coverage on the basis of his/her own current employment status.

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

If You Leave BNY Mellon

If you leave BNY Mellon, your benefits coverage will continue through the end of the month in which you end employment or, if later, the last day of the month in which you are receiving supplemental unemployment benefit payments pursuant to the BNY Mellon Supplemental Unemployment Benefit plan or under a severance arrangement as determined by BNY Mellon. Under federal law, you and your eligible dependents may be entitled to continue your medical, dental, vision, and Health Care FSA coverage. Within three weeks of your termination, you should receive a termination packet describing this information in detail. For more information, or if you do not receive a termination packet, see “COBRA Rights Notice–Health and Welfare Benefits” on page 83 or call the BNY Mellon Benefit Solutions Service Center at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

Changing Coverage

The BNY Mellon Flexible Benefits Program is subject to Section 125 of the Internal Revenue Code, meaning you generally cannot change your benefits elections during the applicable plan year. However, if you experience one of the qualified life events described in this section as permitted by Section 125 and adopted by BNY Mellon, you may change your elections if you provide notice within 31 days from the date of the qualified event. You may also be permitted to change your benefits elections if you provide notice within 31 days (60 days if eligibility for coverage under a Medicaid or state children's health insurance program (CHIP) changes) if one of the other special enrollment events, described in "Special Health Coverage Enrollment" on page 18, applies.

What Is a Qualified Life Event?

You may change your elections during the year if you experience one of the following qualified life event changes:

- **Legal Marital Status—**Events that change your legal marital status, including marriage, death, divorce, legal separation (according to state law) or annulment.
- **Number of Dependents—**Events that change the number of your eligible dependents, including birth, adoption, foster care, placement for adoption or death of a dependent.
- **Employment Status—**Events that change your employment status, or the employment status of your spouse/qualified domestic partner or dependent, including termination of employment, a strike or lockout, a start of or return from an unpaid leave of absence, a change in worksite, or any other employment status change that results in a gain or loss of eligibility under the relevant employer plan (for example, a switch from non-benefited to benefited). If your status changes from non-benefited to benefited or vice versa, your benefits costs will change.
- **Loss of Coverage—**You lose benefits coverage, whether due to loss of employment or another reason.
- **Dependent Eligibility—**Events that cause the gain or loss of a dependent's eligibility for benefits.
- **Residence—**A change in where you, your spouse/qualified domestic partner or dependent lives.
- **Eligibility for Medicare—**You may change your health plan election if becoming Medicare-eligible precludes you from participating in the health plan (e.g., a health savings account) you are enrolled in at such time.

Any election change described above can only be made if you provide notice to the plan administrator within 31 days (60 days if eligibility for coverage under Medicaid or CHIP changes) from the date of the qualified life event and only if the change corresponds to and is consistent with that event.

Consistency Rule

You may change your election because of a qualified life event if:

- the qualified life event affects eligibility for you, your spouse/qualified domestic partner or your dependent under a BNY Mellon plan or a plan maintained by your spouse's/qualified domestic partner's or dependent's employer; and
- the election change is on account of and corresponds to that qualified life event.

How to Report a Qualified Life Event Change

If you experience one of the events described in this section and wish to change certain elections, you may do so within 31 days (60 days if eligibility for coverage under a Medicaid or state children's health insurance program (CHIP) changes) from the date of the qualified event. You may report the event in the online benefits system from work through MyReward (MySource > MyReward > Logon to MyReward > Proceed to My Personal Total Reward Data > MyBenefit Solutions > Life Events), from home at **mybenefits.bnymellon.com** or by calling the BNY Mellon Benefit Solutions Service Center at 1-800-947-4748, option 2. Customer Service hours are Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

If you do not report the change, request a new election and provide supporting documentation within this 31-day period (or this 60-day period if eligibility for coverage under a Medicaid or state children's health insurance program (CHIP) changes), you may not change your elections until the next Open Enrollment period or other qualifying life or special enrollment event.

Please note: If you experience a qualified life event, you may change the number of dependents you cover, but you may not change your health plan option, unless you and your covered spouse/qualified domestic partner or dependent move to an area that is not served by that health plan or when you move to an area where your carrier is no longer the preferred carrier.

What You Can Change

Any election change you make must satisfy the "consistency rule", and you may be asked to provide supporting documentation for all life event changes.

The consistency rule means that you can only change benefits that are directly linked to the qualified change you experience. For example, if you have or adopt a child you can add a new dependent to your coverage. However, you cannot elect a different medical plan when you have or adopt a child since the life event does not have a direct impact on your coverage choice.

The following table lists some common life event changes and the types of benefit adjustments you may request in each situation.

LIFE EVENT CHANGES		
LIFE EVENT	**BENEFIT**	**ALLOWABLE CHANGES**
Marriage or Domestic Partnership*	– Medical – Dental – Vision	Add or discontinue coverage for yourself, your spouse/qualified domestic partner and/or new or existing dependents
	– Spouse/Qualified Domestic Partner Life – Child Life	Elect coverage
	– Supplemental Life & Accidental Death and Dismemberment (AD&D)	Increase or decrease coverage
	– Health Care FSA	Increase your contributions
	– Dependent Care FSA	Elect, increase, decrease or discontinue your contributions
Loss of Spouse or Domestic Partner ***(divorce, separation, annulment, loss of qualified domestic partner status, death)***	– Medical – Dental – Vision	Must discontinue coverage for your former spouse/qualified domestic partner Elect coverage for yourself or dependents who lose coverage under your former spouse's/qualified domestic partner's plan
	– Supplemental Life & Accidental Death and Dismemberment (AD&D)	Increase or decrease coverage
	– Spouse/Qualified Domestic Partner Life	Discontinue spouse/qualified domestic partner coverage
	– Dependent Care FSA	Elect, increase, decrease or discontinue your contributions

LIFE EVENT CHANGES		
Add a New Dependent (birth, adoption, placement for adoption, foster care, legal guardianship)	– Medical – Dental – Vision	Elect coverage for yourself and new or existing dependents
	– Spouse/Qualified Domestic Partner Life – Child Life	Add coverage for dependents
	– Health Care FSA	Elect or increase your contributions
	– Dependent Care FSA	Elect or increase your contributions
Loss of Dependent (change in eligibility or death)	– Medical – Dental – Vision	Must discontinue coverage for the dependent who loses eligibility
	– Dependent Life	Must discontinue coverage for the dependent that loses eligibility
	– Dependent Care FSA	Decrease or discontinue your contributions
Employee/Dependent Gains Eligibility for Other Coverage	– Medical – Dental – Vision	Discontinue coverage for dependent or discontinue all coverage
	– Supplemental Life & Accidental Death and Dismemberment (AD&D)	Elect, increase, decrease or discontinue your contributions
	– Spouse/Qualified Domestic Partner Life – Child Life	Discontinue coverage
Employee/Dependent Loses Eligibility for Other Coverage	– Medical – Dental – Vision	Add dependents or elect coverage
	– Supplemental Life & Accidental Death and Dismemberment (AD&D)	Increase or decrease coverage
	– Spouse/Qualified Domestic Partner Life – Child Life	Elect coverage
	– Health Care FSA	Elect or increase contributions
	– Dependent Care FSA	Elect, increase, decrease or discontinue your contributions

OTHER EVENTS	ALLOWABLE CHANGES
Certain Court Orders	You may elect medical coverage for your child if a qualified medical child support order (QMCSO) requires coverage under BNY Mellon's plan. You may cancel coverage for your child if your spouse, former spouse or other individual provides coverage for the child because he or she is required to do so due to a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody.
Changes Made Under Another Employer's Plan	You may change your election in response to a change made in your spouse's/qualified domestic partner's employer's plan during that plan's enrollment period. This rule applies only if the other employer's plan has a different plan year.
Significant Change in Medical Provider Network	If there is a substantial decrease in the number of physicians participating in a provider network or an HMO, or if your health plan option is eliminated, you may switch to another health plan option or drop coverage if no other viable option is available. BNY Mellon will determine whether the number of physicians participating in an option has decreased substantially.
Changes in Entitlement for Medicare or Medicaid	If you, your spouse/qualified domestic partner or dependent becomes entitled to coverage under Medicare or Medicaid (other than solely under the program for distribution of pediatric vaccines), you may elect to cancel coverage for the entitled person. Note: If you become entitled to Medicare or Medicaid and currently have a spouse/qualified domestic partner or dependent(s) covered under the BNY Mellon plan, you may not cancel coverage for yourself only. If you cancel your coverage, coverage for your spouse/qualified domestic partner and dependent(s) will end as well.
Loss of Medicare, Medicaid or Group Health Coverage Sponsored by an Educational or Government Institution	If you, your spouse/qualified domestic partner or your eligible dependent loses eligibility for Medicare or Medicaid or loses group health coverage sponsored by an educational or government institution, you may add coverage for this person(s). This includes a state children's health insurance program (CHIP), a medical program of an Indian Tribal government or the Indian Health Service, a state benefits risk pool or a foreign government group health plan.

* Expenses for your qualified domestic partner and your qualified domestic partner's children are not eligible for reimbursement through either of the FSAs.

Changes to Dependent Care FSA Elections

You may make changes to your Dependent Care FSA election if you experience a qualified life event (as long as it adheres to the consistency rule) or in any of the following additional situations:

– **Provider Change.** If you switch to a new dependent care provider that charges a different rate than your previous provider, you may adjust your Dependent Care FSA contributions accordingly.

– **Provider Rate Change.** If your dependent care provider's rates change, you may adjust your FSA contributions accordingly. (Note: If your dependent care provider is a relative, you are not permitted to increase your contributions during the year, even if his or her rates increase.)

Special Health Coverage Enrollment

(Applies to Medical, Dental and Vision Coverage)

You may make a change to add medical, dental or vision coverage if Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply. In general, these Special Enrollment Rights apply under the following circumstances:

– **Loss of Other Coverage**—You declined coverage for yourself, your spouse or other eligible dependent because of other health coverage, and the other health coverage is lost. If the other health coverage was COBRA coverage, the full period of COBRA must be exhausted. If the other health coverage was not COBRA, you may change coverage only if the coverage was lost as a result of loss of eligibility or because employer contributions toward the coverage ended. You and your dependents are not eligible for Special Enrollment Rights, however, if you lost coverage because you did not pay premiums on time, voluntarily dropped coverage or are guilty of fraud.

  Note: You may add coverage for yourself in order to cover an eligible dependent who loses coverage under these circumstances. You must notify the BNY Mellon Benefit Solutions Service Center within 31 days after the other health coverage is lost.

– **New Dependent**—You gain an eligible dependent (spouse or child) as a result of marriage, birth, adoption or placement for adoption. If you gain a new dependent, you may add coverage for yourself and your dependents (if you are not already covered) or, if you are already covered, you may add coverage for the new dependent and other eligible family members.

  Note: To elect medical coverage, you must initiate a life event change online or notify the BNY Mellon Benefit Solutions Service Center within 31 days of the marriage, birth, adoption or placement for adoption. See “How to Report a Qualified Life Event Change” on page 14 for more information.

– **Medicaid/CHIP**—If you or your eligible dependent’s coverage under a Medicaid or state children’s health insurance program (CHIP) terminates due to loss of eligibility, or if you or your eligible dependent became eligible for premium assistance under a CHIP or Medicaid plan, you must notify the BNY Mellon Benefit Solutions Service Center within 60 days after such change.

Medical and Prescription Drug

Your health plan options offer quality care, broad coverage and money-saving opportunities. BNY Mellon offers most employees a choice between two national health plan options, each offered by Aetna and UnitedHealthcare, with prescription drug coverage offered through CVS Caremark. Your cost for coverage depends on the plan you elect and the family members you choose to enroll.

Your health plan options:

– Lower Deductible HSA Plan (through Aetna or UnitedHealthcare)

– Higher Deductible HSA Plan (through Aetna or UnitedHealthcare)

– Kaiser Permanente Plan (Los Angeles and San Francisco only)

– HMSA Hawaii Plan (Hawaii only)

– Aetna International Plan (International Expats only)

– No coverage

Your health plan coverage levels:

– Employee

– Employee + Child(ren)

– Employee + Spouse/Qualified Domestic Partner

– Employee + Family (you + your spouse/qualified domestic partner and child or children)

Please note: Summaries of benefits and coverage under Kaiser Permanente, HMSA Hawaii and Aetna International Plans are available on the MyBenefit Solutions enrollment website.

2019 HSA PLAN OPTIONS COMPARISON								
	LOWER DEDUCTIBLE HSA PLAN (IN-NETWORK)		**LOWER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)**		**HIGHER DEDUCTIBLE HSA PLAN (IN-NETWORK)**		**HIGHER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)**	
***Annual Deductible*[1,2]**	\$1,350 Individual; \$2,700 Family *(True Family Deductible)*		\$2,700 Individual; \$5,400 Family *(True Family Deductible)*		\$2,200 Individual; \$4,400 Family *(True Family Deductible)*		\$4,400 Individual; \$8,800 Family *(True Family Deductible)*	
Annual Out-of-Pocket Maximum	**Includes deductible and coinsurance for medical and prescription drugs. Excludes any amount over UCR,[3] non-covered expenses and pre-certification penalties.**							
Base Pay Range	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**
\$0-\$29,999	\$2,250	\$3,500	\$4,500	\$7,000	\$2,800	\$5,600	\$5,600	\$11,200
\$30,000-\$49,999	\$2,750	\$4,500	\$5,500	\$9,000	\$4,000	\$8,000[4]	\$8,000	\$16,000
\$50,000-\$79,999	\$3,750	\$6,000	\$7,500	\$12,000	\$5,000	\$10,000[4]	\$10,000	\$20,000
\$80,000-\$124,999	\$5,650	\$9,500[4]	\$11,300	\$19,000	\$6,000	\$12,000[4]	\$12,000	\$24,000
\$125,000+	\$6,300	\$11,500[4]	\$12,600	\$23,000	\$6,650	\$13,300[4]	\$13,300	\$26,600

2019 HSA PLAN OPTIONS COMPARISON				
	LOWER DEDUCTIBLE HSA PLAN (IN-NETWORK)	**LOWER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)**	**HIGHER DEDUCTIBLE HSA PLAN (IN-NETWORK)**	**HIGHER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)**
PREVENTIVE CARE				
Adult Physical Exam (including Diagnostic Tests and Immunizations)	100% covered (deductible does not apply); according to preventive schedule	60% covered after deductible	100% covered (deductible does not apply); according to preventive schedule	60% covered after deductible
Routine Pediatric Care (including Diagnostic Tests and Immunizations)	100% covered (deductible does not apply)	60% covered after deductible	100% covered (deductible does not apply)	60% covered after deductible
Routine OB/GYN Care (including Pap Tests)	100% covered (deductible does not apply)	60% covered after deductible	100% covered (deductible does not apply)	60% covered after deductible
Mammograms/ PSA Tests	100% covered (deductible does not apply)	60% covered after deductible	100% covered (deductible does not apply)	60% covered after deductible
OFFICE VISITS				
Primary Care Physician	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Specialists	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
PROFESSIONAL SERVICES				
Lab Tests and X-rays	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Advanced Imaging (including MRIs and CAT Scans)	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
OUTPATIENT CARE				
Outpatient Surgery	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Outpatient Physical, Occupational and Speech Therapy	80% covered after deductible; combined in-/out-of-network limit of 60 visits per calendar year for all therapies combined	60% covered after deductible; combined in-/out-of-network limit of 60 visits per calendar year for all therapies combined	80% covered after deductible; combined in-/out-of-network limit of 60 visits per calendar year for all therapies combined	60% covered after deductible; combined in-/out-of-network limit of 60 visits per calendar year for all therapies combined
INPATIENT CARE				
Surgical Services	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Semi-Private Room/Board	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible

2019 HSA PLAN OPTIONS COMPARISON				
	LOWER DEDUCTIBLE HSA PLAN (IN-NETWORK)	**LOWER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)**	**HIGHER DEDUCTIBLE HSA PLAN (IN-NETWORK)**	**HIGHER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)**
EMERGENCY ROOM/URGENT CARE				
Emergency Room	80% covered after deductible	80% covered after deductible for medical emergency only	80% covered after deductible	80% covered after deductible for medical emergency only
Urgent Care Facility	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
MATERNITY CARE				
Prenatal, Delivery and Postnatal Care by OB/GYN	80% covered after deductible (preventive prenatal care is 100% covered)	60% covered after deductible	80% covered after deductible (preventive prenatal care is 100% covered)	60% covered after deductible
Lab Tests and Radiology Services	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Inpatient Hospital	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Fertility Services[5,6]	80% covered after deductible; pre-authorization required; must use Institute of Excellence, if available; lifetime $25K medical and $10K Rx maximum; check with Plan for details	Not covered	80% covered after deductible; pre-authorization required; must use Institute of Excellence, if available; lifetime $25K medical and $10K Rx maximum; check with Plan for details	Not covered
MENTAL HEALTH/ SUBSTANCE ABUSE				
Office Visits	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Inpatient	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
OTHER BENEFITS				
Hearing Aids	80% covered after deductible (max coverage of $5,000 every 2 years in- and out-of- network combined)	60% covered after deductible (max coverage of $5,000 every 2 years in- and out-of- network combined)	80% covered after deductible (max coverage of $5,000 every 2 years in- and out-of- network combined)	60% covered after deductible (max coverage of $5,000 every 2 years in- and out-of- network combined)
Bariatric Surgery[7]	80% covered after deductible; pre-authorization required; must be obtained from an Aetna Institute of Quality or a UHC Center of Excellence	Not covered	80% covered after deductible; pre-authorization required; must be obtained from an Aetna Institute of Quality or a UHC Center of Excellence	Not covered
Applied Behavior Analysis (ABA) Therapy	80% covered after deductible; pre-authorization required	60% covered after deductible; pre-authorization required	80% covered after deductible; pre-authorization required	60% covered after deductible; pre-authorization required

2019 HSA PLAN OPTIONS COMPARISON				
	LOWER DEDUCTIBLE HSA PLAN (IN-NETWORK)	**LOWER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)**	**HIGHER DEDUCTIBLE HSA PLAN (IN-NETWORK)**	**HIGHER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)**
Joint and Spine Surgery	Certain complex joint and spinal surgeries covered 100% after deductible if services are obtained from an eligible Aetna Institute of Quality or a UHC Center of Excellence All other: 80% covered after deductible	60% covered after deductible	Certain complex joint and spinal surgeries covered 100% after deductible if services are obtained from an eligible Aetna Institute of Quality or a UHC Center of Excellence All other: 80% covered after deductible	60% covered after deductible
Transplant Surgery	80% after deductible; must be obtained from an eligible Aetna Institute of Quality or a UHC Center of Excellence	Not covered	80% after deductible; must be obtained from an eligible Aetna Institute of Quality or a UHC Center of Excellence	Not covered
Lifetime Coverage Limit	Unlimited			

[1] Family applies to the Employee + Child(ren), Employee + Spouse/Qualified Domestic Partner and Employee + Family levels of coverage.

[2] Under a true family deductible, if only one family member becomes ill or injured, that person must meet the family deductible (rather than the individual deductible) before the plan reimburses for benefits. In this case, the plan requires satisfaction of the family deductible before any coinsurance will be paid.

[3] Usual, customary and reasonable (UCR) limits.

[4] Out-of-pocket expenses paid for an individual with family coverage are limited to no more than $7,900 for in-network coverage before the Plan reimburses 100 percent of eligible expenses.

[5] Any amounts applied toward this lifetime maximum under coverage with another carrier will be applied toward the $25,000 lifetime medical maximum and/or the $10,000 lifetime drug maximum under this plan.

[6] Both of the following conditions must be met before the plan will pay benefits: (i) prior authorization for infertility services must be obtained from your medical carrier, and (ii) services must be obtained from a recognized Center of Excellence, if one is available in your area. Note: there may be a transition of care benefit available for care currently in process. Contact your medical plan provider for more information.

[7] Both of the following conditions must be met before the plan will pay benefits: (i) prior authorization for bariatric services must be obtained from your medical carrier, and (ii) services, including surgery, must be obtained from a recognized Center of Excellence. Note, there may be a transition of care benefit available for care currently in process. Contact your medical plan provider for more information.

Prescription Drug Benefits

If you elect medical coverage through the Lower Deductible HSA Plan or the Higher Deductible HSA Plan with Aetna or UnitedHealthcare, you will automatically be enrolled for prescription drug coverage through CVS Caremark. (Those enrolled in the Kaiser Permanente, HMSA or Aetna International plans will receive prescription coverage through their medical carrier.)

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

For maintenance drugs, you have the choice of CVS pharmacy or CVS Caremark Mail Service. If you use maintenance drugs, you may fill a 30-day prescription **twice** at the retail level. Then future fills must be completed through the mail-order service in 90-day quantities. You also may pick up a 90-day supply through the Maintenance Choice program at any CVS pharmacy location.

Non-preventive prescription drugs are subject to the deductible/coinsurance provisions, but preventive prescription drugs are not subject to the deductible and are covered under the traditional four-tier prescription drug schedule, offering copayments for generic drugs and coinsurance for formulary (preferred), non-formulary (non-preferred) and specialty drugs. Prescription drug expenses under both health plans now count toward the out-of-pocket maximum, as required by the Affordable Care Act.

Prescription Drug Card

You will receive a prescription drug card from CVS Caremark following your enrollment. This card is separate from your medical card and should be used when you order prescriptions through either a retail pharmacy or mail order service.

2019 PRESCRIPTION DRUG BENEFITS (CVS/CAREMARK)	
Retail	**Preventive Drugs**[1] – Generic: Lesser of $10 copay or retailer's regular cost (deductible does not apply) – Formulary (Preferred) Brand: 25% with $50 minimum and $75 maximum (deductible does not apply) – Non-Formulary (Non-Preferred) Brand: 40% with $75 minimum and $100 maximum (deductible does not apply) **Non-Preventive Drugs** – Generic: 20% after deductible – Formulary (Preferred) Brand: 20% after deductible – Non-Formulary (Non-Preferred) Brand: 40% after deductible
Mail Order[2]	**Preventive Drugs** – Generic: Lesser of $25 copay or regular discount cost (deductible does not apply) – Formulary (Preferred) Brand: 25% with $125 minimum and $187.50 maximum (deductible does not apply) – Non-Formulary (Non-Preferred) Brand: 40% with $187.50 minimum and $250 maximum (deductible does not apply) **Non-Preventive Drugs** – Generic: 20% after deductible[3] – Formulary (Preferred) Brand: 20% after deductible[3] – Non-Formulary (Non-Preferred) Brand: 40% after deductible[3]
Specialty	– Generic: 20% after deductible[4] – Formulary (Preferred) Brand: 20% after deductible[4] – Non-Formulary (Non-Preferred) Brand: 40% after deductible

1 Examples of preventive drugs include, but are not limited to, diabetes medications, cholesterol medications and high blood pressure medications.

2 Medications for chronic conditions are restricted to mandatory mail order or CVS pharmacy after the prescription is filled twice at the retail level; mandatory generic; Step Therapy programs; contact CVS Caremark for additional details.

3 Must use mail order for maintenance drugs after two retail fills or pay full cost of drug at retail.

4 Drugs filled outside the CVS Caremark network will initially be denied, and you will be responsible to pay 100 percent of the cost. You will need to fill out an out-of-network paper claim to be reimbursed by the plan up to the out-of-network coinsurance, after deductible.

Note: CVS Caremark requires prior authorization, quantity limits and/or specialty guideline management for select medications, and these requirements may change from time to time. Current medications subject to these special guidelines are listed in “Value Formulary Quick Reference List” on page 97.

CVS Caremark Value Formulary

The Prescription Drug Formulary is updated regularly and can be accessed at **info.caremark.com/highvalueplan**. If you currently take prescription drugs or need prescription drugs during 2019, it is important that you review this formulary list with your doctor. If your prescribed drug is not on the list, discuss with your doctor whether your treatment plan can include a generic alternative or, if not available or tolerated, a high-quality, preferred name-brand drug included in the new Value Formulary.

CVS Opioid Management Program

CVS aligns their opioid management with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC) to positively influence the prescribing and use of opioids to treat pain. The program limits days’ supply, limits quantity of opioids and requires step therapy. For more information, please contact CVS Caremark at 1-800-685-4130.

Compound Prescriptions

Due to the lack of U.S. Food and Drug Administration (FDA) approval for many ingredients included in compounds and the high cost of these compounded medications, they may not be covered by your prescription plan or may require a prior authorization. If the compound ingredients are not covered, you will be responsible for the full cost of those ingredients. In situations where the compound ingredients are covered through prior authorization, you will pay the share of the cost specified by your prescription benefits.

Over-the-Counter Equivalents

Prescription drugs that have an over-the-counter (OTC) equivalent are not covered by either of the BNY Mellon health plans.

Preventive Therapy Drugs

Preventive drugs are medications that can help prevent a health condition from developing. Examples include blood pressure and cholesterol-lowering medications that may prevent heart attacks and strokes. See the “Preventive Therapy Drug List” on page 98.

Diabetes Discount Program

The Diabetes Discount Program provides a 50 percent discount on diabetes prescriptions and supplies. The discount is provided to all benefits-eligible participants enrolled in either the Lower Deductible HSA Plan or the Higher Deductible HSA Plan who have completed an A1C test in the prior 12 months.

Not all diabetic medications and supplies are eligible for the program discount. Certain diabetic medications and supplies are considered preventive and the discount will apply based on the applicable preventive drug copay tier. For non-preventive diabetic medications and supplies, the 50 percent discount will not apply until the annual deductible has been met. The discount does not apply to any medications on the CVS Caremark Value Priced Generics Drug List.

If you have questions regarding this program, the specific coverages for diabetic medications and supplies, or the testing requirements, please call CVS Caremark at 1-800-685-4130.

Specialty Drug Services

Specialty drugs are prescriptions that are used for the treatment of complex, chronic conditions such as hepatitis, hemophilia, and cancer.

CVS Caremark offers a program for specialty injectable and oral drugs that can provide you with greater convenience, including express delivery, follow-up care calls, expert counseling and superior service. Specialty medications (excluding HIV and transplant therapies) are no longer eligible for a grace fill at non-CVS retail pharmacies or other non-CVS specialty pharmacies. A one-time annual grace fill is available for HIV and transplant therapies. All other specialty prescriptions must be filled through CVS Specialty, and will be accepted at all CVS retail pharmacies. Also, CVS pharmacy locations with a MinuteClinic® have a service that provides education regarding the medication or the injectables you are taking.

Step Therapy Program

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

If your doctor prescribes a brand-name drug for the treatment of an ongoing condition, you will be required to try a medically equivalent but lower-cost alternative to the drug first. You will be contacted before implementation of Step Therapy with a list of the alternative drugs available. After you review the list, you or your pharmacist may contact your doctor to approve the change. If your doctor does not authorize the switch to the preferred drug, the request will be clinically reviewed and you will be informed of the outcome.

Review the CVS Caremark Value Formulary with your doctor if you are being treated for an ongoing condition. Your doctor will help you determine whether your treatment plan can include a generic alternative or, if not available or tolerated, a high-quality preferred brand-name drug included in the Formulary. Please see the “Value Formulary Quick Reference List” on page 97.

Dispense as Written (DAW) Provision

Sometimes, your doctor may determine that it is medically necessary for you to take the brand-name version of a drug, even if a generic version is available. If so, your doctor would write “DAW” at the bottom of the prescription. This means that your prescription must be filled with the brand-name version of the medication.

If you use a DAW prescription and receive a drug’s brand-name version, you will be required to pay the brand copayment plus the cost difference between the brand and generic drug. If you are unable to take a generic equivalent drug for clinical reasons (e.g., you are allergic to the generic filler), your physician can appeal. If your appeal is approved, you can take the brand-name drug without paying the differential.

CVS Caremark Resources and Savings

CVS Caremark offers innovative online solutions at **www.caremark.com**, using a secure, encrypted web environment for transactions and information to empower you to make cost-effective and informed health care decisions. Online features include:

– fast and convenient mail service for new prescriptions and online refills;

– expedited new prescription mail service orders with Fast Start;

– your prescription history;

– tools that allow you to check for lowest-price options;

– Ask-a-Pharmacist and Customer Care to answer your questions;

– information about drug interactions with other drugs, vitamins and foods; and

– health information about specific conditions through Self-Care Centers.

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

Find the Right Help for Complex or Chronic Health Conditions

CVS Caremark AccordantCare™ Health Services and the CVS Health Pharmacy Advisor Counseling Program can help you, as well as your covered dependents, deal with certain complex or chronic, high-cost health conditions.

CVS Caremark AccordantCare Health Services

This program is a voluntary, no-cost service that offers covered employees and dependents with one of 18 complex and chronic conditions the opportunity to work with CVS Health Care Management Nurses to help obtain quality 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 LIST	
– Amyotrophic lateral sclerosis (ALS)	– HIV
– Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)	– Multiple sclerosis
– Crohn's disease	– Myasthenia gravis
– Cystic fibrosis	– Parkinson's disease
– Dermatomyositis	– Polymyositis
– Epilepsy	– Rheumatoid arthritis
– Gaucher disease	– Scleroderma
– Hemophilia	– Sickle cell disease
	– Systemic lupus erythematosus
	– Ulcerative colitis

CVS Health Pharmacy Advisor Counseling Program

This program helps individuals with chronic conditions improve their medication adherence and close gaps in care. You may consult a CVS pharmacist at a time that's convenient for you for quick, confidential advice, information about medications and their effects on your body and guidance to help you stay on track with your medications.

20 Percent Discount on CVS Pharmacy Brand Products

CVS Caremark ExtraCare Health Care is an exclusive program that provides a 20 percent discount at any CVS pharmacy store or online at **www.cvs.com** when you show your CVS Caremark card. The 20 percent discount applies to regularly-priced CVS Pharmacy Brand or CVS Pharmacy Exclusive Brand health-related items of $1 or more. These items include glucose meters, blood pressure monitors, hearing aids, crutches, vitamins, nutritional supplements, sunscreen over 30 SPF and more.

Questions About Your Prescription Coverage?

Call CVS Caremark at 1-800-685-4130. Prospective members should use the following ID number for inquiries: BNYMHSATEST.

2019 Medical Premiums

The rates shown in the table below are 2019 semi-monthly health plan premium amounts. This is the amount that will be withheld from each paycheck for eligible full-time and part-time employees, based on annual base pay. Your base pay for the 2019 plan year is determined as of September 1, 2018, for existing employees or as of your date of hire, if later. To verify your contribution rate after enrollment, go to MyBenefit Solutions. At work: MySource > MyReward > Logon to MyReward > Proceed to My Personal Total Reward Data > MyBenefit Solutions. From home: **mybenefits.bnymellon.com**.

2019 SEMI-MONTHLY MEDICAL PLAN EMPLOYEE PREMIUMS (The amount below will be withheld from each paycheck)						
	Lower Deductible HSA Plan		Higher Deductible HSA Plan		Kaiser Plan	Aetna International
	Preferred Carrier Rate	Non-Preferred Carrier Rate	Preferred Carrier Rate	Non-Preferred Carrier Rate		
Under $30,000						
Employee Only	$19.00	$21.50	$9.50	$10.50	$33.50	$34.50
Employee + Child(ren)	$40.50	$46.00	$20.50	$22.50	$71.50	$73.50
Employee + Spouse/Qualified Domestic Partner	$49.50	$56.50	$25.00	$27.50	$87.50	$90.50
Employee + Family	$74.00	$83.50	$37.00	$41.00	$130.00	$134.00
$30,000 - $39,999						
Employee Only	$40.50	$45.50	$16.50	$18.50	$56.00	$56.00
Employee + Child(ren)	$86.50	$97.00	$35.00	$39.50	$119.50	$119.50
Employee + Spouse/Qualified Domestic Partner	$106.00	$119.00	$43.00	$48.50	$146.50	$146.50
Employee + Family	$157.50	$176.50	$64.00	$72.00	$217.50	$217.50
$40,000 - $49,999						
Employee Only	$47.00	$52.50	$19.50	$22.00	$69.00	$72.00
Employee + Child(ren)	$100.50	$112.00	$41.50	$47.00	$147.00	$153.50
Employee + Spouse/Qualified Domestic Partner	$123.00	$137.50	$51.00	$57.50	$180.50	$188.50
Employee + Family	$182.50	$204.00	$75.50	$85.50	$268.00	$279.50
$50,000 - $79,999						
Employee Only	$51.00	$57.00	$22.00	$24.50	$85.50	$92.00
Employee + Child(ren)	$109.00	$121.50	$47.00	$52.50	$182.50	$196.50
Employee + Spouse/Qualified Domestic Partner	$133.50	$149.00	$57.50	$64.00	$223.50	$240.50
Employee + Family	$198.00	$221.50	$85.50	$95.00	$332.00	$357.50

2019 SEMI-MONTHLY MEDICAL PLAN EMPLOYEE PREMIUMS (The amount below will be withheld from each paycheck)						
	Lower Deductible HSA Plan		Higher Deductible HSA Plan		Kaiser Plan	Aetna International
	Preferred Carrier Rate	Non-Preferred Carrier Rate	Preferred Carrier Rate	Non-Preferred Carrier Rate		
$80,000 - $99,999						
Employee Only	$60.00	$67.00	$28.00	$31.50	$104.50	$97.50
Employee + Child(ren)	$128.00	$143.00	$59.50	$67.00	$223.00	$208.00
Employee + Spouse/Qualified Domestic Partner	$157.00	$175.50	$73.50	$82.50	$273.50	$255.00
Employee + Family	$233.00	$260.00	$108.50	$122.50	$406.00	$378.50
$100,000 - $124,999						
Employee Only	$76.50	$85.50	$35.50	$40.00	$112.00	$134.00
Employee + Child(ren)	$163.00	$182.50	$75.50	$85.50	$239.00	$286.00
Employee + Spouse/Qualified Domestic Partner	$200.00	$223.50	$93.00	$104.50	$293.00	$350.50
Employee + Family	$297.00	$332.00	$138.00	$155.50	$435.00	$520.50
$125,000 - $149,999						
Employee Only	$90.00	$101.00	$42.50	$47.50	$141.00	$136.50
Employee + Child(ren)	$192.50	$216.00	$90.00	$100.50	$301.00	$291.00
Employee + Spouse/Qualified Domestic Partner	$236.00	$264.50	$110.50	$124.00	$369.00	$357.00
Employee + Family	$350.50	$393.50	$164.50	$183.50	$547.50	$530.00
$150,000 - $249,999						
Employee Only	$110.00	$123.00	$51.50	$57.50	$146.50	$156.50
Employee + Child(ren)	$234.00	$262.00	$110.00	$123.00	$312.50	$334.00
Employee + Spouse/Qualified Domestic Partner	$287.50	$321.50	$135.00	$150.50	$383.50	$409.50
Employee + Family	$426.50	$477.50	$200.50	$224.00	$569.00	$607.50
$250,000 and Above						
Employee Only	$128.50	$144.00	$60.50	$67.50	$168.00	$170.00
Employee + Child(ren)	$274.50	$307.50	$129.00	$144.00	$358.50	$362.50
Employee + Spouse/Qualified Domestic Partner	$336.50	$377.00	$158.00	$177.00	$439.50	$445.00
Employee + Family	$499.50	$559.50	$234.50	$262.50	$652.50	$660.00

About the HSA Plans

The Lower Deductible HSA Plan and Higher Deductible HSA Plan are built on traditional health insurance plans with these features:

– Both options offer access to the same national networks of doctors and hospitals provided by Aetna or UnitedHealthcare.

– Preventive care is covered at 100 percent if you use in-network providers.

– You save through negotiated discounts when non-preventive care is received in-network, while retaining the freedom to use out-of-network providers at a higher cost.

– After you reach your annual deductible, BNY Mellon pays 80 percent of the cost of most other eligible in-network care and you pay 20 percent.

– Your out-of-pocket medical costs are limited to an annual maximum—including your deductible and coinsurance—which is the most you will pay in any year.

– Prescription coverage is provided through CVS Caremark with negotiated discounts.

Both of the HSA plan options have a higher deductible than traditional health plans. Thus, high-deductible health plans (HDHPs) make it more important for you to research the price and value of medical services using the price and quality comparison tools, such as those provided by Castlight. You may find that other services have equally effective but less costly alternatives. Asking questions about quality, price and value can help you manage costs without sacrificing quality of care.

At the same time, the Health Savings Account that becomes available to you when you enroll in either HSA Plan option provides you with a way to pay for the higher deductible and other eligible health expenses, in the current year or in the future. See “The Health Savings Account” on page 33 for more information.

Please note: If you enroll in other medical coverage, such as through your spouse’s or qualified domestic partner’s plan, including a general-purpose health care flexible spending account or general purpose health reimbursement account, or are covered by any part of Medicare or TRICARE, by federal law, you are not eligible to make or receive contributions to a Health Savings Account. (While you can still enroll in the Lower Deductible HSA Plan or Higher Deductible HSA Plan, you will not be eligible to make or receive contributions to a Health Savings Account.)

Choosing a Carrier

If you enroll in either the Lower Deductible HSA Plan or Higher Deductible HSA Plan, you will need to choose either the Aetna or UnitedHealthcare network at the time you enroll.

To determine if your health care providers participate in Aetna and/or UnitedHealthcare networks, log on to the carrier websites, or contact Aetna at 1-855-855-8112 or UnitedHealthcare at 1-800-842-0750. If you are currently enrolled in an Aetna or UnitedHealthcare health plan, you can also log on to Castlight at **www.mycastlight.com/ bnymellon** to determine your provider’s participation. Note the “Network Name” associated with the “Health Plan Carrier” options noted below:

HEALTH PLAN CARRIER	NETWORK NAME	HOW TO ACCESS
Aetna	Choice POS II	**www.aetna .com/dse/search?site_id=dse&externalPlanCode=ACPMC|Aetna_Open_Access_POS_II**
UHC	Choice Plus	**www.bnym.welcometouhc.com/home**

Keep in mind, the health plan premiums you pay will be based in part on the medical carrier you choose — Aetna or UnitedHealthcare.

Depending on where you live, one medical carrier may have negotiated greater discounts on average with providers, making that carrier more cost-effective for you and BNY Mellon than the other carrier in that area. Where this happens, the more cost-effective carrier is designated as the preferred carrier.

Your choice of a preferred or non-preferred carrier will affect your 2019 health plan premium rate as explained below:

– When you choose the preferred carrier for your state of residence, your health plan premium rate will be lower than if you choose the non-preferred carrier.

– If no preferred carrier has been identified in your state, you can enroll in either carrier and will pay the 2019 preferred carrier premium rate.

The table below shows the states that will have a preferred carrier in 2019. If you reside in a state that is not listed here, you will pay the same preferred carrier premium rate whether you choose Aetna or UnitedHealthcare.

STATE OF RESIDENCE	PREFERRED CARRIER
California	Aetna
Connecticut	Aetna
Delaware	Aetna
Florida	UnitedHealthcare
Illinois	UnitedHealthcare
Massachusetts	UnitedHealthcare
New Jersey	Aetna
New York	Aetna
Pennsylvania	Aetna
Rhode Island	UnitedHealthcare

During the year, if your state of residence changes:

– **From a non-preferred to a preferred carrier state,** your health plan premium will automatically be adjusted prospectively to the preferred carrier premium rate.

– **From a preferred to a non-preferred carrier state,** your health plan premium will not change during the year of your move, but will be adjusted as appropriate for the following year, based on your eligibility to participate and medical plan option and carrier selected.

Health Plan ID Card

You will receive an Aetna or UnitedHealthcare medical ID card when you first enroll and when you change plan options or carriers. Show this card to get discounts from providers, including doctors and hospitals.

Precertification

You are required to contact Aetna or UnitedHealthcare before a planned inpatient admission or within 48 hours of an emergency admission. If you don't call, and it is later determined that all or part of your stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

Healthy Pregnancy Programs

If you are an expectant mother covered under the Lower Deductible HSA Plan or the Higher Deductible HSA Plan, you are eligible to participate in Aetna's Maternity Program or UnitedHealthcare's Healthy Pregnancy Program (depending on the BNY Mellon health plan carrier you select). These programs help expecting mothers before, during and after pregnancy. Contact the carrier to enroll.

Aetna's Maternity Program

If you are an expectant mother or father, you can participate in Aetna's Maternity Program when you enroll in a health plan through Aetna. Use the program throughout your pregnancy and even after your baby is born. You'll receive:

– Information for a healthier pregnancy, including prenatal care, preterm labor symptoms, what to expect before and after delivery, newborn care and more.

– Special help for pregnancy risks. Some individuals have health conditions or other risk factors that could affect their pregnancy. If you do, you can work with a nurse case manager to help you lower those risks. If you're eligible, you also receive follow-up calls after your delivery, a screening for depression and extra support, if needed.

– Support to quit smoking. By quitting you may lower your baby's risk for preterm delivery, low birth weight and sudden infant death syndrome (SIDS). With Aetna's Smoke-Free Moms-to-Be® Program, you'll receive one-on-one nurse support to help you quit smoking.

– Counseling on lowering preterm labor risks. Some babies are born much sooner than expected. This can raise the risk for complications. If you're at risk of preterm labor, Aetna's Maternity Program can teach you the signs and symptoms of early labor. You'll also hear about new treatment options.

To enroll in Aetna's Maternity Program, call Aetna toll-free at 1-800-CRADLE-1 (1-800-272-3531), weekdays from 8:00 a.m. to 7 p.m. Eastern Time, or log in to the Aetna Navigator at **www.aetna.com** and look under Health Programs. You can also visit Aetna Women's Health at **www.womenshealth.aetna.com** to learn about pregnancy and other women's health-related information, including reproductive health, menopause, depression, breast and heart health, baby care and more.

UnitedHealthcare Maternity Support Program

If you are enrolled in a UnitedHealthcare health plan and are pregnant or thinking about becoming pregnant, you can get valuable educational information, advice and comprehensive case management.

This program offers:

– enrollment by an OB nurse assigned to you;

– preconception health coaching;

– written and online educational resources covering a wide range of topics;

– first and second trimester risk screenings;

– identification and management of at-risk or high-risk conditions that may impact pregnancy;

– pre-delivery consultation;

– coordination with, and referrals to, other benefits and programs available under the health plan;

– a phone call from a nurse approximately two weeks after the birth of your child to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and

– postpartum depression screening.

Participation is completely voluntary and at no extra charge. To take full advantage of the program, mothers and fathers are encouraged to enroll within the first trimester of pregnancy. You can enroll anytime, up to the 34th week of pregnancy.

To enroll in the UnitedHealthcare Maternity Support Program, call 1-800-842-0750.

Infertility Services

If you are dealing with an infertility issue, you can find support to help you determine the course of action for diagnosis and treatment by contacting your Aetna or UnitedHealthcare Health Advantage nurse. Before receiving treatment, you'll receive education and guidance with the help of specialized nurse consultants who work with you throughout the diagnostic and treatment process. These services also include access to infertility treatment providers through their Centers of Excellence (COE) network clinics. These facilities have passed the best practice evaluation criteria, developed by Aetna's and UnitedHealthcare's oversight and advisory committees of practicing clinical experts. The rigorous quality control metrics include high pregnancy rates, reduced risk of multiple births, and superior facility operations and staffing.

Aetna and UnitedHealthcare cover infertility services only when the services are pre-authorized and you receive services at a COE. If a COE is not available, approved treatment will be covered.

Autism Spectrum Disorder Services

Aetna and UnitedHealthcare cover the following services for individuals who have been diagnosed with autism spectrum disorder, whether provided on an outpatient or inpatient basis:

– medically necessary diagnostic evaluations and assessment;
– medication management;
– individual, family, therapeutic group and provider-based case management services;
– crisis intervention;
– medically necessary partial hospitalization/day treatment;
– medically necessary services at a residential treatment facility; and
– medically necessary intensive outpatient treatment.

Applied Behavior Analysis (ABA) Therapy

ABA is a service that uses intensive behavioral and educational therapies that:

– systematically change behavior; and
– are responsible for the observable improvement in behavior.

Prior authorization is required under both Aetna and UnitedHealthcare for ABA benefits, and services may be subject to ongoing reviews and authorization. To begin the authorization process, contact your health plan carrier.

UnitedHealthcare Spine and Joint Solution

If you are enrolled in a UnitedHealthcare health plan, you can participate in the UnitedHealthcare Spine and Joint Solution. The program can provide information and support about:

– spinal fusion surgery;
– spinal disc surgery;
– total hip replacement; and
– total knee replacement.

The Spine and Joint Solution gives you access to some of the nation's leading musculoskeletal facilities through its Centers of Excellence (COE) network. Through this network, you have access to high-quality facilities that must meet the carrier's strict standards for care, quality and efficiency, including number of procedures performed, success rates, cost effectiveness of care and low re-admission and complication rates. Services provided through the COE network will be covered at 100 percent after the deductible.

To contact the Spine and Joint Solution, call 1-888-936-7246, weekdays from 7:00 a.m. to 6:00 p.m. Central Time or go to **www.bnym.welcometouhc.com/home.**

Aetna Spine and Joint Institutes of Quality

If you are enrolled in an Aetna health plan, you have access to the Aetna Institutes of Quality (IOQ), a special network of hospitals and other facilities that specialize in spine surgery, knee replacement and hip replacement. Facilities earn IOQ status for showing high levels of quality and efficiency for certain orthopedic procedures like total joint replacement and spinal surgery. Find a list of IOQ facilities and specialists by visiting **www.aetna.com**: Services provided at an IOQ will be covered at 100 percent after the deductible.

The Health Savings Account

If you enroll in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan, you may be eligible to contribute and receive company contributions to a Health Savings Account. The Health Savings Account offers the following:

- **BNY Mellon contributes to your account.** Provided you enroll in the Health Savings Account and open an account as described in "How the Health Savings Account (HSA) Works" on page 35, BNY Mellon's contribution will be deposited to your Health Savings Account following your first pay following your plan effective date to help you pay for qualified medical expenses. If you enroll after January 1 as a new hire, a prorated BNY Mellon contribution will be made after you enroll.
- **You can budget and save.** Provided you enroll in the Health Savings Account and open an account as described in "How the Health Savings Account (HSA) Works" on page 35, you can also contribute to your Health Savings Account. Please keep in mind that you need to budget for the deductible. And, if you don't use all of the money in your account, your account balance rolls over from one year to the next.
- **Not taxable.** You don't pay federal taxes on any money you and BNY Mellon put into your Health Savings Account or any money taken out—as long as it is used to pay for qualified medical expenses. In most states, Health Savings Account contributions and earnings may also be exempt from state income taxes.
- **It's your money.** The money in your Health Savings Account is yours—to pay for qualified medical expenses today or in the future, even if you leave BNY Mellon for any reason at any time.

IRS Rules About Who Can Contribute to a Health Savings Account

IRS rules determine whether or not you are eligible to make and receive Health Savings Account contributions. If you participate in any part of Medicare or TRICARE; enroll in the HMSA Hawaii Plan, Kaiser Permanente Plan or Aetna International Plan; or are on long-term disability, retired or on COBRA, you are not eligible to make Health Savings Account contributions, receive Company contributions or earn Health Savings Account contributions through participation in the Wellbeing Rewards Program. Active employees enrolled in the Lower Deductible HSA Plan or Higher Deductible HSA Plan who are enrolled in any part of Medicare or TRICARE may not contribute to a Health Savings Account, but will receive BNY Mellon contributions and Wellbeing Rewards contributions through payroll as taxable wages. 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 account, you should not apply for any part of Medicare, Social Security or Railroad Retirement Board (RRB) benefits.

A Health Savings Account is offered in conjunction with the HSA Plans as a voluntary benefit directly from BenefitWallet. The Health Savings Account is not governed by ERISA. BNY Mellon neither endorses BenefitWallet as the Health Savings Account vendor, nor is it sponsoring the Health Savings Account program. BNY Mellon's role with respect to the Health Savings Account is limited to permitting you, as an eligible employee participating in the Plan, to make pre-tax contributions to the Health Savings Account through the Plan's cafeteria plan component.

Health Savings Account Contributions

HEALTH SAVINGS ACCOUNT 2019 CONTRIBUTION LIMITS			
BASE PAY AND COVERAGE LEVEL	**IRS COMBINED MAXIMUM ANNUAL CONTRIBUTION**	**BNY MELLON'S ANNUAL CONTRIBUTION (AUTOMATIC)[1]**	**YOUR MAXIMUM ANNUAL CONTRIBUTION (VOLUNTARY)[2]**
Under $30,000			
Employee Only	$3,500	$700	$2,800
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren) or Employee + Family	$7,000	$1,400	$5,600
$30,000 - $39,999			
Employee Only	$3,500	$600	$2,900
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren) or Employee + Family	$7,000	$1,200	$5,800
$40,000 - $49,999			
Employee Only	$3,500	$500	$3,000
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren) or Employee + Family	$7,000	$1,000	$6,000
$50,000 - $79,999			
Employee Only	$3,500	$400	$3,100
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren) or Employee + Family	$7,000	$800	$6,200
$80,000 and above			
Employee Only	$3,500	$200	$3,300
Employee + Spouse/Qualified Domestic Partner, Employee + Child(ren) or Employee + Family	$7,000	$400	$6,600

[1] If you join BNY Mellon after the beginning of the 2019 plan year, BNY Mellon's Health Savings Account contribution will be pro-rated.

[2] It is your responsibility to monitor your contributions during the year to ensure you do not exceed the IRS maximum allowable contribution. Your maximum contribution should be further reduced by any Health Savings Account deposits earned by completing wellbeing activities by December 31, 2019. You can earn up to $600 in Wellbeing Rewards contributions, or $1,200 if you also cover your eligible spouse/qualified domestic partner. Beginning in the year you attain age 55, you may make additional catch-up contributions of up to $1,000 annually. If you exceed the limit, you may be subject to additional taxes and penalties.

Proration of BNY Mellon Health Savings Account Contribution

If you join BNY Mellon after the beginning of the 2019 plan year, BNY Mellon's contribution to your Health Savings Account will be prorated. To determine your prorated BNY Mellon contribution, find the proration factor corresponding to your month of benefit eligibility. Then find the BNY Mellon annual account contribution corresponding to your base pay and coverage level and multiply the contribution by the proration factor.

PRORATION OF BNY MELLON CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS IN 2019		
HIRE/BENEFIT ELIGIBILITY MONTH	**NUMBER OF MONTHS COUNTED TOWARD CONTRIBUTION AMOUNT**	**PRORATION FACTOR**
November/December 2018	12	1.00
January 2019	11	0.92
February	10	0.83
March	9	0.75
April	8	0.67
May	7	0.58
June	6	0.50
July	5	0.42
August	4	0.33
September	3	0.25
October	2	0.17
November	1	0.08
December	0	0.00

How the Health Savings Account (HSA) Works

BenefitWallet™ is an independent administrator for your Health Savings Account. BenefitWallet allows Health Savings Account holders to invest their account dollars. BenefitWallet begins with an FDIC-insured, interest- bearing checking account where all account deposits are first credited. No minimum balance is required to open and maintain the BenefitWallet HSA Checking Account.

Your BenefitWallet Health Savings Account will not become active until after the date you have completed the enrollment process, your enrollment in either the Lower Deductible HSA Plan or Higher Deductible HSA Plan has been received, and your health plan coverage becomes effective. Unless your health plan coverage begins on the first day of the month, your Health Savings Account will not be effective until the first day of the following month.

You must be enrolled in either the Lower Deductible HSA Plan or Higher Deductible HSA Plan to contribute to a Health Savings Account

Remember that to make your own contributions, you must make an initial Health Savings Account contribution election each year; this election is in addition to your health plan election. You can increase or decrease your Health Savings Account contribution monthly throughout the year.

Once a Health Savings Account checking account balance reaches $1,000, you generally may set up a BenefitWallet Investment Account and begin to diversify your accumulated savings in excess of $1,000 among a selection of investment funds. This fund lineup is selected and monitored by BenefitWallet. **Please note:** A minimum of $1,000 must remain in your BenefitWallet HSA Checking Account. Effective January 1, 2019, BNY Mellon will pay the fee of $2.90 per month charged if you choose to use the BenefitWallet HSA investment platform. There are no additional transaction fees, loads or commissions.

If you participate in a Health Savings Account and leave BNY Mellon, you will be charged $3.25 per month as an account maintenance fee if you keep your checking account open, and an additional $2.90 per month as an investment management fee if you continue to invest your account.

Federal law states that you cannot contribute to a Health Savings Account if you:

– are covered by any other health plan (as an individual, spouse or qualified domestic partner) that is not a qualifying HDHP, including a general purpose Health Care FSA or HRA (limited coverages, such as vision, dental or cancer plans, are permitted);

– are enrolled in any part of Medicare or TRICARE; or

– are claimed as a dependent on another individual's federal tax return.

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

If you also choose to participate in BNY Mellon's Limited Purpose Flexible Spending Account for health care reimbursement, you may use the Limited Purpose FSA for eligible dental, vision, preventive drugs and out-of-network preventive services, and (after the deductible is met) qualified medical expenses. Also, once you meet the annual deductible, you may use the Limited Purpose FSA for qualified medical expenses.

When you open your BenefitWallet Health Savings Account, you will receive a BenefitWallet Welcome Kit. Be sure to read and respond to BenefitWallet with requested information required to activate, contribute to and use your Health Savings Account.

Making Your Health Savings Account Elections

Here's what you need to do to contribute to the Health Savings Account:

1. Choose a health plan coverage level for your high deductible health plan of Individual, Employee + Child(ren), Employee + Spouse/Qualified Domestic Partner or Employee + Family.*
2. Decide how much to contribute to your account annually. You may supplement BNY Mellon's Health Savings Account contributions with your own pre-tax contributions and earned contributions through the Wellbeing Rewards Program. See "Health Savings Account Contributions" on page 34 to determine your maximum permitted contribution amount.
3. Choose how you will contribute to your Health Savings Account. You may contribute via pre-tax payroll deduction, in one or more after-tax lump sums, or a combination of the two.

* If you elect to cover adult children up to age 26, they may not be eligible for reimbursement from your Health Savings Account. See "How the Health Savings Account (HSA) Works" on page 35 for details.

Payroll Deductions and HSA Limits

Select an annual contribution amount, up to the maximum allowable. (If you elect to cover adult children up to age 26, they may not be eligible for reimbursement from your Health Savings Account. See "How the Health Savings Account (HSA) Works" on page 35 for details.)

When you contribute by payroll deduction, your contributions are deducted from your pay before federal and Social Security taxes are deducted, to the extent such amounts do not exceed the maximum contribution limits permitted by the IRS. In most states, Health Savings Account contributions and earnings also are exempt from state income taxes.

You can change the election monthly. The new amount (if your change election is received by the fifteenth of the month) will be effective on the first day of the following month.

While BNY Mellon monitors your Health Savings Account pre-tax payroll contributions and contributions earned through the Wellbeing Rewards Program to help ensure that IRS contribution limits are not exceeded, please note that it is your responsibility to determine whether your total Health Savings Account contributions exceed the maximum IRS contribution limits in a particular year. If your total Health Savings Account contributions (including your own after-tax contributions, pre-tax payroll contributions, contributions earned through the Wellbeing Rewards Program 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, any excess contributions are subject to both income taxes and an excise tax.

Lump-Sum Contributions

If you wish, you may contribute to your Health Savings Account by lump-sum payment, using either a deposit slip from a Health Savings Account checkbook or by electronic funds transfer. Both methods will be described in the Welcome Kit you will receive after enrolling. If you want to:

– make the entire contribution by lump-sum payment, enter $0 for payroll deduction when you enroll. Then, make your lump-sum contribution at any time using the materials you'll receive from BenefitWallet.

– contribute through a combination of payroll deduction and lump-sum payment, enter the annual contribution amount for pre-tax payroll deductions when you enroll. Then, make your lump-sum contribution at any time using a deposit slip from your Health Savings Account checkbook.

Please note: Lump-sum contributions are made using after-tax money, but you may deduct the after-tax Health Savings Account contributions on your 2019 federal income tax return. You also may delay making your lump-sum contribution up to the time you timely file your 2019 federal income tax return. Be sure to consult with your tax advisor if you have questions.

Rollovers or Transfers

If you already have a Health Savings Account at another institution, you can roll over or transfer your funds to BenefitWallet Health Savings Account. More information will be provided in the Welcome Kit you will receive after enrolling.

Medicare and Your Health Savings Account

Health Savings Accounts and Medicare Eligibility

Becoming **eligible** for Medicare does not impact your ability to make contributions to or withdrawals from your Health Savings Account, assuming you otherwise remain HSA-eligible. Once you **enroll** in Medicare, you are no longer eligible to make or receive contributions to your Health Savings Account, but you can continue to pay for qualified medical expenses with your Health Savings Account.

If Your Spouse Has Enrolled in Medicare

You can still contribute to a Health Savings Account if your spouse has enrolled in Medicare, as long as you are covered by an HSA-qualified health plan.

Medicare Enrollment and Health Savings Account Contributions

Your eligibility to make Health Savings Account contributions ends the month you're enrolled in Medicare. Your annual contribution limit is prorated based on the number of months you were eligible to contribute to the Health Savings Account.

Special Note About Health Savings Accounts and Social Security

It's important to note that electing to receive Social Security retirement benefits automatically enrolls you in Medicare Part A (also known as Hospital Insurance). Currently, there is no process within the Social Security Administration to waive this automatic coverage. Conversely, if you meet Medicare's eligibility requirements, you may have the option to voluntarily enroll in Medicare without electing to receive Social Security Retirement Benefits.

If you are beyond your full retirement age when you sign up for Social Security retirement benefits, your enrollment in Part A could be retroactively effective to the month that you turned 65 or, if longer, by as much as six months. Under IRS rules, that retroactive coverage makes you ineligible to make Health Savings Account contributions during the retroactive period. If you contribute to your Heath Savings Account during this time, those contributions may be included in your taxable income and may be subject to tax penalties. It is advisable that you consult with a tax professional to determine the tax implications of your Health Savings Account contributions made after Medicare part A enrollment.

If you are older than age 65 and you are planning to enroll in Social Security, you should consider discontinuing your Health Savings Account contributions for at least six months before you apply for Social Security retirement benefits to avoid any adverse tax consequences.

Paying for Qualified Medical Expenses

Once you have enrolled in Medicare, you can no longer make or receive contributions, but you may continue to use the funds from your Health Savings Account for the same qualified expenses you've always used account funds for, plus these additional expenses:

– Medicare Part A deductible and premiums

– Medicare Part B premiums and co-insurance

– Medicare Part D prescription drug premiums

– Medicare out-of-pocket expenses

Please note: You cannot use your Health Savings Account to pay premiums for a Medicare supplemental policy.

Calculating Your Contribution Limit

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

To calculate your personal contribution limit:

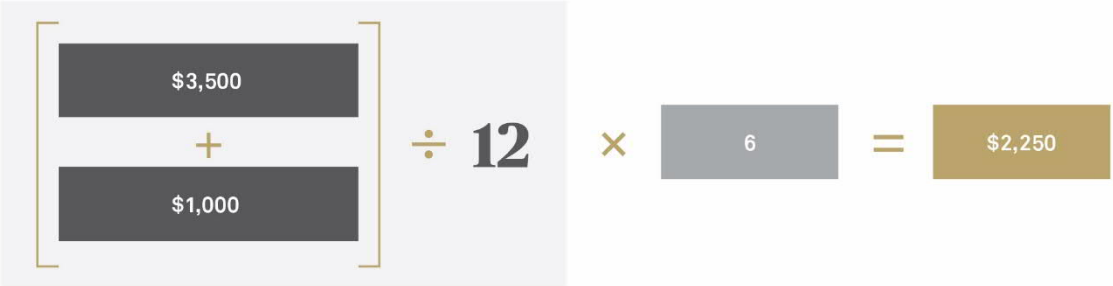
– Take the total annual Health Savings Account contribution limit based on your coverage type for a Health Savings Account (individual or family) and the annual catch-up contribution amount of $1,000 (if you are age 55+).

– Divide that amount by 12.

– Multiply it by the number of months you qualify that year.

Example:

- You are eligible to contribute to your HSA for six months this year.
- Assuming the 2019 individual contribution limit, plus the age 55 or older $1,000 catch-up contribution, your personal contribution limit would be:



How the Health Accounts Compare

	HEALTH SAVINGS ACCOUNT	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT
Who owns it?	Employee	BNY Mellon	BNY Mellon
Who contributes to the account?	BNY Mellon and employee	Employee	Employee
Can unused amounts carry or roll over?	Yes	Yes, up to $500	Yes, up to $500
Is interest earned?	Yes, interest-bearing checking account; once balance reaches $1,000,the amount over $1,000 may be invested	No	No
Is the account subject to COBRA continuation?	No	Yes	Yes
How are contributions made?	Through BNY Mellon and employee contributions	Employee contributions	Employee contributions
Is there a contribution limit?	Yes. The 2019 limits are $3,500 for individual coverage and $7,000 for dependent coverage, as established by the IRS.	Yes. The 2019 limit is $2,650 for Health Care FSA as established by the IRS.	Yes. The 2019 limit is $2,650, as established by the IRS.
Is there a "catch-up" contribution provision for older workers?	Yes. Employees age 55 or older may contribute an additional $1,000 per year.	No	No
What are the tax benefits for employees?	BNY Mellon and employee contributions are tax-free. Withdrawals/reimbursements for qualified medical expenses are tax-free.	Employee contributions are tax-free, which reduces annual taxable income. Reimbursements for qualified medical expenses are tax-free.	Employee contributions are tax-free, which reduces annual taxable income. Reimbursements for qualified medical expenses are tax-free.
What health care expenses can be paid from the account?	Any qualified medical expense as defined under Section 213(d) of the federal tax code, except for health insurance premiums, with specific exceptions.	Any qualified medical expense as defined under Section 213(d) of the federal tax code, except for health insurance premiums. Long-term care services are tax deductible, but not reimbursable.	Any eligible dental and vision expenses. In addition, qualified medical expenses as defined under Section 213(d) of the federal tax code once the HSA plan deductible has been satisfied. Health insurance premiums and long-term care services are not reimbursable.
Can amounts in account be used for non-health care expenses for those over age 65?	Yes. Non-health care distributions must be included in gross income, but are not subject to the additional 20% tax penalty.	No	No
Can COBRA premiums be reimbursed from the account?	Yes. Distributions to pay premiums reimbursed for COBRA are tax-free.	No	No

	HEALTH SAVINGS ACCOUNT	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT
Must a qualified medical expense occur during the plan year the contribution is made?	No. You cannot use Health Savings Account contributions to pay for expenses incurred prior to establishing the Health Savings Account; however, you can use contributions to pay for eligible expenses incurred after establishing the Health Savings Account even if you are no longer covered by a high deductible health plan.	In general, yes; however, you may carryover up to $500 to the following plan year.	In general, yes; however, you may carryover up to $500 to the following plan year.
Is use of a debit card allowed?	Yes	Yes	No
Can I contribute if I'm enrolled in any part of Medicare or TRICARE?	No	Yes	No
What happens to the account when I leave BNY Mellon?	You can take your account with you	You forfeit any unused amounts. You may file a claim for expenses incurred through the last day of the month in which your coverage ends subject to any COBRA rights that may apply	You forfeit any unused amounts. You may file a claim for expenses incurred through the last day of the month in which your coverage ends subject to any COBRA rights that may apply
Are other accounts available at the same time?	Only with a Limited Purpose FSA	No	Only with a Health Savings Account

Note: If you enroll for other medical coverage that is not a qualifying high-deductible health plan, such as through your spouse's or qualified domestic partner's plan, including a general purpose Health Care FSA or health reimbursement account, or are covered by any part of Medicare (including Part A, Part B, etc.) or TRICARE, by federal law, you aren't permitted to make or receive contributions to a Health Savings Account. (This is an IRS rule.)

Using Your HSA Plan During the Year

Meet Your Deductible

The deductibles for both HSA Plans are listed in Medical and Prescription Drug on page 19. Your deductible applies to medical services other than preventive care and preventive prescriptions. So, if you go to your doctor for an illness or a medical condition before you meet the deductible, you pay the full cost of the office visit.

IN-NETWORK AND OUT-OF-NETWORK	
Employee Only	**Just covering yourself?** You'll need to meet the individual deductible before you start paying coinsurance
*Family**	**Covering yourself and one or more family members?** You'll need to meet the family deductible before any family member can begin to pay the coinsurance amount. When any combination of family members meets the family deductible, the entire covered family will begin paying the coinsurance amount. **For example:** You cover your spouse and three children under the Lower Deductible HSA Plan, which has a $2,700 family deductible for in-network services. During the year, you pay $1,500 for medical services for you, $700 for your spouse and $500 for one of your kids because you haven't met the family deductible. The total cost of medical services for the three of you is $2,700, so the family deductible is now met. BNY Mellon and the whole family of five will begin paying the coinsurance amount until the out-of-pocket maximum is met.

* For the HSA plan family coverage, if only one family member incurs medical expenses in a plan year, that person must meet the family deductible before BNY Mellon begins paying and the plan reimburses for benefits.

Know When Your Deductible Applies

The deductible is the amount you pay for medical services before BNY Mellon will begin to share the cost of care. Use this chart as a guide to understand when your deductible applies.

SERVICE TYPE	DEDUCTIBLE APPLIES	DEDUCTIBLE DOES NOT APPLY
Preventive Care Office Visit Routine physicals (adult and child), mammograms, well childcare (immunizations)	✓ (out-of-network)*	✓ Covered at 100% (in-network only)*
Diagnostic Care Office Visit Family/general practice, internal medicine, pediatrician, ob/gyn	✓	
Mental Health, Behavioral Health and Substance Abuse Inpatient and outpatient services	✓	
X-rays, Blood Tests, Outpatient Tests	✓	
Outpatient Surgery	✓	
Hospital Care	✓	
Emergency Room/Urgent Care Centers	✓	
Physical, Speech and Occupational Therapy	✓	
Preventive Prescriptions		✓
Non-Preventive Prescriptions	✓	

* Out-of-network preventive covered at 60 percent after deductible.

Understand Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most you pay in deductible and coinsurance each year for certain medical and prescription drug services. Remember, you must meet your deductible for certain medical expenses before your coinsurance applies. If you reach your out-of-pocket maximum, BNY Mellon will pay 100 percent of eligible expenses.

HSA PLAN	LOWER DEDUCTIBLE HSA PLAN (IN-NETWORK)		LOWER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)		HIGHER DEDUCTIBLE HSA PLAN (IN-NETWORK)		HIGHER DEDUCTIBLE HSA PLAN (OUT-OF-NETWORK)	
Annual Out-of-Pocket Maximum **Includes deductible and coinsurance for medical and prescription drugs. Excludes any amount over UCR,* non-covered expenses and pre-certification penalties.**								
Base Pay Range	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**
$0-$29,999	$2,250	$3,500	$4,500	$7,000	$2,800	$5,600	$5,600	$11,200
$30,000-$49,999	$2,750	$4,500	$5,500	$9,000	$4,000	$8,000**	$8,000	$16,000
$50,000-$79,999	$3,750	$6,000	$7,500	$12,000	$5,000	$10,000**	$10,000	$20,000
$80,000-$124,999	$5,650	$9,500**	$11,300	$19,000	$6,000	$12,000**	$12,000	$24,000
$125,000+	$6,300	$11,500**	$12,600	$23,000	$6,650	$13,300**	$13,300	$26,600

* Usual, customary and reasonable (UCR) limits

** Out-of-pocket expenses paid for an individual with family coverage will be limited to no more than $7,900 for in-network coverage before the HSA plan reimburses 100 percent of eligible expenses.

Prepare for Your Doctor Visit

What questions do you want to ask? What questions are you afraid to ask? How much is it going to cost? You'll feel more comfortable if you spend a little time preparing for your visit before you go.

- Make a list of the things you want to discuss. With a list, you can be sure to cover everything you need and you'll be better able to answer your doctor's questions. Here are some suggestions of things to cover:
  - Any symptoms you are having
  - Smoking, eating, drinking and exercise habits
  - Your health history
  - Your family background
- **Confirm whether the doctor is in-network or out-of-network.** Whether you are searching for a primary care physician or have been going to the same doctor for many years, make sure you understand the financial savings associated with using doctors within your network. You can find an in-network doctor or facility contracted with Aetna or UnitedHealthcare, and compare providers and services by estimated costs and quality ratings, see "**Castlight: Make Informed Health Care** Choices" on page 46 for more information.
- **Explain the reason for your visit.** When you make your appointment for your wellbeing visit or preventive screening, make sure that the purpose of your visit is properly understood, and be sure to confirm at the time of arrival. Assuming you use an in-network provider, taking these steps can help ensure your preventive services will be paid at 100 percent.

Note: During your checkup, if you receive a diagnosis for an issue, or treatment or screenings for a condition for which you have already been diagnosed, the visit is not considered preventive and the deductible and coinsurance will apply.

– **Ask about the cost of care.** When you call to schedule an appointment (preventive, diagnostic, etc.), you can ask the estimated cost. You can also use Castlight's cost estimator to understand the price before you go. Castlight provides personalized cost estimates based on your location, your medical option and whether you've met your deductible. See "**Castlight: Make Informed Health Care** Choices" on page 46 for more information.

– **Bring a list of all medications, allergies and other doctors you see.** The more your doctor knows about your current health, the better he or she can get a grasp on your health needs. Include over-the-counter products (vitamins, herbal remedies, aspirin, etc.) so you can avoid drug interactions or side effects due to mixing medications. Be sure to review the CVS Value Formulary (list of covered prescription drugs), which can provide significant cost savings for you and your covered dependents by promoting the use of generic medications.

– **Bring your medical ID card.** Present your medical ID card at the time you receive care. When you see an in-network doctor, you don't pay anything at the time of your visit, but the doctor's office will need your ID card to confirm your coverage and determine your cost for treatment. After your visit, your doctor will send a bill to your health plan carrier. You may also receive a copy of this bill for your records—but you're still not required to pay anything yet.

Know What to Ask Your Doctor

Did you know that doctor visits only last 13 to 16 minutes on average? Make the most of your time together by taking an active role in the conversation.

(Source: Physician Compensation Report 2016, Medscape)

– **Tell your doctor your medical history.** If you have allergies or have experienced a reaction to a specific drug in the past, be sure to share that with your doctor. If the doctor is your primary care physician, he or she may already have this information from prior visits. If you don't have a primary care physician, consider selecting a trusted general practitioner so you'll be treated by someone familiar with your medical history each time you seek care.

– **Make sure you understand the reason for any medical tests and treatment options that the doctor prescribes.** Ask your doctor to review any test results or explain medical terms with which you are unfamiliar. There's no such thing as a dumb question when it comes to your health.

– **Ask your doctor about his or her experience or about seeing another doctor for a second opinion.** You are the customer, so there's nothing wrong with making sure you are comfortable. Remember, through BNY Mellon you have access to Best Doctors, an independent, third-party health firm, for an additional opinion and support.

– **Ask about any prescriptions being ordered.** Find out if they're necessary and why. Review the CVS Value Formulary or ask your doctor if a generic drug or over-the-counter equivalent is available. If appropriate for your situation and your doctor prescribes a generic drug or over-the-counter medication, they may work just as well and cost you less. Finally, be sure to ask about dosage and any potential drug/food interactions.

Know What to Do After Your Visit

You've met with your doctor and have a prescription in hand. Now what? Knowing what to do next can save you time and money.

- **Know your costs.** Your medical option covers in-network preventive care and screenings (i.e., annual physical and age-appropriate mammogram) at 100 percent. For in-network diagnostic office and specialist visits (i.e., sick visits), you'll pay the in-network negotiated office visit rate until you meet your deductible. Once you meet your deductible, you'll pay 20 percent of the cost (in-network) until you meet your out-of-pocket maximum. Visits to out-of-network providers will always cost you more. For out-of-network services, once you meet your deductible, you'll pay 40 percent of the cost until you meet your out-of-pocket maximum.
- **Get any prescriptions filled.** Make sure that you use a CVS/pharmacy or CVS Caremark Mail Service to save you time and money. Generally, the CVS Caremark prescription plan automatically offered through Lower Deductible HSA Plan or the Higher Deductible HSA Plan offers lower prices for generic drugs.
- **It's important to follow your doctor's treatment plan carefully.** In many cases, increased health risks may occur when individuals do not follow the treatment plan outlined by their physician.
- **Call your doctor with questions.** It's your health. Give it the attention it deserves.
- **Review your Explanation of Benefits (EOB) from your carrier.** The EOB shows what BNY Mellon paid and the exact amount you owe the doctor or facility—listed under "Member Responsibility. Check to ensure that all listed services were received and coded correctly and match the copy of the bill you received from your doctor or facility. If there are discrepancies, contact your carrier. **Remember:** In-network preventive care is covered at 100 percent. For all other care, you must meet your deductible—which you can pay using funds from your Health Savings Account—before BNY Mellon starts sharing the cost. Review the preventive care guidelines in "Obtain 100 Percent-Paid Preventive Care" on page 44 and remember to talk to your doctor and Medical Plan carrier about whether the care you receive is preventive or diagnostic for purposes of health insurance.
- **Check out the amount listed under "Member Responsibility" on your EOB—that's what you owe the doctor.** You can use your Health Savings Account to pay your doctor if you have money in your account, or you can pay the doctor out of pocket.
- **Second opinion? Use Best Doctors Expert Medical Opinion** when you need to understand a diagnosis or treatment option. This service provides an additional resource when you need information about a diagnosis of a condition or how to treat a complicated condition. A specialist will conduct a review of your diagnosis and treatment plan, and either confirm what you have been told or recommend a change.

Obtain 100 Percent-Paid Preventive Care

It's easy to put off getting an annual physical. But when it's covered at 100 percent, why wait? Your medical option covers in-network preventive care and screenings at 100 percent, so take advantage of the benefit and get your preventive care—for you and your covered family members.

What Is Preventive Care?

Preventive care helps identify potential health problems early when they may be easier and less costly to treat. Guidelines are based on your age and gender. The following table lists a selection of the more common preventive services, some of which are based on age, that are covered at 100 percent when obtained in network. For a complete list of your preventive care benefits, as well as a description of any age parameters, visit the Department of Health and Human Services website. Please contact your provider to determine whether services will be covered as preventive.

CHILDREN	MALE	FEMALE	
– Annual physicals – Immunizations – Well-baby care	– Annual physicals – Colonoscopy and anesthesia performed in connection with a preventive colonoscopy – Depression screening, including major depressive disorder – Diabetes mellitus: baseline for high-risk individuals – Gender-based preventive services for transgender individuals – High blood pressure screening – Immunizations – Latent tuberculosis infection screening – Low- and moderate-dose generic statin medications for those ages 40 - 70 – Medical/family history – Osteoporosis test – Prostate cancer screening – Syphilis screening – Tobacco-use cessation	– Annual physicals – Aspirin coverage for women of childbearing age who are at an increased risk of preeclampsia – Breastfeeding support and counseling – Colonoscopy and anesthesia performed in connection with a preventive colonoscopy – Depression screening, including major depressive disorder – Diabetes mellitus: baseline for high-risk individuals – Gender-based preventive services for transgender individuals – Genetic counseling and BRCA genetic testing for women who have had a non-BRCA related breast or ovarian cancer	– High blood pressure screening – Immunizations – Latent tuberculosis infection screening – Low- and moderate-dose generic statin medications for those ages 40 - 70 – Mammograms – Medical/family history – More FDA-approved contraception options – Osteoporosis test – Preventive services related to pregnancy for dependent children – Syphilis screening – Tobacco-use cessation – Well-woman exams

Note: During your checkup, if you receive a diagnosis for an issue, or treatment or screenings for a condition for which you have already been diagnosed, the visit is not considered preventive and the deductible and coinsurance will apply. Also, while the preventive exam provided by your physician is covered at 100 percent, if blood or other lab work is required, your deductible and coinsurance may apply to those services. As a reminder, if blood work or other lab work is required, make sure such work is performed by in-network providers, to the extent possible.

Preventive Screenings—Protect Your Health and Finances

Some health conditions don't have symptoms. That's where free preventive screening tests can help. With regular screening tests of your blood pressure and cholesterol, as well as colonoscopies and mammograms when requested by your physician, your doctor may be able to catch a disease or health condition early. The earlier you detect these conditions; the sooner you may be able to get them under control. You will be able to lower your risk of serious illness, costly medical care and hospital stays down the line. (Source: WebMD)

Remember to talk to your doctor and Medical Plan carrier about whether the care you receive is preventive or diagnostic for purposes of health insurance.

What Are Preventive Therapy Drugs?

Preventive drugs are medications that can help prevent a health condition from developing. Examples include blood pressure, prescribed aspirin, statin medications and cholesterol-lowering medications that may prevent heart attacks and strokes. See the "Preventive Therapy Drug List" on page 98.

Castlight: Make Informed Health Care Choices

If you participate in BNY Mellon sponsored Lower Deductible HSA Plan or Higher Deductible HSA Plan through Aetna or United Healthcare, you and your eligible dependents can use **Castlight** to make better informed health care choices all year-round. Castlight is a personalized tool that helps you easily compare your potential health care costs. You can use Castlight to compare cost estimates and quality ratings for doctors' and dentists' visits and health care services. The tool can help you understand what's covered by your health plan, see where you are with respect to your deductible status, review simple explanations of past expenses and much more. In addition, with Castlight's "myStrength," you can participate in online evidence-based therapy to address stress, depression, anxiety and other behavioral health concerns.

Best Doctors: Get Help with Important Medical Decisions

Best Doctors is a confidential medical consultation service to help you make better informed decisions about your medical care. Best Doctors offers three services at no cost to you, your spouse/qualified domestic partner or your parents/parents-in-law:

– **Expert Medical Opinion** provides a comprehensive medical review and a detailed report, based on the information you provide, when you are faced with a difficult medical diagnosis or decision.

– **Find A Best Doctor™** helps you find a treating physician or specialist for your specific condition. From its database of U.S. physicians in their specialties, Best Doctors will take careful steps to recommend physicians for your situation. They will contact the physician's office, confirm health plan participation and appointment availability, and even prepare you for your visit with important questions to ask. You can use Best Doctors' Find A Best Doctor service in combination with its Expert Medical Opinion services, or independently.

– **Ask The Expert™** helps get you quick answers to basic health questions.

For more information, call Best Doctors at 1-866-904-0910 between Monday through Friday 8:00 a.m. and 9:00 p.m. Eastern Time.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside money from your pay on a tax-free basis, as described below. The money you set aside can be used to pay for certain health care and dependent care expenses. You benefit from planning for upcoming expenses, and you also save on your taxes. You do not have to be enrolled in a BNY Mellon-sponsored health plan to contribute to an FSA.

YOUR FSA ENROLLMENT OPTIONS	
Health Care FSA	***Dependent Care FSA***
No participation	No participation
Contribute up to $2,650 a year	Contribute up to $5,000 a year

You will elect an annual contribution amount when you enroll. To determine how much will be deducted each pay date, divide your annual contribution by 24; or, if you enroll mid-year as a newly hired employee or as a result of a qualified life event, divide by the number of pay periods remaining in the year.

The amounts in your FSA(s) can be used to reimburse you for qualified medical or eligible dependent care expenses that are incurred from January 1, 2019 through December 31, 2019, as an active employee. You must submit all claims by the reimbursement deadline of **June 30, 2020**. Please note that you may carry over $500 each year from your Health Care FSA for use in the following year.

If you elect either the Lower Deductible HSA Plan or Higher Deductible HSA Plan for 2019, your Health Care FSA becomes a Limited Purpose FSA. See “Limited Purpose FSA” on page 51 more information.

Important Reminders

- You must re-enroll each year to participate in either of the FSAs.
- Expenses for your qualified domestic partner and your qualified domestic partner’s children generally are not eligible for reimbursement through either of the FSAs.
- By law, if you enroll in either the Lower Deductible HSA Plan or Higher Deductible HSA Plan, you may not participate in the General Purpose Health Care FSA; however, you may participate in the Limited Purpose Health Care FSA, which will allow you to pay for non-medical health care expenses, like dental, vision, preventive prescription drugs and out-of-network preventive care benefits. And, after you meet the annual HSA plan deductible, you may seek reimbursement for other qualified medical plan expenses.
- If you enroll in either HSA plan, you will not be eligible to use the FSA debit card but may submit documentation of eligible expenses for reimbursement from the Limited Purpose FSA. To obtain reimbursement of qualified medical expenses, you must submit documentation showing that the deductible has been met, along with your first post-deductible expense reimbursement submission.
- Most over-the-counter (OTC) drug expenses are not eligible for reimbursement. Non-drug OTC health care expenses (such as bandages) are eligible for reimbursement. So are insulin, diabetic supplies and OTC drugs for which you have a doctor’s prescription.

How FSAs Work

1. You decide how much to contribute to each account annually, based on the eligible out-of-pocket expenses you anticipate during the upcoming calendar year. Remember, most over-the-counter drugs are not eligible for reimbursement. The contribution amount you choose must be in dollars and cents, and the number of cents must be an even number.
2. Contributions are deducted from your pay before federal, Social Security and, in most cases, state taxes are calculated. (If you live in New Jersey or Pennsylvania, contributions to the Dependent Care FSA are not exempt from state taxes.)

3. You may use your FSA to reimburse yourself for qualified medical expenses and eligible dependent care expenses, using tax-free dollars. Except for the $500 Health Care FSA carryover from your 2019 health care FSA for use in the 2020 plan year, claims against your 2019 FSAs must be submitted by the reimbursement deadline of June 30, 2020. **Pleases note:** If you have a Health Care FSA, you may use your FSA debit card to pay for qualified medical expenses if you do not have a Health Savings Account. If you do have a Health Savings Account, you can pay expenses out-of-pocket and submit online claims with appropriate documentation for reimbursement after the deductible is met.
4. Go to MyBenefit Solutions (via MyReward or at **mybenefits.bnymellon.com**) to complete FSA reimbursement requests.
5. If you leave BNY Mellon or transition to a non-benefits-eligible position, you may file a claim for expenses incurred through the last day of the month in which your coverage ends subject to any COBRA rights that may apply.

Keep Your Receipts

If you are asked for documentation for an expense and do not have a receipt, the claim will be denied.

Debit Card Convenience with Health Care FSA

If you do not have a Health Savings Account, but elect to contribute to a Health Care FSA, you will receive a debit card to pay for qualified medical expenses at the point of purchase. Your debit card saves you the inconvenience of paying out-of-pocket for an expense, then filing for reimbursement. Your annual contribution is available to you as of your plan effective date, so you can begin using your card starting on that date. Here's how it works:

1. **You will receive a cardholder package in the mail** after you enroll; the package will contain your FSA debit card and instructions for activating this card for use. Additional cards may be ordered online. Access Your Spending Account on the MyBenefit Solutions site (via MyReward or at **mybenefits.bnymellon.com**).
2. **Use the card to make qualified purchases** at pharmacies, grocery stores and discount stores. Note: The IRS only allows FSA debit card purchases at stores that comply with an Inventory Information Approval System (IIAS). To find a list of compliant stores in your area, go to **www.sigis.com** and click Resources, then SIGIS Merchant List. If you attempt to make a qualified purchase from a non-compliant store, your debit card may be rejected. However, you may still complete the purchase with out-of-pocket funds and submit a claim for reimbursement.
3. **Most eligible transactions will be approved automatically** by the FSA vendor. In some cases, however, you may receive a letter or email requesting documentation to support certain expenses.
4. **Keep your receipts,** because even if a transaction is automatically approved at the point of purchase, you may still be required to provide documentation. If you receive a request for additional documentation and do not respond within 30 days, your card will be suspended until you supply the requested information or submit another claim to cover that expense.
5. **Keep your debit card,** as it is intended to be used for up to three years. If you use your entire balance early in the year, do not throw your card(s) away. The card will be re-activated each year you participate in the Health Care FSA. If you lose your card, please call Alight immediately to report your missing card and order a new one. You will be responsible for any charges until you report the card as lost or stolen. Fraudulent charges are handled per Visa's standard "fraud/dispute" process. Contact the phone number on the back of your debit card, or alternatively, 1-800-947-4748, option 2, to report a missing card or fraudulent card activity.
6. **If you have a Limited Purpose FSA,** you will not be able to use your Health Care FSA debit card and must seek reimbursement for any eligible expenses through MyBenefit Solutions.

For more information, access Your Spending Account (YSA) on the MyBenefit Solutions site (via MyReward, or at **mybenefits.bnymellon.com**).

Paying Online

You can pay many of your qualified health care expenses and eligible dependent care expenses directly from your applicable FSA with no need to complete paper forms*. It's quick, easy, secure and available online 24/7.

To pay a provider:

– Log in to your applicable FSA account at MyBenefit Solutions (via MyReward, or at **mybenefits.bnymellon.com**).

– Hover over the Health Care or Dependent Care tab.

– Select "Submit Health Care" or "Submit Dependent Care Claim." Then under "Enter Expenses" > Reimbursement Method, choose "Pay My Provider" and follow the instructions.

– If you pay for eligible recurring expenses, you even have the option to set up automatic payments.

* You must still provide documentation.

Access Your Health Account on the Your Spending Account Website

Sign up on the Your Spending Account website to receive text alerts that will provide information on your account balance and notify you when action is needed on a debit card claim. New participants will receive a Welcome Letter with instructions once enrollment is complete.

Filing a Claim

You also can file a claim online to request reimbursement for your eligible expenses:

– Go to MyBenefit Solutions (via MyReward, or at **mybenefits.bnymellon.com**) to log into your account, hover over the Health Care or Dependent Care tab.

– Select "Submit Health Care Claim" or "Submit Dependent Care Claim."

– Complete all the information requested on the form and submit.

– Scan receipts, Explanation of Benefits and other supporting documentation.

– Attach supporting documentation to your claim by clicking the upload button.

– To speed processing, remember to save receipts that show exactly what you paid for, the amount and date of service.

– Most claims are processed within one to two business days after they are received, and payments are sent soon thereafter.

If you prefer to submit a paper claim by fax or mail, you can go to MyBenefit Solutions (via MyReward, or at **mybenefits.bnymellon.com**) to download a claim form. Follow the instructions for submission, printing and then mailing or faxing that claim form along with your claim documentation.

When Your Coverage Ends

If you leave BNY Mellon or transition to a non-benefits-eligible position or otherwise stop participation in your FSA, you may file a claim for expenses incurred through the last day of the month in which your coverage ends. You may, however, be able to continue your Health Care Flexible Spending Account under COBRA.

Questions

If you have questions about either the Health Care or Dependent Care FSA, contact BNY Mellon Benefit Solutions at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

Health Care FSA Eligible Expenses

Expenses are eligible for reimbursement from the Health Care FSA if they:

– qualify for deduction on your federal income tax return; and

– are not reimbursable under any health care benefits covering you or your family members.

Examples of qualified medical expenses include:

– deductibles, copayments, prescriptions and certain over-the-counter items (insulin, over-the-counter drugs for which you have a valid prescription);

– non-drug over-the-counter purchases, such as contact lens cleaner, bandages and blood pressure monitors);

– costs for hearing exams; and

– any costs above what your plan pays.

IRS regulations do not allow reimbursement for dietary supplements, such as vitamins. You cannot use the Health Care FSA to reimburse yourself for premiums you pay for health care coverage.

For a complete list of qualified medical expenses, consult a tax adviser. You can also see IRS Publication 502 (Medical and Dental Expenses), which is available on MySource or at **www.irs.gov/Forms-&-Pubs**.

Over-the-counter medicine (such as allergy, cold and pain medication) is only reimbursable under the Health Care FSA if you have a prescription from a physician.

Dependent Care FSA Eligible Expenses

This account can be used for eligible daycare expenses for your eligible dependents if:

– both you and your spouse work; or

– you are a single parent; or

– your spouse attends school full time.

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

– your children under age 13;

– a disabled spouse who lives with you for more than half of the year; and

– any other relative or household member who receives more than half of his or her support from you, resides in your home, is physically or mentally unable to care for himself or herself, and who is not the qualifying child of the employee or any other individual.

You are required to notify Human Resources that your family member no longer meets the definition of an eligible dependent by calling 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

Examples of eligible expenses include the cost of:

– daycare provided in your home, as long as the care provider is not a dependent under age 19;

– daycare provided outside your home, for example by a qualified daycare facility, day camp, preschool or before- or after-school program; and

– any other childcare or eldercare expense allowed by the IRS as a qualified expense.

See IRS Publication 503 (Child and Dependent Care Expenses), which is available on MySource or at **www.irs.gov/Forms-&-Pubs**.

The IRS limits the amount employers can exclude from an employee's income for dependent care assistance to $5,000 per year. This limitation applies both to your contributions to BNY Mellon's Dependent Care Flexible Spending Account and to the value of childcare services provided by BNY Mellon. The value of the 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 $5,000 limit. If so, the excess will be reported as wages and will be subject to income and payroll taxes.

Health Care FSA During a Leave of Absence

If you take a paid leave of absence, you may continue to participate in the Health Care FSA.

If you take an unpaid leave of absence, your participation will be suspended until you return to active employment. However, you may submit claims for expenses incurred before your leave began. You will need to re-enroll in the FSA within 31 days of your return to work.

To receive a copy of BNY Mellon's Leave of Absence policy or provide the required notice that you are taking a leave of absence, call 1-800-947-4748, option 3.

Dependent Care FSA During a Leave of Absence

If you take a leave of absence—whether paid or unpaid—expenses incurred during your leave are not eligible for reimbursement. To provide the required notice that you are taking a leave of absence, call 1-800-947-4748, option 3.

Important FSA Rules

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

– You must decide how much to contribute before the year begins. Once you make your election, you cannot stop, start or change contributions unless you have a qualified life event. See "What Is a Qualified Life Event?" on page 14 for more details on qualified life events.

– You may carry over up to $500 left in your Health Care FSA at the end of the year to the following year.

– "Use it or lose it." You must use the full amount in your Dependent Care FSA, or you will forfeit any money left over. You will forfeit any amount greater than $500 left in your Health Care FSA. You will have until June 30, 2020, to claim reimbursement for eligible expenses incurred during 2019.

– You cannot transfer contributions between accounts, and (with the exception of the $500 Health Care FSA carry-over) you cannot use contributions from one year to pay for any other year's expenses.

– You cannot "double-dip." If you are reimbursed from the Health Care FSA, you cannot receive reimbursement for these same expenses through a Health Savings Account or a health reimbursement account, nor deduct those expenses on your federal income tax return.

– You cannot claim childcare or eldercare expenses on both the Dependent Care FSA and the federal Dependent Care Tax Credit.

Should You Use the Dependent Care FSA or the Dependent Care Tax Credit?

The Dependent Care FSA is not for everyone. For some people, the Dependent Care Tax Credit is more worthwhile. However, tax rules are complex and change frequently. To determine which choice is better for you, you should consult a tax advisor.

Limited Purpose FSA

By law, participation in a General Purpose FSA disqualifies you from making contributions to a Health Savings Account, although you can still enroll in a high deductible health plan. However, to help you pay eligible health care expenses when enrolled in the Lower Deductible HSA Plan or Higher Deductible HSA Plan, you can enroll in the Limited Purpose FSA. For 2019, you can contribute up to $2,650 through convenient payroll deductions.

Your contributions to the Limited Purpose FSA may only be used for the reimbursement of eligible dental, vision, preventive drug and out-of-network preventive care expenses, and after you have met your plan's annual deductible, other qualified medical expenses. The Limited Purpose FSA is subject to the same IRS rules that apply to flexible spending accounts. This means that (with the exception of the $500 carry-over for the Health Care FSA) you will lose any Limited Purpose FSA contributions you do not use—so plan carefully.

Dental and Vision

BNY Mellon provides a choice of dental and vision plans. For 2019, you'll have a choice of three dental plans and one vision plan.

Dental Benefits

Dental coverage helps with the cost of routine dental care and major services for you and your family.

BNY Mellon provides a choice of three dental plans. All the dental options offer a variety of coverage levels, allowing you to choose the dental coverage that best meets the needs of you and your family.

Your options include:

– MetLife Option 1 (Preferred Dental Program without orthodontic coverage)

– MetLife Option 2 (Preferred Dental Program with orthodontic coverage)

– Aetna DMO

– No coverage

Your dental coverage levels:

– Employee

– Employee + Child(ren)

– Employee + Spouse/Qualified Domestic Partner

– Employee + Family (you + your spouse/qualified domestic partner and child(ren)

MetLife Dental Options

The two MetLife options are Preferred Dental Program (PDP) organizations. As with the health plans, you may visit any provider you choose, but the plan will pay a greater benefit when you stay within the network. Network providers will also file your claims for you. If you use an out-of-network provider, you will have to pay out-of-pocket at the time services are received, then submit your claim for reimbursement.

Out-of-network reimbursement is based on usual, reasonable and customary (URC) charges instead of the negotiated rate used for in-network claims. If you receive care from an out-of-network dentist, you pay your share of the URC charge, plus the difference between the URC charge and your dentist's actual fee. Out-of-network usual, reasonable and customary ("URC") charges are charged at the 80th percentile which means that 80 percent of dentists in your geographic area charge that fee or less.

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

During Open Enrollment, if you change your MetLife option from the MetLife PDP Option 2 (with orthodontia benefits) to the MetLife PDP Option 1, any orthodontia benefits previously approved but not yet received will be forfeited, that is, not paid.

	METLIFE PDP OPTION 1		METLIFE PDP OPTION 2	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Annual Deductible	$75 per individual $150 per family[1]		$50 per individual $100 per family[1]	
Choice of Any Provider	Yes[2]		Yes[2]	
Plan Payments				
Diagnostic and Preventive Services – Routine cleanings, routine exams (2 per calendar year) – Bitewing X-rays (1 per calendar year) – Full mouth or panoramic X-rays (once every 60 months) – Topical fluoride application (to age 19; 2 in a calendar year) – Sealants (to age 19; first and second permanent molars, once per tooth every 5 years)	100% of PDP fee[2]	80% of URC[2]	100% of PDP fee[2]	90% of URC[2]
Basic Services – Fillings (silver) – Resin (white) fillings – Endodontics – Non-surgical periodontics – Simple extractions – Oral surgery – Consultations (1 per calendar year) – Space maintainers	80% of PDP fee[2,3] after deductible	60% of URC[2] after deductible	90% of PDP fee[2,3] after deductible	80% of URC[2] after deductible
Major Services – Bridges – Inlays – Onlays – Crowns – Dentures – Dental implants and preparation for the installation of implants – Surgical periodontics – Extraction of impacted 3rd molars (wisdom teeth) – General anesthesia – Bruxism	50% of PDP fee[2,3] after deductible	30% of URC[2] after deductible	60% of PDP fee[2,3] after deductible	50% of URC[2] after deductible

	METLIFE PDP OPTION 1		METLIFE PDP OPTION 2	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Orthodontia Services[4] (covered for dependents under age 19; lifetime maximum $1,500 per child)	Not covered		50% up to $1,500[2] (for children under age 19)	
Annual Maximum	$1,500 per individual		$1,500 per individual	
Lifetime Orthodontia Maximum	Not applicable		Up to $1,500 per child under age 19	

[1] Family applies to the Employee + Child(ren), Employee + Spouse/Qualified Domestic Partner, and Employee + Family levels of coverage.

[2] If you use an out-of-network dentist, plan payments are based on usual, reasonable and customary (URC) charges.

[3] The plan pays this percentage after you meet the annual deductible.

[4] Orthodontia is eligible on a monthly basis only. So if treatment continues into the next plan year, you must elect the plan with the orthodontia coverage to continue to be reimbursed. Charges for services not yet rendered are not allowed. Upfront reimbursement for the entire procedure is prohibited unless treatment is complete and braces have been removed. You must remain covered under this plan to receive continued reimbursement for orthodontic services.

Age, frequency limitations or exclusions may apply to certain services. For specific details, please contact MetLife directly.

Aetna DMO

The Aetna DMO is a Dental Maintenance Organization. As with an HMO, you receive a benefit only when you use a participating provider. You must select a primary care dentist (PCD) who will provide most of your dental care and provide referrals, if needed. If you elect coverage for any eligible dependents, each dependent must also select a primary dentist (family members do not all have to select the same one). Here's how:

– If you are enrolling in the Aetna DMO using the online system, go to the secure member website at **www.aetna.com** and click Log In/Register. You will be prompted to enter your DMO primary dentist's six-digit dental office number for each covered person. For information on the six-digit dental office number, click here or call 1-855-855-8112. No form is required.

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

– When you go to the dentist, tell the office your name, date of birth and member ID number (available on the secure member website).

– There are no deductibles or dollar maximums for covered services. Most diagnostic, preventive and basic services are covered in full at no out-of-pocket cost to you. There are some out-of-pocket costs associated with major services and orthodontic treatment as indicated in the table below. There is no annual or lifetime limit for orthodontics.

– You will not receive a member ID card when you enroll in the Aetna DMO. However, you can print a card for you and your dependents by going to the secure member website at **www.aetna.com**.

– If you elect Aetna DMO coverage, live in California or Arizona and do not select a primary care dentist, one may be selected for you. View your ID card online to determine if one was selected on your behalf.

– If you are re-enrolling in the Aetna DMO and want to change your primary dentist, contact the plan directly. Dental plan phone numbers and website addresses can be found in the *Contact Information* section of this Guide.

AETNA DMO[1]	
Annual Deductible	None
Choice of Any Provider	No
Plan Payments	
Diagnostic and Preventive Services – Routine cleanings (2 per calendar year) – Routine exams (4 per calendar year) – Bitewing X-rays (2 sets per calendar year) – Full mouth X-rays (once every 3 years) – Emergency palliative treatment – Fluoride application (dependent children up to age 18; 1 per calendar year) – Sealants (1 every 3 rolling years on permanent molars only; no age limit) – Oral hygiene instruction	100% of PCD fee Must use primary dentist or coordinated care
Basic Services – Amalgam (silver), anterior composite fillings – Root canal therapy – anterior and bicuspids – Apicoectomy – Simple extractions – Root planing and scaling	100% of PCD fee Must use primary dentist or coordinated care
Major Services – Bridges – Inlays – Onlays – Root canal therapy – molars – Osseous surgery – Crowns – Crown lengthening – Dentures – Prosthetics – Full/Partial bony impactions	60% of PCD fee Must use primary dentist or coordinated care
Orthodontia Services[2] (Adults and children covered with no lifetime maximum; charges for orthodontic services are based on procedures performed; contact Aetna for details)	50% of the participating provider contracted amount
Annual Maximum	None
Lifetime Orthodontia Maximum	None

[1] Aetna covers services only when your PCD coordinates your coverage; no coverage is available out of network.

[2] Orthodontia is eligible on a monthly basis only. Charges for services not yet rendered are not allowed. Upfront reimbursement for the entire procedure is prohibited unless treatment is complete and braces have been removed. You must remain covered under this plan to receive continued reimbursement for orthodontic services.

Age, frequency limitations or exclusions may apply to certain services. For specific details, please contact Aetna directly.

2019 Dental Premiums

The rates shown in the table below are 2019 semi-monthly dental plan premium amounts. This is the amount that will be withheld from each paycheck per pay period for eligible full-time and part-time employees.

2019 SEMI-MONTHLY EMPLOYEE PREMIUMS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAYCHECK)			
	MetLife PDP Option 1	***MetLife PDP Option 2***	***Aetna DMO***
Employee	$9.00	$16.59	$4.17
Employee + Child(ren)	$20.24	$37.34	$9.37
Employee + Spouse/Qualified Domestic Partner	$17.73	$32.71	$8.21
Employee + Family	$32.50	$59.95	$15.04

About ID Cards

Neither the MetLife options nor the Aetna DMO issues ID cards. For the MetLife options, just give your MetLife dentist your employee ID number, and he or she will submit your claim. **Your group number is 116273**. For the Aetna DMO, tell your dentist your name, date of birth and member ID number (available on the secure member website).

Things to Consider

Here are some things to consider as you make your dental decision:

– Would your family members consistently use primary dentists? If so, consider the Aetna DMO option, which is less expensive because of the restriction to network coverage.

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

– How often do you receive dental care? If your usual expenses are lower than the dental plan premiums, you may want to use Health Care FSA pre-tax dollars (see “Flexible Spending Accounts” on page 47) to cover those expenses instead of choosing dental coverage. Even if you have dental coverage, you can still use the Health Care FSA to pay out-of-pocket dental expenses.

Vision Benefits

The Vision Service Plan (VSP) includes coverage for exams, glasses or contact lenses, and discounts for laser surgery.

Your vision coverage choices:

– Vision Service Plan

– No coverage

Your vision coverage levels:

– Employee

– Employee + Child(ren)

– Employee + Spouse/Qualified Domestic Partner

– Employee + Family (you + your spouse/qualified domestic partner and child(ren)

How the Plan Works

When you enroll in the plan, you have access to VSP's network of eye care doctors. Each time you need vision care, you decide whether to use an in-network provider or an out-of-network provider. You save money if you go through the VSP network for your services and supplies.

SERVICES	VSP NETWORK BENEFITS COVERAGE	FREQUENCY
Exam	Covered in full One $10 copayment will be applied to the exam or eyewear purchased.	Every calendar year
Prescription Glasses Lenses – Single vision – Lined bifocal – Lined trifocal	Covered in full Polycarbonate lenses for dependent children covered in full	Every calendar year
Frame	Covered up to $150 and 20% discount off any additional out-of-pocket expense	Every other calendar year
Contacts	Covered up to $130. This allowance applies to the cost of your contacts. The cost of the fitting and evaluation exam will be no more than $60. This exam is in addition to your vision exam to ensure proper fit of contacts.	Every calendar year (Contact lenses are in lieu of glasses. When you choose contacts, you will be eligible for frames two calendar years after the contacts were obtained.)
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price from contracted facilities After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	Not applicable

SERVICES	NON-VSP NETWORK BENEFITS COVERAGE	FREQUENCY
Exam	Covered up to $50 One $10 copayment will be applied to the exam or eyewear purchased.	Every calendar year
Prescription Glasses Lenses: – Single vision – Lined bifocal – Lined trifocal – Lenticular	Single vision/covered up to $50 Lined bifocal/covered up to $75 Lined trifocal/covered up to $100 Lenticular lenses/covered up to $125	Every calendar year
Frame	Covered up to $70	Every other calendar year
Contacts	Elective contact lens covered up to $105 Medically necessary contact lens covered up to $210 This allowance applies to the cost of your lenses and the fitting and evaluation exam. This exam is in addition to your vision exam to ensure proper fit of contacts.	Every calendar year (Contact lenses are in lieu of glasses. When you choose contacts you will be eligible for frames two calendar years after the contacts were obtained.)
Laser Vision Correction	None	Not applicable

EXTRA DISCOUNTS AND SAVINGS—WHEN VISITING A VSP NETWORK DOCTOR, YOU'LL RECEIVE
– 30 percent off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20 percent off from any VSP doctor within 12 months of your last WellVision Exam.
– Average 35 to 40 percent savings on all non-covered lens options.
– 15 percent discount off the cost of contact lens exam (fitting and evaluation).

Finding a Network Provider

To obtain a list of network providers in your area, or to request a claim form for out-of-network providers, call VSP at 1-800-877-7195 or go to **www.vsp.com**.

If you are reviewing provider information online, you may see a disclaimer stating that VSP cannot guarantee that the doctors on the list participate in your plan. Disregard this statement, as the BNY Mellon plan allows you to use the full network of VSP doctors.

In-Network Benefits

When you go to a network provider, you pay a $10 copayment. With in-network benefits, the plan covers the following:

– one pair of eyeglass lenses, or contact lenses up to $130, each calendar year. Contact lenses can be delivered to your home. You pay the cost of any cosmetic features, such as bifocal lenses with no lines;

– one pair of frames every two years, up to $150, with an additional 20 percent discount off any out-of-pocket expenses; and

– laser vision correction (discounts only).

Out-of-Network Benefits

You may use providers who do not participate in the VSP network, but you will pay more. In addition, you must pay the provider in full out-of-pocket, then submit a claim to VSP. The plan will reimburse you a set dollar amount toward the cost of exams, lenses and frames.

Paying for Vision Services

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

– Network Provider – Contact your VSP provider to schedule an appointment. Let the provider know that you have VSP coverage, and ask the provider to obtain an authorization for you. At the time of your visit, pay the provider the required copayment and overages.

– Out-of-Network Provider – Pay the provider directly, and submit a claim for reimbursement. Claim forms are available at **www.vsp.com** or by calling 1-800-877-7195. You must file claims within six months of the date services are received. You will need to provide the following information on your VSP claim form:

  – your provider's bill, including a detailed list of the services you received;

  – your VSP identification number;

  – your name, phone number and address;

  – the company name: BNY Mellon Corporation;

  – the patient's name, date of birth, phone number and address (if different from yours); and

  – the patient's relationship to you (for example, self, spouse, child).

The Vision Service Plan (VSP) includes coverage for exams, glasses or contact lenses, and discounts for laser surgery.

2019 Vision Premiums

The rates shown in the table below are 2019 semi-monthly vision plan premium amounts. This is the amount that will be withheld from each paycheck per pay period for eligible full-time and part-time employees.

2019 SEMI-MONTHLY EMPLOYEE PREMIUMS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAYCHECK)	
Employee	$3.53
Employee + Child(ren)	$7.05
Employee + Spouse/Qualified Domestic Partner	$7.76
Employee + Family	$11.99

About ID Cards

You will not receive an ID card for this plan. Once you enroll, simply call a VSP provider to schedule an appointment. Be sure to tell the provider's staff that you have VSP coverage when you call and be prepared to provide the last four digits of your Social Security number. The provider and VSP will handle the rest. **Your group number is 12156679.**

Health and Wellbeing

The Wellbeing Program includes health management programs sponsored by BNY Mellon for eligible employees and their eligible dependents. The Program is rooted in a holistic approach to physical, emotional, financial and social wellbeing and allows you and your family to explore many areas of wellbeing you might not typically prioritize. The Program meets you where you are, rewards you for your efforts and should be meaningful to you in practice—whether it's something you are already doing or an area in which you want to focus.

Wellbeing resources are delivered by leading health care companies, including Aetna, UnitedHealthcare, CVS, Castlight, Doctor On Demand, WebMD Health Services, Virgin Pulse, Best Doctors, the Employee Assistance Program (EAP), Premise Health, Ayco, BenefitWallet and Voya. The program is confidential, voluntary and 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.)

To learn more about the wellbeing resources and incentives described here, visit HealthHub at **www.healthhub.bnymellon.com**.

The Employee Assistance Program (EAP), Best Doctors, Castlight, CVS, Doctor On Demand, Health Advantage, onsite Health Centers operated by Premise Health, WebMD and any similar services offered under the Wellbeing Program are not affiliated with BNY Mellon. While BNY Mellon offers these program services to its eligible employees and their dependents, it does not endorse, review or recommend any program physician, specialist or medical facility nor any advice, recommendation or treatment given or prescribed.

In the event of any discrepancy between this information and the applicable plan documents, the terms of the applicable plan documents will apply.

Improve Your Wellbeing and Earn Rewards Along the Way

The Wellbeing Rewards Program empowers you to be your best—physically, emotionally, financially, and socially. You and your covered spouse/qualified domestic partner can each earn up to $600 in 2019 Wellbeing Rewards program contributions by participating in points-based activities between January 1, 2019 and December 31, 2019.

All Wellbeing Rewards Program contributions will be paid in the same way—as deposits to your Health Savings Account when you are enrolled in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan. Benefits-eligible employees who waive medical plan coverage may participate in these wellbeing activities but will not be eligible to receive the financial incentives. Participation in the Wellbeing Rewards program is completely voluntary.

Please note that IRS rules prevent active employees enrolled in any part of Medicare or TRICARE from making or receiving contributions to a Health Savings Account. BNY Mellon contributions and Wellbeing Rewards Program contributions for these groups will be paid through payroll on a taxable basis. In addition, employees on long-term disability, pre-65 retirees, COBRA participants and those employees enrolled in Kaiser, HMSA Hawaii and Aetna International Plans are not eligible to make or receive Health Savings Account contributions.

ACTIVITY	POINTS EARNED
Biometric screening	100 points
Wellbeing assessment	50 points
Being tobacco-free	50 points
Preventive exams	50 points
Mental health screening	50 points
Flu shot	50 points
Virgin Pulse engagement platform	Up to 600 points
Telephonic health coaching	Up to 600 points
Onsite health coaching	Up to 600 points
Ayco financial planning and education	100 points (employee only)

ACTIVITY	POINTS EARNED
Health Savings Account contributions	50 points (employee only)
401(k) savings	50 points (employee only)
401(k) investing	50 points (employee only)
View your plan benefits and complete a search on the Castlight site	100 points
Best Doctors Expert Medical Opinion	150 points
Health Advantage Program	150 points
AccordantCare	Up to 200 points

Note that some activities are available only to employees. Find more information at **www.webmdhealth.com/bnymellon**.

Special Information if You Are Covered by the Kaiser, HMSA Hawaii or Aetna International Health Plan

Eligible employees and their spouse/qualified domestic partner who enroll in the Aetna International, Kaiser and HMSA Hawaii plans through BNY Mellon are eligible to participate in wellbeing activities; however, wellbeing rewards are only available to those who participate in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan.

Alternative Means to Earning Incentives

Incentives for participating in the 2019 Wellbeing Rewards Program are available to all eligible employees and their spouses/qualified domestic partners (in most cases) who are covered by the BNY Mellon-sponsored Lower Deductible or Higher Deductible HSA Plan through either Aetna or United Healthcare. If you think you might be unable to meet a standard or activity for an incentive under this Program, you might, in many cases, qualify for an opportunity to earn the same incentive by different means. Contact WebMD at 1-888-258-9275 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.

2019 IRS Limits Impacting Health Savings Account Incentives

While BNY Mellon monitors your Health Savings Account pre-tax payroll contributions and contributions earned through the Wellbeing Rewards Program to help ensure that IRS contribution limits are not exceeded, please note that it is your responsibility to determine whether your total Health Savings Account contributions exceed the maximum IRS contribution limits in a particular year. If your total Health Savings Account contributions (including your own after-tax contributions, pre-tax payroll contributions, contributions earned through the Wellbeing Rewards Program 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, any excess contributions are subject to both income taxes and an excise tax. Please see “Health Savings Account Contributions” on page 34 for more information.

Financial Protection Benefits

BNY Mellon offers a range of benefits that help safeguard you and your family in the event of an illness, injury or death. This section describes the short-term disability (STD) and long-term disability (LTD) benefits, as well as the life and accidental death and dismemberment (AD&D) insurance coverage available, to provide financial protection.

This section also has information about Ayco financial planning and education resources.

Disability Coverage

Disability coverage protects you and your family by continuing all or part of your base pay when an illness or injury prevents you from working.

Short-term Disability (STD)

BNY Mellon provides STD benefits through its salary continuance payroll practice at no cost to you; there is no need to enroll. This benefit generally replaces all or part of your base pay if an illness or injury keeps you away from work for more than seven consecutive days.

Long-term Disability (LTD)

BNY Mellon provides a core level of LTD coverage through Lincoln Financial Group to provide income for you if you are disabled longer than 26 weeks and meet the plan's definition of disability.

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

Note: Any LTD income you receive from this plan will be reduced by benefits you or your family receive from other sources, such as Social Security or Worker's Compensation.

LTD payments are determined using a percentage of your base pay (not including overtime pay, bonuses or other special forms of pay). In addition, your base pay used in determining LTD benefits will be capped at $300,000.

Things to Consider

Here are some things to consider as you make your LTD coverage decision:

– How much money would it take to maintain your current lifestyle? If you were to become disabled, would 60 percent of your base pay be enough to meet your current expenses? Remember, your LTD benefit will be based on your base pay up to $300,000 and does not consider any bonus compensation. Note that you pay for this coverage with pre-tax dollars, which means that any LTD payments you receive will be subject to federal (and, in most cases, state and local) income taxes. Supplemental disability insurance is available.
– Does your spouse/qualified domestic partner earn a steady income?

Life and Accident Coverage

Life and accident coverage, administered by MetLife, provides financial protection for your family in case of death or serious injury.

Three kinds of coverage are available to you:

– Life insurance
– Accidental death and dismemberment (AD&D) insurance
– Travel accident insurance (administered by National Union Fire Insurance Company of America)

In addition, you may purchase dependent life insurance coverage for your spouse or qualified domestic partner and eligible children.

Coverage Amounts

If one times your annual base pay results in a number that is not a multiple of $1,000, your coverage will be rounded up to the next higher $1,000. For example, if your annual base pay is $27,750 and you have life insurance coverage of one times your base pay, your coverage amount would be $28,000.

Things to Consider

Here are some things to consider as you make your life and accident coverage decisions:

– Would your family have other sources of income if you were unable to work?

– What predictable costs (such as college tuition or mortgage payments) would you like to see taken care of if something happened to you?

– Do you have a private source of insurance in addition to BNY Mellon coverage?

– Do you have enough protection for your family?

– Does your spouse/qualified domestic partner earn a steady income? If so, you may not need as much insurance coverage as you would if you were the sole wage earner.

Life and Accident Coverage at a Glance

DESCRIPTION AND CHOICES		
	EMPLOYEE COVERAGE	**BENEFICIARY**
Life Insurance	– Basic – You automatically receive BNY Mellon-paid coverage equal to your annual base pay, up to $500,000. – Buy down – You may "buy down" to $50,000 of coverage and receive a credit (if your annual base pay is greater than $50,000). – Supplemental – You may purchase additional coverage of one to eight times your annual base pay, up to a $3 million maximum, subject to Evidence of Insurability.	You must choose a primary beneficiary.
AD&D Insurance	– Basic – You automatically receive basic BNY Mellon-paid coverage equal to your annual base pay, up to $500,000. – Supplemental – You may purchase additional coverage of one to eight times your annual base pay, up to a $3 million maximum.	You must choose a primary beneficiary.

DESCRIPTION AND CHOICES		
Travel Accident Insurance	– Basic – You automatically receive BNY Mellon-paid coverage equal to five times your annual base pay, with a minimum coverage amount of $250,000 and a maximum coverage amount of $4 million. – This coverage pays a benefit if you have a serious accident while traveling on company business (or commuting to or from work). – The plan pays a full benefit in the event of death and a partial benefit if you suffer certain serious injuries.	Same as your basic life insurance beneficiary.
DEPENDENT COVERAGE		
Spouse/Qualified Domestic Partner Life Insurance	– No Coverage – $25,000 – $50,000	You are automatically the beneficiary for this coverage.
Child Life Insurance	– No Coverage – $10,000 – $15,000 – If you elect coverage, it includes all of your dependent children—you do not elect separate coverage for each child.	You are automatically the beneficiary for this coverage.

Cost of Coverage

Your cost for life and AD&D insurance coverage is based on your age as of December 31, 2019, the level of coverage you select and your base pay as of September 1, 2018, or your hire date, if later. Base pay does not include overtime pay, bonuses or other special forms of pay. Only the first $500,000 of annual base pay is considered for this purpose.

If the combined total amount of basic life insurance coverage exceeds $50,000, federal tax law requires that the value of the coverage above $50,000 (called “imputed income”) is taxable to you as federal income and subject to Social Security. The amount that is taxable to you (usually a minimal amount, calculated using an age-related table published by the Internal Revenue Service) will be shown on your pay statement in the earnings column. Supplemental and dependent coverage is not subject to the age-related table rules. The premiums will be paid with after-tax dollars.

Extra Protection for Your Family

In the event of your death while an active employee, your covered dependents will be eligible to receive three months of extended medical coverage paid in full by BNY Mellon. This benefit is paid when your dependents elect COBRA (a plan to continue coverage under certain benefits for a specified period).

Evidence of Insurability

You will need to provide Evidence of Insurability (EOI), or proof of good health, to MetLife to purchase Supplemental Life Insurance coverage.

After you make an election requiring EOI, a link that will prompt you to complete the form electronically will appear under action items on the Benefits Enrollment site. If you do not enroll online within seven days, a form will be sent to you automatically if your coverage election requires EOI.

Employee Coverage

Life Insurance

BNY Mellon automatically provides you with coverage equal to your annual base pay. Additional benefits include but are not limited to:

– an accelerated death benefit; and

– portability and/or the ability to convert your policy.

Additional details about these benefits are available on MySource.

Your Life Insurance Coverage Choices

– Basic – You automatically receive BNY Mellon-paid coverage equal to your annual base pay, up to $500,000.

– Buy down – You may “buy down” to $50,000 of coverage and receive a credit (if your annual base pay is greater than $50,000).

– Supplemental – You may purchase additional coverage of one to eight times your annual base pay, up to a $3 million maximum, subject to Evidence of Insurability as described above.

AD&D Insurance

AD&D (accidental death and dismemberment) insurance provides financial protection for your family in the event of your death or serious injury in an accident. BNY Mellon automatically provides you with coverage equal to your annual base pay at no cost to you.

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

Your AD&D Insurance Coverage Choices

– Basic – You automatically receive basic BNY Mellon-paid coverage equal to your annual base pay, up to $500,000.

– Supplemental – You may purchase additional coverage of one to eight times your annual base pay, up to a $3 million maximum.

Travel Accident Insurance

In addition to AD&D insurance, BNY Mellon provides you with travel accident insurance that provides accident protection for you while you travel on company business or commute to and from work.

If you’re on a company business trip and have an accident, travel accident insurance pays full benefits in the event of your death, or partial benefits if you suffer certain serious injuries. BNY Mellon provides you with coverage equal to five times your annual base pay, with a minimum coverage amount of $250,000 and a maximum coverage amount of $4 million. This coverage is provided automatically at no cost to you. There is no need to enroll.

Dependent Coverage

Spouse/Qualified Domestic Partner Life Insurance

This benefit provides life insurance coverage for your spouse or qualified domestic partner. You are automatically the beneficiary for this coverage. You pay for this coverage with after-tax dollars.

You may choose from the following three options:

– No Coverage

– $25,000

– $50,000

Child Life Insurance

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

You may choose from the following three options:

– No Coverage

– $10,000

– $15,000

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

Ayco Financial Planning

Financial Planning and Education Resources

Ayco* financial coaches can help you plan for your future use of health care; answer questions about Health Savings Develop your financial wellbeing with Ayco*. Ayco services include digital tools and financial coaching designed to help you build a strong foundation, and plan for your financial future.

Ayco financial coaches can help you plan for your future use of health care; answer questions about Health Savings Accounts and Flexible Spending Accounts; address your other insurance needs, including life, accident and disability insurance; and assist you with other broad-based financial questions.

BNY Mellon provides access to Ayco at no cost to all US benefits-eligible employees.

To learn more:

– Call 1-800-947-4748, option 7, Monday through Friday between 9 a.m. and 5 p.m. Eastern Time. Evening appointments are available Monday through Thursday until 8 p.m. Eastern Time.

– **At work:** Single sign-on access through **MyReward** (MySource > HR & Personal > MyReward > Logon to MyReward > Proceed to My Personal Total Reward Data > Ayco Financial Planning).

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

While Ayco is a service made available to its employees by BNY Mellon, BNY Mellon does not review, provide or endorse any financial planning advice or information obtained from Ayco or its advisors. Ayco is not affiliated with BNY Mellon, and BNY Mellon receives no consideration (monetary or otherwise) from Ayco in connection with this service.

* The Ayco Company, L.P., (Ayco) is a subsidiary of The Goldman Sachs Group, Inc. and an affiliate of Goldman, Sachs & Co., a worldwide, full-service investment banking, broker-dealer and asset management organization.

Time Off and Personal

BNY Mellon believes in a healthy balance of work and personal responsibilities.

This section describes the flexible time off opportunities to support your and your family's needs.

Flex Vacation Purchase

In addition to your regular earned vacation, BNY Mellon offers you the opportunity to purchase additional vacation time during fall Open Enrollment.

Your flex vacation choices (if hired prior to November 30, 2018):

– No participation

– Buy one day

– Buy two days

– Buy three days

– Buy four days

– Buy five days

Your cost for each option depends on your annual base pay. The annual cost of each vacation day is your annual base pay (as of September 1, 2018, or your hire date, if later) divided by 260. That annual cost is then divided by 24 to determine your cost per-pay.

If you work part time, each flex vacation day you purchase is equal to 1/5 of your weekly work hours. For example, if you work 25 hours a week, each flex vacation day you purchase would be equal to five work hours.

Something to Consider

Additional vacation days can be helpful if you know you'll definitely use them. Consider whether you have an upcoming event that you know will require extra time away from work, like getting married, having a child, attending a family reunion or planning a move and then make your flex vacation purchase decisions.

How Flex Vacation Works

Provided you are hired on or before November 30, 2018, you can purchase additional vacation days for 2019 prior to your enrollment deadline. Once you elect to purchase flex vacation days, you will not be able to change your selection following the close of Open Enrollment.

Flex vacation days are only available for use after you have used your entire regular vacation allotment for 2019. Finally, like your regular vacation time, you must obtain your manager's advance approval prior to using your flex vacation day(s).

Except where otherwise required by law, you cannot return flex vacation day(s) once purchased; nor can you carry flex vacation day(s) over into the next calendar year. Thus, if you do not use your flex vacation days during the calendar year, you will lose them.

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.

Legal 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 2019. The following notices (and related information) are intended to be, and are, 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 at 1-800-947-4748, option 2, Monday through Friday between 8:30 a.m. and 8:00 p.m. Eastern Time.

– **Value of Health Benefits**—The value of your health benefits received in the immediately preceding year will be reported in Box 12 on your 2019 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 you receive in January 2019 should not be included in your taxable income when you file your taxes. You will also not be subject 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 at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

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 more restrictive 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 the Uniformed Services Employment and Reemployment Rights Act of 1994 ("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 **www/dol.gov/vets/**.

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 at 1-800-947-4748, option 2.

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 BNY Mellon, your state may have a premium assistance program that can help pay for coverage, using funds from its 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 or to find out whether you qualify, 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 believe 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 visit **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-sponsored plan, your employer must allow you to enroll in your employer-sponsored 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-sponsored 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 in paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your state for more eligibility information.

STATE	SERVICE	WEBSITE	PHONE NUMBER
Alabama	Medicaid	**http://myalhipp.com/**	1-855-692-5447
Alaska	Medicaid	The AK Health Insurance Premium Payment Program Website**: http://myakhipp.com/** Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	1-866-251-4861
Arkansas	Medicaid	**http://myarhipp.com/**	1-855-MyARHIPP (855-692-7447)
Colorado	Medicaid CHP+	Health First Colorado: **https://www.healthfirstcolorado.com/** CHP+: **http://Colorado.gov/HCPF/Child-Health-Plan-Plus**	1-800-221-3943 (TTY 711) 1-800-359-1991 (TTY 711)
Florida	Medicaid	**http://flmedicaidtplrecovery.com/hipp/**	1-877-357-3268
Georgia	Medicaid	**http://dch.georgia.gov/medicaid** (click on Health Insurance Premium Payment (HIPP))	404-656-4507
Indiana	Medicaid	**http://www.in.gov/fssa/hip/ (for low-income adults 19-64)** **http://www.indianamedicaid.com (all other Medicaid)**	1-877-438-4479 1-800-403-0864
Iowa	Medicaid	**http://dhs.iowa.gov/hawk-i**	1-800-257-8563
Kansas	Medicaid	**http://www.kdheks.gov/hcf/**	1-785-296-3512
Kentucky	Medicaid	**http://chfs.ky.gov**	1-800-635-2570
Louisiana	Medicaid	**http://dhh.louisiana.gov/index.cfm/subhome/1/n/331**	1-888-695-2447
Maine	Medicaid	**http://www.maine.gov/dhhs/ofi/public-assistance/index.html**	1-800-442-6003 (TTY 711)
Massachusetts	Medicaid and CHIP	**http://www.mass.gov/eohhs/gov/departments/masshealth/**	1-800-862-4840
Minnesota	Medicaid	**http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp**	1-800-657-3739
Missouri	Medicaid	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana	Medicaid	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**	1-800-694-3084
Nebraska	Medicaid	**http://www.ACCESSNebraska.ne.gov**	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada	Medicaid	**http://dhcfp.nv.gov**	1-800-992-0900
New Hampshire	Medicaid	**http://www.dhhs.nh.gov/ombp/nhhpp/**	603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
New Jersey	Medicaid	**http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**	609-631-2392
	CHIP	**http://www.njfamilycare.org/index.html**	1-800-701-0710

STATE	SERVICE	WEBSITE	PHONE NUMBER
New York	Medicaid	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina	Medicaid	**https://www.dma.ncdhhs.gov/**	919-855-4100
North Dakota	Medicaid	**http://www.nd.gov/dhs/services/medicalserv/medicaid/**	1-844-854-4825
Oklahoma	Medicaid and CHIP	**http://www.insureoklahoma.org**	1-888-365-3742
Oregon	Medicaid	**http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html**	1-800-699-9075
Pennsylvania	Medicaid	**http://www.dhs.pa .gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm**	1-800-692-7462
Rhode Island	Medicaid	**http://www.eohhs.ri.gov/**	1-855-697-4347
South Carolina	Medicaid	**https://www.scdhhs.gov**	1-888-549-0820
South Dakota	Medicaid	**http://dss.sd.gov**	1-888-828-0059
Texas	Medicaid	**http://gethipptexas.com/**	1-800-440-0493
Utah	Medicaid	**https://medicaid.utah.gov**	1-877-543-7669
	CHIP	**http://health.utah.gov/chip**	1-877-543-7669
Vermont	Medicaid	**http://www.greenmountaincare.org/**	1-800-250-8427
Virginia	Medicaid	**http://www.coverva.org/programs_premium_assistance.cfm**	1-800-432-5924
	CHIP	**http://www.coverva.org/programs_premium_assistance.cfm**	1-855-242-8282
Washington	Medicaid	**http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program**	1-800-562-3022 Ext. 15473
West Virginia	Medicaid	**http://mywvhipp.com**	1-855-MyWVHIPP (1-855-699-8447)
Wisconsin	Medicaid and CHIP	**https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf**	1-800-362-3002
Wyoming	Medicaid	**https://wyequalitycare.acs-inc.com/**	307-777-7531

To see if any more states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, you can contact either:

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Key Things to Know About the Affordable Care Act (ACA)

The ACA's individual mandate requires that nearly everyone have medical coverage or pay a penalty. If you are benefits-eligible and enrolled in a BNY Mellon health plan under the Plan, you are in compliance with the individual mandate.

– Our health plans offer the level of coverage to satisfy the individual mandate.

– Our health plans offer affordable coverage with at least the minimum benefit value (called "minimum essential coverage") required under the ACA.

– 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 large part of the cost for your medical coverage. Generally, in the public marketplace, you will pay the entire cost of your coverage.

For more information about the ACA, visit **www.healthcare.gov**.

Health Insurance Marketplace Coverage Options

PART A: General Information

The Affordable Care Act offers all Americans 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 new 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 9.86 percent of your household income for the year, 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, if you are an employee of BNY Mellon, 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 at 1-800-947-4748, option 2.

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 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	1-800-947-4748, option 2

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

– 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 19. 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.

If you have medical coverage through a medical plan offered by BNY Mellon and Medicare while receiving LTD Plan benefits, and you or any of your covered dependents are receiving Social Security Disability benefits, Medicare becomes the primary coverage after 24 months of receiving Social Security Disability benefits. However, in the case of end-stage renal failure, Medicare becomes primary after the first 30 months. (As you approach either of these milestones, approximately 60 days prior to reaching 24 months of LTD, Alight will send you a notice advising you of your upcoming eligibility for Medicare.)

If you or your covered dependents are enrolled in both Medicare and a BNY Mellon group health plan, your employment status will determine whether the BNY Mellon medical plan or Medicare is the primary claims payer. Because you are classified as “inactive” status when approved for Long-term Disability (LTD), Medicare would be the primary coverage for any Medicare-eligible dependents.

LTD and Medicare Guidelines for Employees on BNY Mellon Medical Coverage:

Employer coverage can remain primary for up to 24 months after the effective date of Social Security Disability benefits (30 months in the case of end-stage renal failure). However, Medicare will become primary when the earliest of the following events occur:

Employees:

– You are approved for Medicare based on your Social Security Disability status.
– The 1st of the month in which you turn age 65.

Dependents:

– Dependents turn age 65.
– Dependents are already Medicare eligible or become Medicare eligible once the employee begins Long-Term Disability status.

To avoid paying the first 80 percent of Medicare Part B covered expenses, you must enroll in both Parts A & B of Medicare coverage once Medicare becomes primary. If you do not enroll in both Medicare Parts A & B, you may incur substantial out-of-pocket expenses because BNY Mellon medical coverage will pay secondary to Medicare and will not cover all of those expenses.

BNY Mellon medical plans will only pay eligible expenses as though you were enrolled in Medicare Part A and Part B. For this reason, you should make sure to enroll in both Part A and Part B. Exceptions may apply in certain cases of vocational rehabilitation and under certain HMOs. If you are currently part of a "grandfathered" group that is eligible to participate in a Medicare plan, that information will be reflected on the enclosed confirmation statement.

If you have questions about Medicare, please call 1-800-MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048).

BNY Mellon's plans follow the non-duplication method when coordinating benefits. In cases where a BNY Mellon plan is determined to be the secondary coverage, the applicable plan will pay only the difference between the amount normally reimbursed by that plan and the amount reimbursed by the primary coverage. This means if you are covered under two plans, you may not necessarily receive more benefits than you would if the BNY Mellon plan was your only coverage.

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. If you have or are eligible for Medicare, this Notice also tells you where to find more information to help you make decisions about your prescription drug coverage. At the end of this Notice is information about where you can get help to make decisions about prescription drug coverage. If you are not currently eligible for Medicare, the Notice may be helpful to you when you become eligible for Medicare.

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:

– Aetna Lower Deductible HSA Plan (Health Savings Account)
– UnitedHealthcare Lower Deductible HSA Plan (Health Savings Account)
– Aetna Higher Deductible HSA Plan (Health Savings Account)
– UnitedHealthcare Higher Deductible HSA Plan (Health Savings Account)
– Kaiser Permanente California (Los Angeles)
– Kaiser Permanente California (San Francisco)
– HMSA Hawaii
– 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.

Read this Medicare Prescription Drug Notice carefully. If you are eligible for Medicare, it explains the options you have under Medicare prescription drug coverage and can help you decide whether you want to enroll. 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. 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 2018). If you drop coverage under a BNY Mellon Creditable Coverage Plan, you may be eligible for a special enrollment period in which to sign up for a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and keep your BNY Mellon coverage, your BNY Mellon coverage will not change. However, if you drop your BNY Mellon Creditable Coverage Plan coverage (which includes prescription drug coverage), you may not be able to get this coverage back.

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.

If you drop or lose coverage under a BNY Mellon Creditable Coverage Plan, and you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage (once your applicable Medicare enrollment period ends), 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 what most other people pay. 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.

If you don't enroll in Medicare prescription drug coverage when eligible, and change your mind later, you may pay more.

If you wait until after you are eligible for your initial enrollment in a Medicare prescription drug plan, your monthly premium for a Medicare prescription drug plan could be much higher than it would have been if you had enrolled when initially eligible. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your premium will go up at least 1 percent per month for every month that you did not have that coverage after the date you were first eligible for a Medicare prescription drug plan. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage.

If you don't enroll in a Medicare prescription drug plan when first eligible, you also may have to wait to enroll.

Generally, you can only join a Medicare prescription drug plan during the Medicare annual enrollment period (October 15 – December 7 in 2018). This may mean the number of months you have to wait for coverage will be longer, which could make your premium higher. If you decide to enroll in a Medicare prescription drug plan and keep your BNY Mellon coverage, your BNY Mellon coverage will not change. If you drop your BNY Mellon Non-Creditable Coverage Plan coverage (which includes prescription drug coverage), you may not be able to get this BNY Mellon coverage back. 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 this BNY Mellon coverage back later.

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 at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m., Eastern Time.

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).

October 2018

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

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, 2019

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 for the self-insured health plans sponsored by BNY Mellon details the uses and disclosure that the BNY Mellon self-insured health plans may make of your health information, along with your rights and BNY Mellon's self-insured health plan's obligations with respect to that information.

BNY Mellon's benefits program includes both self-insured and insured plans. This notice contains a list of all of these plans, indicating which are self-insured and which are not. If you are enrolled in an insured plan, 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 self-insured 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 at 1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.

BNY MELLON-SPONSORED HEALTH PLANS/PROGRAMS FOR U.S.-BASED EMPLOYEES		
SELF-INSURED PLANS/PROGRAMS		**INSURED PLANS/PROGRAMS**
– Aetna Lower Deductible HSA and Higher Deductible HSA Plans – Best Doctors® – Castlight – CVS/Caremark Pharmacy Advisor Counseling – CVS/Caremark Prescription Program – Doctor On Demand – Employee Assistance & Work/Life Program	– MetLife Preferred Dental Program – Premise Health – UnitedHealthcare Lower Deductible HSA and Higher Deductible HSA Plans – Vision Service Plan (VSP) – WebMD Health Services	– 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 self-insured health plans and programs, which are listed below, 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.

– Aetna Lower Deductible HSA Plan (Health Savings Account)

– Aetna Higher Deductible HSA Plan (Health Savings Account)

– Best Doctors®
– Castlight
– CVS/Caremark Prescription Program and Pharmacy Advisor Counseling
– CVS Accordant Care and MinuteClinic
– Doctor On Demand
– Premise Health
– UnitedHealthcare Lower Deductible HSA Plan (Health Savings Account)
– UnitedHealthcare Higher Deductible HSA Plan (Health Savings Account
– The Employee Assistance Program (EAP)
– MetLife Preferred Dental Program
– Vision Service Plan (VSP)
– WebMD Health Services

“We,” “us,” and “Plan” refer to all the health plans and programs 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;
– 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 procedures, 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 at 1-800-947-4748, option 2 (Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time). 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
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 2019.

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 Title11 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 (your divorce or legal separation from 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 1-800-947-4748, option 2.

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. When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 36 months for your spouse and dependent children:

– Your death;
– Your divorce or legal separation; or
– Your dependent stops being eligible for coverage under the Plan as a "dependent child".

When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 18 months for qualified beneficiaries:

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

When the qualifying event is your reduction in hours or your termination of employment and you were entitled to Medicare benefits prior to the qualifying event, additional coverage for your spouse and dependents may be available. Your spouse and dependents would be eligible to receive up to 36 months of COBRA continuation coverage from the date of your entitlement to Medicare. For example, if you became entitled to Medicare 8 months before the date your employment terminates, COBRA continuation coverage for your spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months prior to the qualifying event).

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 18 months of COBRA coverage;
– The disability must last at least until 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 1-800-947-4748, option 2.

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 1-800-947-4748, option 2.

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, call1-800-947-4748, option 2.

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 1-800-947-4748, option 2 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 1-800-947-4748, option 2 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, Medicaid, 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. Additionally, you may qualify for a 30-dayspecial enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. Some of these options may cost less than COBRA continuation coverage.

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

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: 1-800-947-4748, option 2, 8:30 a.m. to 8:00 p.m. Eastern Time Monday through Friday.

Please address any written correspondence to:

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

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 Wellbeing Assessment ("WBA") 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 WBA or to participate in the biometric screening or any other medical examinations. If you think you might be unable to meet a standard or activity for an incentive under this Program, you might qualify for an opportunity to earn the same incentive by different means. Contact WebMD at 1-888-258-9275 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 vendor program partners will provide your personal health data, including WBA and biometric screening input or results, or other personal information, to BNY Mellon, except as permitted by law. 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 that meet your health and wellness needs.

Individual participation will be reported to BNY Mellon and vendor partners for purposes of Wellbeing Program incentive administration. Vendor partners (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 vendor partners for estimating overall plan costs, it will not receive any of your personal health data under any circumstance.

The programs and services provided by vendor partners, including, but not limited to, Premise Health, The Ayco Company, L.P., Beacon Health Options, WebMD Health Services, Castlight, CVS Caremark, Virgin Pulse, Voya, Best Doctors, Aetna, and United Healthcare, 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 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 programs 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

Terms You Should Know

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

Base Pay

As used in this Guide, “base pay” generally means your annualized base pay as of September 1, 2018, or your hire date, if later, based on a normal work week not exceeding 40 hours. It generally excludes commissions, overtime pay, bonuses, payments in lieu of vacation, all non-regular payments and any other special purpose payments. For commissioned employees, base pay is determined by using the Annual Benefits Base Rate (ABBR), which is determined annually. In addition, the IRS limits the amount of base pay that can be considered in determining plan benefits each year. Salary reduction contributions, Code Section 132(f) transportation plan and similar salary reductions, as well as any deferred compensation contributions, are included in the calculation of your base pay.

COBRA

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

Coinsurance

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

Copayment (or Copay)

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

Deductible

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

Dispense as Written (DAW)

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

Explanation of Benefits (EOB)

A statement, usually from a claims administrator, to a plan member who files a claim. The statement details how and why benefit payments were made or not made and summarizes the charges submitted and processed, the amount allowed, the amount the plan paid and what the plan member owes, if applicable.

Formulary

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

Health Savings Account (HSA)

A special tax-sheltered savings account that is similar to a traditional individual retirement account (IRA), but designated for qualified health care expenses. You can use a Health Savings Account to pay for future qualified health care expenses on a tax-free basis. Contributions, earnings and distributions are exempt from federal income and Social Security (FICA) taxes when used to pay for qualified health care expenses. To participate in a Health Savings Account, you must enroll in the Lower Deductible HSA Plan or the Higher Deductible HSA Plan under Aetna or UnitedHealthcare.

High-Deductible Health Plan

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

HIPAA

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

Imputed Income

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

- a combined total amount of basic life and supplemental life insurance coverage greater than $50,000; or
- qualified domestic partner or related dependent coverage.

In-Network or Network Care

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

Out-of-Network Care

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

Out-of-Pocket Maximum

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

* Includes deductibles and coinsurance; does not include copayments, premiums, any amounts over usual, customary and reasonable (UCR), non-covered expenses and precertification penalties.

Preferred/Non-Preferred Carriers

Depending on where you live, one medical carrier may offer greater provider discounts on average—making it more cost-effective for you and BNY Mellon—than the other. In these states, the carrier with the greater discounts on average is referred to as the preferred carrier. The carrier with fewer negotiated discounts is referred to as the non-preferred carrier.

Preferred/Non-Preferred Drugs

Your cost for prescription drugs depends partly on how that medication is classified by your prescription drug provider. Your cost is lowest when you have your prescription filled with a generic drug. If you purchase the plan’s preferred brand-name drug, you pay a higher copayment. Your cost is highest if you purchase a non-preferred brand-name drug.

Pre-Tax or Tax-Free Contributions

Contributions to pay for your health care coverage or deposits to your Limited or General Purpose FSA or Health Savings Account, as applicable, that are generally exempt from federal income and Social Security taxes, as well as many state income taxes.

Preventive Care

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

Primary Care Physician (PCP)

A licensed doctor who has a contract to provide services in a health plan. PCPs provide basic health care services and referrals to specialists. They maintain continuity of care during periods of illness or injury.

Primary Care Dentist (PCD)

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

Qualified Medical Child Support Order (QMCSO)

In certain situations, courts may issue orders directing that health benefits under an employer-sponsored plan be provided to certain individuals, usually a family member of an employee or retiree.

Qualified Medical Expenses

Qualified medical expenses are expenses as defined in Internal Revenue Code Section 213(d). These include health care expenses not covered by your plan, such as dental and vision care expenses, as well as coinsurance for medical and prescription drug expenses.

Spouse

For the purposes of BNY Mellon's Health and Welfare plans, a "spouse," is a person to whom you are legally-married and who is treated as your spouse or surviving spouse pursuant to the Internal Revenue Code and ERISA.

True Family Deductible

Under a true family deductible, if only one family member becomes ill or injured, that person must meet the family deductible (rather than the individual deductible) before the plan reimburses for benefits.

Usual, Customary and Reasonable (UCR)

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

Contact Information

BNY MELLON BENEFIT SOLUTIONS SERVICE CENTER			
BNY Mellon Benefit Solutions Service Center (general questions)	1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time	**mybenefits.bnymellon.com**	
HEALTH PLANS			
Aetna Lower Deductible HSA Plan ***Aetna Higher Deductible HSA Plan***	1-855-855-8112	**www.aetna .com/dse/search?site_id=dse&externalPlanCode=ACPMC|Aetna_Open_Access_POS_II**	– Click “Start a New Search” – Choose tab to search by Location, Name, Advanced Search or Conditions & Procedures – Enter search criteria and choose the appropriate plan under “Select a plan”
UnitedHealthcare Lower Deductible HSA Plan ***UnitedHealthcare Higher Deductible HSA Plan***	1-800-842-0750	**www.bnym.welcometouhc.com** **www.liveandworkwell.com**	– Click on “Find a Doctor/Hospital” link – Select your choice of plan – Enter search criteria
CALIFORNIA AND EXPATRIATE HEALTH PLANS			
Kaiser Permanente California (Southern and Northern)	1-800-464-4000	**www.kaiserpermanente.org**	– To find a doctor or facility: – Highlight the “Locate Our Services” tab – Highlight and click “Find Doctors & Locations” – Select your region
Aetna International	Toll free: 1-800-231-7729 Direct: 1-813-775-0190	**www.aetnainternational.com**	

PRESCRIPTION DRUG PLAN (FOR AETNA AND UNITEDHEALTHCARE PLANS)			
CVS Caremark	1-800-685-4130	**www.caremark.com**	– If already a member, enter login ID and password – If not registered, click “Not Registered” and enter required fields – Click “Member Quick Links” to learn about the plan
CVS Caremark AccordantCare™ Health Services	1-800-948-2497	**www.accordant.com**	– If already a member, enter username or email and password – If not registered, click “Register” and enter required fields
CVS Health Pharmacy Advisor Counseling Program	1-800-685-4130	**www.caremark.com**	– If already a member, enter login ID and password – If not registered, click “Not Registered” and enter required fields
DENTAL PLANS			
MetLife PDP Options 1 & 2	1-866-665-1494	**www.metlife.com/mybenefits**	– Company Name – BNY Mellon – Click “Find a Dentist” – Enter search criteria
Aetna DMO	1-855-855-8112	**www.aetna .com/dse/search?site_id=dse&externalPlanCode=DMO|DMO**	– Click “Start a New Search” – Search for: “Dentists (Primary Care)” – Type: “Primary Care Dentists (PCD)” – Plan: “Aetna DMO”

VISION PLAN			
Vision Service Plan (VSP)	1-800-877-7195	**www.vsp.com**	– Click “Members” and log in: first-time users must register – Click “Find a VSP Doctor” – **Please Note:** You may see a disclaimer stating that VSP cannot guarantee that the doctors on the list participate in your plan. Disregard this statement, as BNY Mellon participates in the Signature Network plan with the full network of doctors.
COBRA THIRD-PARTY ADMINISTRATOR			
Alight	1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time	**mybenefits.bnymellon.com**	
LIFE INSURANCE/AD&D			
MetLife	1-800-947-4748, option 2, Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time	**mybenefits.bnymellon.com**	
FLEXIBLE SPENDING AND HEALTH REIMBURSEMENT ACCOUNTS			
Alight	1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time	**mybenefits.bnymellon.com**	
HEALTH SAVINGS ACCOUNTS			
BenefitWallet	1-877-472-4200	**www.mybenefitwallet.com**	

HEALTH CARE DECISION SUPPORT			
Castlight	1-866-960-0873	**www.mycastlight.com/bnymellon**	– Find and compare doctors, hospitals and medical services – Understand your medical plan and what's covered – Track what you've paid toward your deductible and out-of-pocket maximum – Receive personalized recommendations
Best Doctors	1-866-904-0910	**members.bestdoctors.com**	– Find a specialist – Request a consultation – Ask The Expert™
PERSONAL WELLBEING			
Employee Assistance Program (EAP)	1-855-55ACCESS (1-855-552-2237)	**www.achievesolutions.net/bnym**	Access confidential, professional consultation for life's challenges
Doctor On Demand	1-800-997-6196	**www.doctorondemand.com/bnymellon** support@doctorondemand.com	Access a national network of doctors 24/7 to manage common health problems
CVS MinuteClinics®	1-866-389-2727	**www.cvs.com/minuteclinic**	Quickly and easily get the care you need at affordable prices
Virgin Pulse	1-888-671-9395	**join.virginpulse.com/bnymellon**	– Track healthy activities – Create and join challenges – Get personalized tips and more
WebMD	1-888-258-9275	**www.webmdhealth.com/bnymellon**	– 2019 Wellbeing Rewards Program – Find health/wellbeing information – Participate in health coaching

FINANCIAL PLANNING AND EDUCATION RESOURCES			
Ayco	1-800-947-4748, option 7; coaches are available Monday through Friday between 9:00 a.m. and 5 p.m. Eastern Time. Evening appointments are available Monday through Thursday until 8:00 p.m. Eastern Time.	**www.aycofn.com**	– Online access from work: Single sign-on access through MyReward (MySource > MyReward > Logon to MyReward > Proceed to My Personal Total Reward Data > Ayco Financial Planning) – From home: Visit **www .ayco .com/login/bnymellon.** You can login using the username and password you created during registration through MyReward at work, or register as a new user.

Value Formulary Quick Reference List

The Value Formulary Quick Reference List is not an all-inclusive list but represents a summary of prescribed medications within select therapeutic categories. This useful reference tool can assist medical providers in selecting therapeutically-appropriate and cost-effective products for their patients. This document represents a closed formulary plan design.

This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*. Unless specifically indicated, drug list products will include all dosage forms, except for orally disintegrating formulations. Some prescription benefit plan designs may alter coverage of certain products or vary copay amounts based on the condition being treated. This document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, preference for brands and mandatory generics whenever available.

This list is not an all-inclusive list and does not guarantee coverage. Please visit **Caremark.com** for a complete list.

ANALGESICS

§ NSAIDs
diclofenac
diflunisal
etodolac
fenoprofen
flurbiprofen
ibuprofen
ketoprofen
ketoprofen ext-rel
ketorolac
meloxicam
nabumetone
naproxen
oxaprozin
piroxicam
sulindac
tolmetin

VISCOSUPPLEMENTS
GEL-ONE **PA, SP**
VISCO-3 **PA, SP**

ANTI-INFECTIVES

ANTIBACTERIALS

§ CEPHALOSPORINS
cefadroxil
cefdinir
cefpodoxime
cefprozil
cefuroxime
cephalexin

§ ERYTHROMYCINS / MACROLIDES
azithromycin
clarithromycin
clarithromycin ext-rel
erythromycins
DIFICID **PA**

§ FLUOROQUINOLONES
ciprofloxacin
ciprofloxacin ext-rel
levofloxacin
moxifloxacin

§ PENICILLINS
amoxicillin
amoxicillin-clavulanate
amoxicillin-clavulanate ext-rel
ampicillin
dicloxacillin
penicillin VK

§ TETRACYCLINES
doxycycline hyclate
doxycycline monohydrate susp
minocycline
minocycline ext-rel
tetracycline

§ ANTIFUNGALS
clotrimazole troches
fluconazole
griseofulvin microsize
itraconazole
nystatin
terbinafine tablet
voriconazole

ANTIVIRALS

§ HEPATITIS C AGENTS
ribavirin **PA, SP**
EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) **PA, SP, QL**
HARVONI (genotypes 1, 4, 5, 6) **PA, SP, QL**
REBETOL **PA, SP**
VOSEVI ***, PA, SP, QL**

§ HERPES AGENTS
acyclovir
famciclovir
valacyclovir

§ INFLUENZA AGENTS
oseltamivir **QL, PA**

§ MISCELLANEOUS
atovaquone
clindamycin
ivermectin
linezolid **PA**
linezolid inj **PA**
metronidazole
nitrofurantoin ext-rel
nitrofurantoin macrocrystals
praziquantel
rifabutin
sulfamethoxazole-trimethoprim
vancomycin **QL**
EMVERM

CARDIOVASCULAR

§ ACE INHIBITORS
captopril
enalapril
lisinopril
perindopril
ramipril
trandolapril

§ ACE INHIBITOR / CALCIUM CHANNEL BLOCKER COMBINATIONS
amlodipine-benazepril

§ ACE INHIBITOR / DIURETIC COMBINATIONS
captopril-hydrochlorothiazide
enalapril-hydrochlorothiazide
lisinopril-hydrochlorothiazide

§ ANGIOTENSIN II RECEPTOR ANTAGONISTS / DIURETIC COMBINATIONS
irbesartan / irbesartan-hydrochlorothiazide
losartan / losartan-hydrochlorothiazide
olmesartan / olmesartan-hydrochlorothiazide
valsartan / valsartan-hydrochlorothiazide

§ ANTIARRHYTHMICS
acebutolol
amiodarone
disopyramide
dofetilide **PA, SP**
flecainide
ibutilide
propafenone
propafenone ext-rel
sotalol
NORPACE CR

ANTILIPEMICS

§ BILE ACID RESINS
cholestyramine
colestipol

§ FIBRATES
fenofibrate
gemfibrozil

§ HMG-CoA REDUCTASE INHIBITORS
atorvastatin
pravastatin
rosuvastatin
simvastatin

§ NIACINS
niacin ext-rel

PCSK9 INHIBITORS
REPATHA **PA, SP, QL**

§ BETA-BLOCKERS
atenolol
bisoprolol
carvedilol
labetalol
metoprolol succinate ext-rel
metoprolol tartrate 25 mg, 50 mg, 100 mg
nadolol
pindolol
propranolol
propranolol ext-rel

§ BETA-BLOCKER / DIURETIC COMBINATIONS
atenolol-chlorthalidone
bisoprolol-hydrochlorothiazide
metoprolol-hydrochlorothiazide
nadolol-bendroflumethiazide
propranolol-hydrochlorothiazide

§ CALCIUM CHANNEL BLOCKERS
amlodipine
diltiazem ext-rel
felodipine ext-rel
isradipine
nicardipine
nifedipine ext-rel

LEGEND **PA**: Prior Authorization **PA, QL:** Quantity Limit is applied after Prior Authorization approval **QL**: Quantity Limit
QL, PA: If Quantity Limit is exceeded, Prior Authorization may apply
SP: Specialty Drug **ST**: Step Therapy **ST, PA:** If Step Therapy requirements are not met, Prior Authorization may apply

verapamil ext-rel

§ DIGITALIS GLYCOSIDES

digoxin
digoxin ped elixir

§ DIURETICS

amiloride
amiloride-hydrochlorothiazide
bumetanide
chlorthalidone
furosemide
hydrochlorothiazide
indapamide
metolazone
spironolactone-hydrochlorothiazide
torsemide
triamterene-hydrochlorothiazide

HEART FAILURE

CORLANOR
ENTRESTO

§ NITRATES

isosorbide dinitrate
isosorbide dinitrate ext-rel tabs
isosorbide mononitrate
isosorbide mononitrate ext-rel
nitroglycerin sublingual
nitroglycerin transdermal

§ MISCELLANEOUS

hydralazine
methyldopa
midodrine
ranolazine ext-rel

CENTRAL NERVOUS SYSTEM

ANTIANXIETY

§ BENZODIAZEPINES

alprazolam **QL**
alprazolam orally disintegrating tablet **QL**
clorazepate **QL**
diazepam **QL**
lorazepam **QL**
oxazepam **QL**

§ MISCELLANEOUS

buspirone
fluvoxamine

ANTIDEPRESSANTS

§ SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)

citalopram
escitalopram
fluoxetine
paroxetine HCl ext-rel
paroxetine HCl tabs
sertraline

§ SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)

desvenlafaxine succinate ext-rel
duloxetine
venlafaxine
venlafaxine ext-rel

§ MISCELLANEOUS AGENTS

bupropion
bupropion ext-rel
mirtazapine
mirtazapine orally disintegrating tablet
trazodone

HYPNOTICS

§ NONBENZODIAZEPINES

zaleplon **QL, PA**
zolpidem **QL, PA**
zolpidem ext-rel **QL, PA**

MIGRAINE

§ SELECTIVE SEROTONIN AGONISTS

naratriptan **QL, PA**
rizatriptan **QL, PA**
rizatriptan orally disintegrating tabs **QL, PA**
sumatriptan **QL, PA**
zolmitriptan orally disintegrating tabs **QL, PA**
zolmitriptan tabs **QL, PA**

§ MULTIPLE SCLEROSIS AGENTS

glatiramer **PA, SP, QL**
AUBAGIO **PA, SP, QL**
AVONEX **PA, SP, QL**
BETASERON **PA, SP, QL**
COPAXONE **PA, SP, QL**
GILENYA **PA, SP, QL**
OCREVUS **PA, SP, QL**
REBIF **PA, SP, QL**
TECFIDERA **PA, SP, QL**
TYSABRI **PA, SP, QL**

ENDOCRINE AND METABOLIC

ANTIDIABETICS

AMYLIN ANALOGS

SYMLINPEN **ST, PA**

§ BIGUANIDES

metformin
metformin ext-rel

§ BIGUANIDE / SULFONYLUREA COMBINATIONS

glipizide-metformin

DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

JANUVIA **ST, PA**

DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR / BIGUANIDE COMBINATIONS

JANUMET **ST, PA**
JANUMET XR **ST, PA**

INCRETIN MIMETIC AGENTS

OZEMPIC **ST, PA**
TRULICITY **ST, PA**
VICTOZA **ST, PA**

INCRETIN MIMETIC AGENT / INSULIN COMBINATIONS

SOLIQUA **ST, PA**

INSULINS

BASAGLAR
FIASP
HUMULIN R U-500
LEVEMIR
NOVOLIN
NOVOLOG
NOVOLOG MIX

§ INSULIN SENSITIZERS

pioglitazone

§ INSULIN SENSITIZER / BIGUANIDE COMBINATIONS

pioglitazone-metformin

§ INSULIN SENSITIZER / SULFONYLUREA COMBINATIONS

pioglitazone-glimepiride

SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS

FARXIGA **ST, PA**
JARDIANCE **ST, PA**

SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITOR / BIGUANIDE COMBINATIONS

SYNJARDY **ST, PA**
SYNJARDY XR **ST, PA**
XIGDUO XR **ST, PA**

§ SULFONYLUREAS

glimepiride
glipizide
glipizide ext-rel
glyburide
glyburide, micronized

SUPPLIES

ACCU-CHEK AVIVA PLUS STRIPS AND KITS [1]
ACCU-CHEK COMPACT PLUS STRIPS AND KITS [1]
ACCU-CHEK GUIDE STRIPS AND KITS [1]
ACCU-CHEK SMARTVIEW STRIPS AND KITS [1]
BD INSULIN SYRINGES AND NEEDLES
LANCETS

CALCIUM REGULATORS

§ BISPHOSPHONATES

alendronate
ibandronate
risedronate

CONTRACEPTIVES

MONOPHASIC

§ 20 mcg Estrogen

ethinyl estradiol-drospirenone
ethinyl estradiol-levonorgestrel
ethinyl estradiol-norethindrone acetate
ethinyl estradiol-norethindrone acetate and iron

§ 25 mcg Estrogen

ethinyl estradiol-norethindrone acetate and iron

§ 30 mcg Estrogen

ethinyl estradiol-desogestrel
ethinyl estradiol-drospirenone
ethinyl estradiol-levonorgestrel
ethinyl estradiol-norethindrone acetate
ethinyl estradiol-norethindrone acetate and iron
ethinyl estradiol-norgestrel

§ 35 mcg Estrogen

ethinyl estradiol-ethynodiol diacetate
ethinyl estradiol-norethindrone
ethinyl estradiol-norgestimate

§ 50 mcg Estrogen

ethinyl estradiol-ethynodiol diacetate

§ BIPHASIC

ethinyl estradiol-desogestrel

§ TRIPHASIC

ethinyl estradiol-desogestrel
ethinyl estradiol-levonorgestrel
ethinyl estradiol-norethindrone
ethinyl estradiol-norgestimate

§ EXTENDED CYCLE

ethinyl estradiol-levonorgestrel

§ PROGESTIN ONLY

norethindrone

EMERGENCY CONTRACEPTION

ELLA

§ INJECTABLE

medroxyprogesterone acetate 150 mg/mL

§ TRANSDERMAL

norelgestromin/ethinyl estradiol - Xulane

VAGINAL

NUVARING

ESTROGENS

§ ORAL

estradiol

§ TRANSDERMAL

estradiol

§ VAGINAL

estradiol vaginal crm

ESTROGEN / PROGESTINS

§ ORAL

estradiol-norethindrone
ethinyl estradiol-norethindrone acetate

HUMAN GROWTH HORMONES

HUMATROPE **PA, SP**

§ PHOSPHATE BINDER AGENTS

calcium acetate
sevelamer carbonate

§ PROGESTINS

§ ORAL

medroxyprogesterone
norethindrone acetate
progesterone, micronized

VAGINAL

ENDOMETRIN

§ SELECTIVE ESTROGEN RECEPTOR MODULATORS

raloxifene
OSPHENA

§ THYROID SUPPLEMENTS

levothyroxine
liothyronine

GASTROINTESTINAL

§ H_2 RECEPTOR ANTAGONISTS

cimetidine
famotidine
ranitidine

§ PROTON PUMP INHIBITORS

lansoprazole
lansoprazole soluble tabs
omeprazole
pantoprazole

GENITOURINARY

§ BENIGN PROSTATIC HYPERPLASIA

alfuzosin ext-rel
doxazosin
finasteride
tamsulosin
terazosin

§ URINARY ANTISPASMODICS

oxybutynin
oxybutynin ext-rel
tolterodine
trospium

§ VAGINAL ANTI-INFECTIVES

clindamycin cream
metronidazole
terconazole

HEMATOLOGIC

ANTICOAGULANTS

§ INJECTABLE

enoxaparin

§ ORAL

warfarin
XARELTO

§ PLATELET AGGREGATION INHIBITORS

clopidogrel
dipyridamole
dipyridamole ext-rel/aspirin
prasugrel
BRILINTA
ZONTIVITY

IMMUNOLOGIC AGENTS

AUTOIMMUNE AGENTS

ANKYLOSING SPONDYLITIS

COSENTYX **PA, SP, QL**
ENBREL **PA, SP, QL**
HUMIRA **PA, SP, QL**

CROHN'S DISEASE

HUMIRA **PA, SP, QL**
STELARA
SUBCUTANEOUS **#, PA, SP, QL**

After failure of HUMIRA

PSORIASIS

HUMIRA **PA, SP, QL**
OTEZLA **PA, SP, QL**
STELARA
SUBCUTANEOUS **PA, SP, QL**
TALTZ **PA, SP, QL**

PSORIATIC ARTHRITIS

COSENTYX **PA, SP, QL**
ENBREL **PA, SP, QL**
HUMIRA **PA, SP, QL**
OTEZLA **PA, SP, QL**

RHEUMATOID ARTHRITIS

ENBREL **PA, SP, QL**
HUMIRA **PA, SP, QL**
KEVZARA **PA, SP, QL**
ORENCIA CLICKJECT **PA, SP, QL**
ORENCIA
SUBCUTANEOUS **PA, SP, QL**
XELJANZ 5 MG **PA, SP, QL**
XELJANZ XR **PA, SP, QL**

ULCERATIVE COLITIS

HUMIRA **PA, SP, QL**
SIMPONI **PA, SP, QL**

ALL OTHER CONDITIONS

ENBREL **PA, SP, QL**
HUMIRA **PA, SP, QL**

RESPIRATORY

§ ANAPHYLAXIS TREATMENT AGENTS

epinephrine auto-injector
EPIPEN
EPIPEN JR

§ ANTICHOLINERGICS

ipratropium inhalation solution **QL**
INCRUSE ELLIPTA **QL**

ANTICHOLINERGIC / BETA AGONIST COMBINATIONS

§ SHORT ACTING

ipratropium-albuterol inhalation solution **QL**
COMBIVENT RESPIMAT **QL**

LONG ACTING

BEVESPI AEROSPHERE **QL**

BETA AGONISTS, INHALANTS

§ SHORT ACTING

albuterol inhalation solution **QL**
albuterol sulfate, CFC-free aerosol **QL**
levalbuterol nebulizer solution concentrate **QL**
PROAIR HFA **QL**
PROAIR RESPICLICK **QL**

LONG ACTING

Hand-held Active Inhalation

STRIVERDI RESPIMAT **QL**

Nebulized Passive Inhalation

PERFOROMIST **QL**

§ LEUKOTRIENE RECEPTOR ANTAGONISTS

montelukast

§ NASAL STEROIDS

flunisolide
fluticasone

STEROID / BETA AGONIST COMBINATIONS

ADVAIR **QL**
ADVAIR HFA **QL**
BREO ELLIPTA **QL**
SYMBICORT **QL**

§ STEROID INHALANTS

budesonide inhalation suspension **QL, PA**
ARNUITY ELLIPTA **QL**
FLOVENT DISKUS **QL**
FLOVENT HFA **QL**
QVAR REDIHALER **QL**

TOPICAL

DERMATOLOGY

§ ACNE

benzoyl peroxide cream, lotion
clindamycin gel, lotion, solution
erythromycin gel 2%
erythromycin solution
erythromycin-benzoyl peroxide
sulfacetamide lotion 10%
tretinoin

OPHTHALMIC

BETA-BLOCKERS

§ Nonselective

timolol maleate

§ Selective

betaxolol solution

§ CARBONIC ANHYDRASE INHIBITORS

dorzolamide

§ CARBONIC ANHYDRASE INHIBITOR / BETA-BLOCKER COMBINATIONS

dorzolamide-timolol maleate

§ PROSTAGLANDINS

latanoprost

§ SYMPATHOMIMETICS

brimonidine 0.15%, 0.2%

BNY Mellon High Deductible Health Plan (HDHP) - Health Savings Account (HSA)
Preventive Therapy Drug List

(11/01/18)

ANTI-INFECTIVES

ANTIRETROVIRAL AGENTS

abacavir/lamivudine
abacavir
atazanavir
didanosine
efavirenz
fosamprenavir
lamivudine
lamivudine/zidovudine
lopinavir/ritonavir
nevirapine
ritonavir
stavudine
tenofovir
zidovudine
APTIVUS
ATRIPLA
BIKTARVY
CIMDUO
COMBIVIR
COMPLERA
CRIXIVAN
DELSTRIGO
DESCOVY
EDURANT
EMTRIVA
EPIVIR
EPZICOM
EVOTAZ
FUZEON
GENVOYA
INTELENCE
INVIRASE
ISENTRESS
ISENTRESS HD
JULUCA
KALETRA
LEXIVA
NORVIR
ODEFSEY
PIFELTRO
PREZCOBIX
PREZISTA
RESCRIPTOR
RETROVIR
REYATAZ
SELZENTRY
STRIBILD
SUSTIVA
SYMFI
SYMFI LO
SYMTUZA
TIVICAY
TRIUMEQ
TRIZIVIR
TROGARZO
TRUVADA
TYBOST
VIDEX
VIDEX EC
VIRACEPT
VIRAMUNE
VIRAMUNE XR
VIREAD
VITEKTA
ZERIT
ZIAGEN

ANTICOAGULANTS/ ANTIPLATELETS

ANTICOAGULANTS

enoxaparin
fondaparinux
warfarin
Jantoven
ARIXTRA
BEVYXXA
COUMADIN
COUMADIN INJECTION
ELIQUIS
FRAGMIN
IPRIVASK
LOVENOX
PRADAXA
SAVAYSA
XARELTO

PLATELET AGGREGATION INHIBITORS

aspirin 81 mg
clopidogrel
dipyridamole
dipyridamole ext-rel/aspirin
prasugrel
AGGRENOX
BRILINTA
CLOPIDOGREL KIT
DURLAZA
EFFIENT
PLAVIX
YOSPRALA
ZONTIVITY

Over-the-Counter (OTC) products require a prescription. Coverage may vary by plan.

ANTICONVULSANTS

carbamazepine
carbamazepine ext-rel
clonazepam
divalproex sodium delayed-rel
divalproex sodium ext-rel
ethosuximide
felbamate
lamotrigine
lamotrigine ext-rel
levetiracetam
levetiracetam ext-rel
oxcarbazepine
phenobarbital
phenytoin
phenytoin sodium extended
primidone
tiagabine
topiramate
topiramate ext-rel
valproic acid
vigabatrin
zonisamide
Epitol
APTIOM
BANZEL
BRIVIACT
CARBATROL
CELONTIN
DEPAKENE
DEPAKOTE
DEPAKOTE ER
DILANTIN
FELBATOL
FYCOMPA
GABITRIL
KEPPRA
KEPPRA XR
KLONOPIN
LAMICTAL
LAMICTAL XR
MYSOLINE
ONFI
OXTELLAR XR
PEGANONE
PHENYTEK
QUDEXY XR
ROWEEPRA
SABRIL
SPRITAM
TEGRETOL
TEGRETOL-XR
TOPAMAX
TRILEPTAL
TROKENDI XR
VIMPAT
ZARONTIN
ZONEGRAN

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CARDIOVASCULAR CONDITIONS - OTHER

ANTIARRHYTHMIC AGENTS
amiodarone
disopyramide
dofetilide
flecainide
propafenone
propafenone ext-rel
sotalol
sotalol AF
Pacerone
BETAPACE
BETAPACE AF
MULTAQ
NORPACE
NORPACE CR
RYTHMOL SR
SORINE
SOTYLIZE
TIKOSYN

ORAL ANTIANGINAL AGENTS
isosorbide dinitrate
isosorbide dinitrate ext-rel
isosorbide mononitrate
isosorbide mononitrate ext-rel
DILATRATE-SR
ISORDIL

SL and chewable formulations are not included on this list.

TRANSDERMAL/TOPICAL ANTIANGINAL AGENTS
nitroglycerin transdermal
Minitran
NITRO-BID
NITRO-DUR

CORONARY ARTERY DISEASE

ANTIHYPERLIPIDEMICS
atorvastatin
cholestyramine
colesevelam
colestipol
ezetimibe
fenofibrate
fenofibric acid
fenofibric acid delayed-rel
fluvastatin
fluvastatin ext-rel
gemfibrozil
lovastatin
niacin ext-rel
pravastatin
rosuvastatin
simvastatin
Niacor
Prevalite
ALTOPREV
ANTARA
COLESTID
CRESTOR
FENOGLIDE
FIBRICOR
FLOLIPID
KYNAMRO
LESCOL XL
LIPITOR
LIPOFEN
LIVALO
LOPID
NIASPAN
PRAVACHOL
QUESTRAN/QUESTRAN LIGHT
TRICOR
TRIGLIDE
TRILIPIX
WELCHOL
ZETIA
ZOCOR
ZYPITAMAG

COMBINATION ANTIHYPERLIPIDEMICS
amlodipine/atorvastatin
ezetimibe/simvastatin
CADUET
VYTORIN

DIABETES

DIAGNOSTIC AGENTS AND SUPPLIES
BLOOD GLUCOSE MONITORS - ALL
BLOOD GLUCOSE STRIPS - ALL
CONTROL SOLUTIONS
INSULIN SYRINGES, INFUSION SETS, AND NEEDLES - ALL
KETONE BLOOD TEST STRIPS - ALL
LANCETS, LANCET DEVICES
OMNIPOD INSULIN INFUSION PUMP
URINE TESTING STRIPS - ALL
V-GO INSULIN DELIVERY DEVICE

Over-the-Counter (OTC) products require a prescription. Coverage may vary by plan

INHALED DIABETES AGENTS
AFREZZA

INJECTABLE DIABETES AGENTS
ADLYXIN
ADMELOG
APIDRA
BASAGLAR KWIKPEN
BYDUREON
BYETTA
FIASP
HUMALOG
HUMULIN
LANTUS
LEVEMIR
NOVOLIN
NOVOLOG
OZEMPIC
SOLIQUA
SYMLINPEN
TOUJEO
TRESIBA
TRULICITY
VICTOZA
XULTOPHY

Over-the-Counter (OTC) products require a prescription. Coverage may vary by plan.

ORAL DIABETES AGENTS
acarbose
alogliptin
alogliptin/metformin
alogliptin/pioglitazone
chlorpropamide
glimepiride
glipizide
glipizide ext-rel
glipizide/metformin
glyburide
glyburide, micronized
glyburide/metformin
metformin
metformin ext-rel
miglitol
nateglinide
pioglitazone
pioglitazone/glimepiride
pioglitazone/metformin
repaglinide
repaglinide/metformin
tolbutamide
ACTOPLUS MET
ACTOPLUS MET XR
ACTOS
AMARYL
D-CARE DM2 KIT
DUETACT
FARXIGA
FORTAMET
GLUCOPHAGE
GLUCOPHAGE XR
GLUCOTROL
GLUCOTROL XL
GLUMETZA
GLYNASE
GLYSET
GLYXAMBI
INVOKAMET
INVOKAMET XR
INVOKANA
JANUMET
JANUMET XR
JANUVIA
JARDIANCE
JENTADUETO
JENTADUETO XR
KAZANO
KOMBIGLYZE XR

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METAGLIP
NESINA
ONGLYZA
OSENI
PRANDIN
PRECOSE
QTERN
RIOMET
SEGLUROMET
STARLIX
STEGLATRO
STEGLUJAN
SYNJARDY
SYNJARDY XR
TRADJENTA
XIGDUO XR

HEMATOLOGIC AGENTS

ADVATE
ADYNOVATE
AFSTYLA
ALPHANATE
ALPHANINE SD
ALPROLIX
BEBULIN
BENEFIX
CORIFACT
ELOCTATE
FEIBA
HELIXATE FS
HEMOFIL M
HUMATE-P
IDELVION
IXINITY
JIVI
KOATE-DVI
KOGENATE FS
KOVALTRY
MONOCLATE-P
MONONINE
NOVOEIGHT
NUWIQ
PROFILNINE SD
RECOMBINATE
RIXUBIS
TRETTEN
XYNTHA

HYPERTENSION

ACE INHIBITORS/ANGIOTENSIN II RECEPTOR ANTAGONISTS AND COMBINATION AGENTS

amlodipine/benazepril
benazepril
benazepril/hydrochlorothiazide
candesartan
candesartan/hydrochlorothiazide
captopril
captopril/hydrochlorothiazide
enalapril
enalapril/hydrochlorothiazide
eprosartan
fosinopril
fosinopril/hydrochlorothiazide
irbesartan
irbesartan/hydrochlorothiazide
lisinopril
lisinopril/hydrochlorothiazide
losartan
losartan/hydrochlorothiazide
moexipril
moexipril/hydrochlorothiazide
olmesartan
olmesartan/hydrochlorothiazide
perindopril
quinapril
quinapril/hydrochlorothiazide
ramipril
telmisartan
telmisartan/hydrochlorothiazide
trandolapril
trandolapril/verapamil ext-rel
valsartan
valsartan/hydrochlorothiazide
ACCUPRIL
ACCURETIC
ALTACE
ATACAND
ATACAND HCT
AVALIDE
AVAPRO
BENICAR
BENICAR HCT
COZAAR
DIOVAN
DIOVAN HCT
EDARBI
EDARBYCLOR
EPANED
HYZAAR
LOTENSIN
LOTENSIN HCT
LOTREL
MICARDIS
MICARDIS HCT
PRESTALIA
PRINIVIL
QBRELIS
TARKA
VASERETIC
VASOTEC
ZESTORETIC
ZESTRIL

BETA-BLOCKERS AND COMBINATION AGENTS

acebutolol
atenolol
atenolol/chlorthalidone
betaxolol
bisoprolol
bisoprolol/hydrochlorothiazide
carvedilol
carvedilol phosphate ext-rel
labetalol
metoprolol
metoprolol succinate ext-rel
metoprolol/hydrochlorothiazide
nadolol
nadolol/bendroflumethiazide
pindolol
propranolol
propranolol ext-rel
propranolol/hydrochlorothiazide
timolol maleate
BYSTOLIC
BYVALSON
COREG
COREG CR
CORGARD
CORZIDE
DUTOPROL
INDERAL LA
KAPSPARGO
LEVATOL
LOPRESSOR
LOPRESSOR HCT
TENORETIC
TENORMIN
TOPROL-XL
TRANDATE
ZIAC

CALCIUM CHANNEL BLOCKERS AND COMBINATION AGENTS

amlodipine
diltiazem
diltiazem ext-rel
diltiazem XR
felodipine ext-rel
isradipine
nicardipine
nifedipine
nifedipine ext-rel
nisoldipine ext-rel
verapamil
verapamil ext-rel
Afeditab CR
Cartia XT
Dilt-XR
Matzim LA
Nifediac CC
Taztia XT
ADALAT CC
CALAN
CALAN SR
CARDIZEM
CARDIZEM CD
CARDIZEM LA
ISOPTIN SR
NORVASC
PROCARDIA
PROCARDIA XL
SULAR
TIAZAC
VERELAN

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VERELAN PM

DIURETICS
amiloride/hydrochlorothiazide
chlorothiazide
chlorthalidone
hydrochlorothiazide
indapamide
methyclothiazide
spironolactone/hydrochlorothiazide
triamterene/hydrochlorothiazide
ALDACTAZIDE
DIURIL
DYAZIDE
MAXZIDE
MICROZIDE

OTHER ANTIHYPERTENSIVE AGENTS
amlodipine/olmesartan
amlodipine/telmisartan
amlodipine/valsartan/ hydrochlorothiazide
clonidine
clonidine transdermal
guanabenz
guanfacine
hydralazine
methyldopa
methyldopa/hydrochlorothiazide
minoxidil
olmesartan/amlodipine/ hydrochlorothiazide
AZOR
CATAPRES
CATAPRES-TTS
EXFORGE
EXFORGE HCT
TEKTURNA
TEKTURNA HCT
TRIBENZOR
TWYNSTA

IMMUNIZING AGENTS

ALLERGENIC EXTRACTS
ALLERGENIC EXTRACTS - ALL

IMMUNIZATIONS
VACCINES - ALL

MENTAL HEALTH

ANTIDEPRESSANTS
amitriptyline
amoxapine
bupropion
bupropion ext-rel
citalopram
clomipramine
desipramine
desvenlafaxine ext-rel
doxepin
duloxetine delayed-rel
escitalopram
fluoxetine
fluoxetine delayed-rel
fluvoxamine
imipramine HCl
imipramine pamoate
maprotiline
mirtazapine
nortriptyline
paroxetine HCl
paroxetine HCl ext-rel
phenelzine
protriptyline
sertraline
tranylcypromine
trazodone
trimipramine
venlafaxine
venlafaxine ext-rel
Irenka
ANAFRANIL
APLENZIN
CELEXA
CYMBALTA
DESVENLAFAXINE ER
EFFEXOR XR
EMSAM
FETZIMA
FLUOXETINE 60 mg
FORFIVO XL
KHEDEZLA
LEXAPRO
MARPLAN
NARDIL
NORPRAMIN
OLEPTRO
PAMELOR
PARNATE
PAXIL
PAXIL CR
PEXEVA
PRISTIQ
PROZAC
REMERON
SURMONTIL
TOFRANIL
TRINTELLIX
VENLAFAXINE ER
VIIBRYD
WELLBUTRIN SR
WELLBUTRIN XL
ZOLOFT

ANTIPSYCHOTICS
aripiprazole
chlorpromazine
clozapine
fluphenazine
fluphenazine decanoate
haloperidol
loxapine
olanzapine
olanzapine orally disintegrating tabs
paliperidone
perphenazine
quetiapine
quetiapine ext-rel
risperidone
thioridazine
thiothixene
trifluoperazine
ziprasidone
ABILIFY
ABILIFY MAINTENA
ARISTADA
CLOZARIL
EQUETRO
FANAPT
FAZACLO
GEODON
HALDOL
HALDOL DECANOATE
INVEGA
INVEGA SUSTENNA
INVEGA TRINZA
LATUDA
REXULTI
RISPERDAL
RISPERDAL CONSTA
SAPHRIS
SEROQUEL
SEROQUEL XR
VERSACLOZ
VRAYLAR
ZYPREXA
ZYPREXA ZYDIS

OBSESSIVE COMPULSIVE DISORDER
fluvoxamine ext-rel

OSTEOPOROSIS

alendronate
calcitonin
calcitonin/salmon
ibandronate
raloxifene
risedronate
zoledronic acid 5 mg/100 mL
ACTONEL
ATELVIA
BINOSTO
BONIVA
BONIVA INJECTION
EVISTA
FOSAMAX
FOSAMAX PLUS D
MIACALCIN NASAL SPRAY
PROLIA
RECLAST

PREVENTIVE CARE SERVICES

AGENTS FOR CHEMICAL DEPENDENCY
acamprosate calcium

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buprenorphine sublingual
buprenorphine/naloxone sublingual
disulfiram
naltrexone
Depade
ANTABUSE
BUNAVAIL
PROBUPHINE
SUBLOCADE
SUBOXONE FILM
VIVITROL
ZUBSOLV

ANTI-OBESITY AGENTS
benzphetamine
diethylpropion
diethylpropion ext-rel
phendimetrazine
phendimetrazine ext-rel
phentermine
ADIPEX-P
BELVIQ
BELVIQ XR
CONTRAVE
LOMAIRA
QSYMIA
REGIMEX
SAXENDA
XENICAL

BOWEL PREPARATIONS
peg 3350/electrolytes
Gavilyte
CLENPIQ
COLYTE
GOLYTELY
MOVIPREP
NULYTELY
OSMOPREP
PREPOPIK
SUPREP

SMOKING DETERRENTS
bupropion ext-rel
nicotine polacrilex
nicotine transdermal
CHANTIX
NICODERM CQ
NICORETTE GUM
NICORETTE LOZENGE
NICOTROL INHALER
NICOTROL NS
ZYBAN

Over-the-Counter (OTC) products require a prescription. Coverage may vary by plan.

MISCELLANEOUS
cholecalciferol (D3)

Over-the-Counter (OTC) products require a prescription. Coverage may vary by plan.

RESPIRATORY DISORDERS

RESPIRATORY AGENTS
budesonide suspension
cromolyn sodium nebulizer solution
fluticasone/salmeterol
montelukast
zafirlukast
zileuton ext-rel
ACCOLATE
ADVAIR
ADVAIR HFA
AIRDUO RESPICLICK
ALVESCO
ARNUITY ELLIPTA
ASMANEX
ASMANEX HFA
BREO ELLIPTA
CINQAIR
DULERA
FASENRA
FLOVENT DISKUS
FLOVENT HFA
NUCALA
PULMICORT
PULMICORT FLEXHALER
QVAR REDIHALER
SINGULAIR
SPIRIVA RESPIMAT 1.25 mcg
SYMBICORT
SYNAGIS
XOLAIR
ZYFLO
ZYFLO CR

SUPPLIES
SPACER DEVICES
SPACER SUPPLIES

VARIOUS CONDITIONS

ANTI-MALARIAL AGENTS
atovaquone/proguanil
chloroquine
mefloquine
MALARONE
PRIMAQUINE

DENTAL CARIES PREVENTION
sodium fluoride
PEDIATRIC MULTIVITAMINS WITH FLUORIDE - ALL MARKETED PRODUCTS

HEREDITARY ANGIOEDEMA AGENTS
CINRYZE
HAEGARDA

IMMUNOSUPPRESSIVE AGENTS
cyclosporine caps
mycophenolate mofetil
mycophenolate sodium delayed-rel
sirolimus
tacrolimus
Gengraf
ASTAGRAF XL
CELLCEPT
ENVARSUS XR
MYFORTIC
NEORAL
NULOJIX
PROGRAF
RAPAMUNE
SANDIMMUNE
ZORTRESS

MULTIPLE SCLEROSIS AGENTS
glatiramer
AUBAGIO
AVONEX
BETASERON
COPAXONE
EXTAVIA
GILENYA
LEMTRADA
OCREVUS
PLEGRIDY
REBIF
TECFIDERA
TYSABRI

WOMEN'S HEALTH

ANTIESTROGENS
tamoxifen
SOLTAMOX

AROMATASE INHIBITORS
anastrozole
exemestane
letrozole
ARIMIDEX
AROMASIN
FEMARA

CONTRACEPTIVES
CONTRACEPTIVES - ALL PRESCRIPTION FORMULATIONS

Over-the-Counter (OTC) emergency contraceptive products require a prescription. Coverage may vary by plan.

PRENATAL VITAMINS
folic acid
PRENATAL VITAMINS - PRESCRIPTION

Over-the-Counter (OTC) products require a prescription. Coverage may vary by plan.

Please note: Human immunodeficiency virus (HIV) drugs are being added as of January 1, 2019. This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*.

Some strengths or dosage forms may not be included in the Preventive Therapy Drug List and certain products or categories may not be covered, regardless of their appearance in this document. Please check with your plan provider should you have any questions about coverage. Additional medications may be included in this list from time to time in compliance with Affordable Care Act requirements and/or U.S. Internal Revenue Service (IRS) guidance. This list includes medications considered preventive by the IRS; it may not include all preventive medications.

This Preventive Therapy Drug List has been adopted by the referenced health plan. CVS Caremark® makes no representations regarding its compliance with applicable legal requirements. The Preventive Therapy Drug List should be modified as necessary or desired by the plan sponsor based on the advice of the plan sponsor's counsel.

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