2018 Benefits Guide

Make Informed Choices When You Enroll

Revised October 2018

BNY MELLON

About this Guide

This document is a Summary of Material Modifications to the 2017 version intended to notify you of important changes made to BNY Mellon's benefit plans for the plan year beginning on January 1, 2018. The information set forth in this Guide is in summary form. 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

The BNY Mellon benefits program provides you with the flexibility to choose high-quality, affordable coverage that is best for you and your dependents.

Please use this 2018 Benefits Guide to find the information you need to make informed decisions about your 2018 BNY Mellon Benefits.

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 2018 benefits to help ensure you have coverage that meets your and your dependent's needs. Your enrollment deadline will be included with your enrollment information.

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, 2018 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 18 for more information). Your next opportunity to make changes will be during Open Enrollment for the next plan year.

Choosing Your Health Plan

In addition to the information in this Guide, BNY Mellon offers a variety of online tools to help you choose your health plan and help you make informed decisions when using your benefits. Many of these tools are available on the MyBenefit Solutions website at **http://mybenefits.bnymellon.com**. For more information, see "Tools to Help You Choose the Right Health Plan" on page 14. Additional information is available on the HealthHub website at **www.healthhub.bnymellon.com**.

How to Enroll

To enroll, access the MyBenefit Solutions website at work or at home:

– **At Work:** Go to MySource > MyReward > Log on to MyReward > Proceed to My Personal Total Reward Data > MyBenefit Solutions

– **At Home:** Go to **http://mybenefits.bnymellon.com**. (If you 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.

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 82 for more details. Also, note that Medicare eligibility may impact your medical plan choices for 2018. Carefully review this document to ensure you make the right decision for 2018.

Enrollment Reminders

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

– Designate your beneficiaries for life, accidental death and dismemberment (AD&D) and travel accident insurance.

Enrollment 2018

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 2018 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.

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 2018 BENEFIT OPTIONS AT A GLANCE	

Medical	– No coverage
	– Both Aetna and UnitedHealthcare offer two plans:
	  – Plan HRA (Health Reimbursement Account)
	  – Plan HSA (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)
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)

YOUR 2018 BENEFIT OPTIONS AT A GLANCE	
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/Domestic Partner Life Insurance	– No coverage – $25,000 benefit – $50,000 benefit
Child Life Insurance	– No coverage – $10,000 benefit – $15,000 benefit
Health Care Flexible Spending Account (FSA)	– No contribution – Elect to contribute up to $2,600 annually
Limited Purpose Flexible Spending Account (FSA)	– No contribution – Elect to contribute up to $2,600 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 2018 if you were hired on or prior to November 30, 2017

Medical Option Highlights

For 2018, most employees have a choice between the following two national health plan options, each offered by Aetna and UnitedHealthcare, with prescription drug coverage offered through CVS Caremark:

Option 1: Plan HRA

Health Reimbursement Account

See details in "Plan HRA (Health Reimbursement Account)" on page 38

Option 2: Plan HSA

Health Savings Account

See details in "Plan HSA (Health Savings Account)" on page 42

Note: Based on IRS rules, if you enroll in other medical coverage that is not a qualifying high-deductible health plan, such as through your spouse's or domestic partner's plan, including a general purpose Health Care FSA or HRA, or are covered by any part of Medicare (Part A, Part B, etc.) or Tricare, by federal law, you aren't eligible to contribute to the HSA.

Choosing a Carrier

If you enroll in Plan HSA or Plan HRA, you will need to choose either the Aetna or UnitedHealthcare network at the time you enroll. **Keep in mind, the health plan contribution 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 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 2018 health plan contributions as explained below:

– When you choose the preferred carrier for your state of residence, your health plan contributions 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 2018 preferred carrier contribution rate.

The table below shows the states that will have a preferred carrier in 2018. If you reside in a state that is not listed here, you will pay the same preferred carrier premium 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 medical plan premium will automatically be adjusted to the preferred carrier contribution rate.

– From a preferred to a non-preferred carrier state, your medical 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.

Provider Networks

Both Aetna and UnitedHealthcare offer large, national provider networks. It is a good idea to think about the care you and your dependents may need in 2018 and consider the following:

– Do you live in a preferred carrier state where your contributions might be lower with the preferred carrier?

– Do the doctors and facilities you currently use belong to the Aetna or UnitedHealthcare network?

– If you will need more or different care in 2018, which carrier offers the network providers that best meet your needs?

To review the Aetna and UnitedHealthcare provider networks, see “Choosing a Carrier” on page 8.

If you enroll in Plan HRA or Plan HSA with Aetna or UnitedHealthcare, you can also use Castlight (see page 52 for more information) to locate and compare doctors, hospitals or other providers in the Aetna or UnitedHealthcare networks.

Health Care Reform

Under the Affordable Care Act, nearly every American must have medical coverage in 2018 or pay a penalty. Here is what it means for you, as a BNY Mellon benefits-eligible employee:

– Our health plans offer affordable coverage with at least the minimum benefit value (called “minimum essential coverage”).

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

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

– If you are benefits-eligible and enroll in a BNY Mellon health plan, you will comply with the individual mandate.

If you would like to learn more about health care reform, visit **www.healthcare.gov**, which is managed by the U.S. Department of Health & Human Services.

Note: The repeal or replacement of the Affordable Care Act has been a priority of the 2017 legislative agenda, but no new legislation has been passed to date. We encourage you to make 2018 medical coverage decisions keeping in mind that the Affordable Care Act is still law and that the future of the House and Senate healthcare efforts remains unclear.

Choosing a Health Plan

To decide which health plan option is right for you:

– Review “How the Plans Work” on page 24 to become familiar with the details of Plan HRA and Plan HSA.

– Read “Comparing the Plans” on page 30 to compare Plan HRA’s and Plan HSA’s features.

– Understand how the health plans’ medical contributions compare by reviewing the “2018 Medical Contributions” table on page 32.

– Use the “Illustrated Plan Comparisons” beginning on page 52 and the cost profiles and personalized web modeling tools listed in “Tools to Help You Choose the Right Health Plan” on page 14, to make an informed decision based on your projected 2018 costs and needs.

Dental Option Highlights

– To find a network dentist, or if you have questions about your coverage, visit the plan carrier’s website or call the member services number. See “Contact Information” on page 100 for website addresses and phone numbers.

– If you choose the Aetna DMO, you must elect a Primary Care Dentist.

Flexible Spending Accounts (FSAs) Highlights

– BNY Mellon offers three FSAs: Health Care, Limited Purpose Health Care and Dependent Care.

– Your 2018 health plan election determines whether you are eligible to enroll in the Health Care FSA or the Limited Purpose FSA.

– Your health plan election does not affect your participation in a Dependent Care FSA.

– For more information on the FSAs, including eligibility, contributions, tax benefits and other provisions, see “Flexible Spending Accounts” on page 56. To see how the Health Care and Limited Purpose FSAs compare with the Health Savings Account under Plan HSA, review “How the Health Accounts Compare” on page 50.

– Over-the-counter (OTC) drugs are not eligible for reimbursement from a Health Care or Limited Purpose Health Care FSA. Non-drug OTC purchases, such as bandages, are eligible for reimbursement, as well as insulin and any OTC drug for which you have a doctor’s prescription.

– The maximum you can contribute annually to a Health Care FSA or Limited Purpose Health Care FSA is $2,600.

– With the exception of the $500 Health Care/Limited Purpose Health Care FSA carry-over, eligible 2018 expenses must be incurred during the plan year (January 1, 2018, through December 31, 2018) and submitted for reimbursement by June 30, 2019. (Any unused amounts over $500 are subject to the IRS “use it or lose it” forfeiture rule unless eligible expenses are submitted for reimbursement on or before June 30, 2019. Reimbursement is limited to expenses incurred in 2018.

Flex Vacation Highlights

– Employees hired after November 30, 2017 are not eligible to purchase vacation for 2018.

– If you are a part-time employee, note that each flex vacation day you purchase is equal to 1/5 of your weekly work hours. To see how this is calculated, refer to “Flex Vacation Purchase” on page 75.

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.

Dependents include:

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

– your 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 “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 grandchildren for dental coverage for Texas residents only (according to the terms of the covered benefit);

– your parents and parents-in-law (even if not members of your household) for Best Doctors only (according to the terms of the covered benefit); and

– all of your household members (e.g., spouse, domestic partner, parents, grandparents) for AccessSolutions EAP only, according to the terms of the covered benefit.

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 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.

Domestic Partner Definition

BNY Mellon defines 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 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 prohibit legal marriage;
– are not legally married to anyone else, and any prior marriages have been dissolved through death or divorce;
– are not domestic partners with anyone else, and any prior domestic partnerships have been terminated;
– share joint responsibility for each other's welfare and financial obligations;
– have shared for at least the prior six months and continue to 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 domestic partners with any state or local government domestic partnership registry, if residing in a state or locality that provides 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 provides domestic partner registration); 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, joint ownership or a common leasehold interest in real property).

How to Enroll

Enrollment Reminders

– Check your personal information, such as address and phone number, to ensure that all information is accurate and up to date.
– Designate or verify your beneficiaries for life, AD&D and travel accident insurance.

Enrolling on MyBenefit Solutions

Access the MyBenefit Solutions website at work or at home:

– At Work: Go to MyReward (MySource > MyReward > Log on to MyReward > Proceed to My Personal Total Reward Data > MyBenefit Solutions)
– At Home: Go to **http://mybenefits.bnymellon.com** (if you 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.

If You Need to Choose a Primary Care Dentist (PCD)

If you enroll in the Aetna DMO, you will need to choose a primary care dentist (PCD). 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 care dentist's six-digit dental office number for each covered person. For information on the six-digit dental office number, go to **www.aetna.com/dse/search?site_id=dse&externalPlanCode=DMO|DMO** or call 1-855-855-8112. No form is required.
– If you are enrolling in the Aetna DMO via the MyBenefit Solutions website, you will be prompted to enter your DMO PCD's six-digit dental office number for each covered person; the number can be found at **www.aetna.com/dse/search?site_id=dse&externalPlanCode=DMO|DMO**, or call 1-855-855-8112. No form is required to enroll.
– 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.

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 Miss the Enrollment Deadline

The following chart shows the default coverage you will receive for 2018 if you do not enroll by the deadline provided with your enrollment information.

COVERAGE YOU WILL RECEIVE	
	Newly Benefited Employees
Medical	No coverage
HSA Contributions (available only if you enroll in Plan HSA)	No employee contributions; you may change your HSA contribution amount monthly throughout the year
Dental	No coverage
Vision	No coverage
LTD 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/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 FSA	No participation
Limited Purpose FSA	No participation
Dependent Care FSA	No participation
Flex Vacation	No participation

When Coverage Becomes Effective and Terminates

BNY Mellon holds an Open Enrollment period every year in the fall. The benefits you choose during the Open Enrollment period will become effective on the following January 1, and remain in effect through the earliest of December 31 of the following calendar year or the last day of the month you transition to a status that is ineligible for benefit coverage, including termination.

If you are newly eligible for benefits during 2018 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, 2018 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. For new domestic partners, because of the six-month cohabitation/codependence requirement, the domestic partner will be covered on the first day of the month following the date on which he/she became eligible (see “Domestic Partner Definition” on page 11). 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 HSA 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 18. Your next opportunity to make changes will be during Open Enrollment for the 2019 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 Plan HRA or Plan HSA 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/domestic partner, child) insurance, supplemental AD&D insurance, supplemental long-term disability insurance, and flex vacation.

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/domestic partner and child 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.

For example, assume you earn $45,000 a year and contribute $1,000 toward the cost of your benefits. You pay no federal income, Social Security or Medicare taxes on that $1,000. In this case, your taxable income for the year, before subtracting your personal exemptions and your standard deduction, would be $44,000 instead of $45,000. That means you pay about $176* less in taxes for the year than if you spent that $1,000 elsewhere.

For federal tax purposes, the full value of the health care benefits provided to your dependents (e.g., your 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.

* These numbers are just an illustration; your actual tax savings may vary. This example is based on tax rates for 2017. It assumes that you are a married employee, with total income of $45,000, filing jointly with four exemptions in 2018, and that you are taking the standard deduction.

Your Per-Pay Cost

The per-pay contributions 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.

You will pay for benefits through regular payroll deductions, generally on a pre-tax basis. (You pay for spouse/domestic partner and child life insurance coverage on an after-tax basis.)

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 71.

Pricing Structure for Medical Coverage

Health plan premiums are based on five criteria:

– your base pay;

– the plan option you choose;

– the carrier you choose;

– the number of eligible dependents you choose to cover; and

– for 2018, health plan premium reductions earned by completing certain wellbeing program activities. Eligible employees and their covered spouse/qualified domestic partner who become new participants in a BNY Mellon health plan on or after September 12, 2017, as well as expats who enroll in Aetna International, employees on long-term disability, military leave and pre-65 retirees will automatically receive the 2018 health plan premium reduction.

The per-pay contributions are shown in “2018 Medical Contributions” on page 32. Generally, the lower your base pay, the more BNY Mellon contributes toward the cost of your coverage.

Tools to Help You Choose the Right Health Plan

BNY Mellon offers a variety of online resources and tools to help you choose your health plan, and then make more informed everyday decisions when using your benefits.

The following tools are available on MyBenefit Solutions. At work: MySource > MyReward > Logon to MyReward > Proceed to My Personal Total Reward Data > MyBenefit Solutions. From home: **http://mybenefits.bnymellon.com**.

Medical Expense Estimator

The Medical Expense Estimator is designed to help you estimate your 2018 health care expenses under both Plan HRA and Plan HSA.

Decision Direct

The Decision Direct tool is designed to help you more easily compare your health plan options. Decision Direct is an easy-to-use tool that offers you specific, personalized enrollment suggestions. By answering a few simple questions about your benefit needs and preferences, Decision Direct helps you compare the plans to determine the best option for you. In addition, you can learn about enrollment decisions others have made in hypothetical scenarios.

Flexible Spending Account Estimator

Estimate how much to contribute to the Health Care and Dependent Care Flexible Spending Accounts based on anticipated annual expenses.

Health Savings Account Estimator

Estimate how much to contribute to the Health Savings Account based on anticipated annual qualified health care expenses.

Physician Finder

Use Castlight to locate in-network providers, view cost estimates and quality ratings for doctors’ visits and medical services, review your past medical claims and expenses if you were previously covered under BNY Mellon sponsored Plan HRA or Plan HSA with Aetna or UnitedHealthcare, and understand what expenses would be covered by the health plan you’re considering for 2018. Visit **http://www.mycastlight.com/bnymellon** or call a Castlight Guide at 1-866-960-0873, available Monday through Friday, 8:00 a.m. to 9:00 p.m. Eastern Time.

You can also contact Aetna at 1-855-855-8112 or UnitedHealthcare at 1-800-842-0750 (depending on the health plan carrier you select) to access health and wellbeing advocacy services. 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**

Guide to Using Your Health Plan Benefits

This guide will help you navigate the day-to-day decisions and situations you’ll encounter when you need medical care, such as:

– how to prepare for a doctor’s visit;

– when and how to use your Health Savings Account or Health Reimbursement Account to pay for care; and

– the resources and tools available from the carriers and wellbeing program providers to help you make better-informed decisions.

You can find the Guide to Using Your Health Plan Benefits on the HealthHub site at **www.healthhub.bnymellon.com**. Just select the version that’s appropriate to your health plan (Plan HSA or Plan HRA).

Health and Wellbeing

Wellbeing Program

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, AccessSolutions Employee Assistance & Work/Life program, 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 Plan HSA, 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**.

Improve Your Wellbeing and Earn Incentives Along the Way

BNY Mellon employees and their spouse/domestic partner who are covered under a BNY Mellon medical plan can earn up to $1,000 in health care incentives for participating in the 2018 Wellbeing Rewards Program.

INCENTIVE TYPE	HOW TO EARN	INCENTIVE
Health Plan Premium Reduction	Complete the WebMD Wellbeing Assessment (WBA) and biometric screening (between September 12 and November 10, 2017)	$400 annual premium reduction per eligible participant
Health Account Deposit	Select and participate in points-based activities between September 12, 2017 and August 31, 2018 to earn up to 600 points and unlock incentives *The WBA must be completed first.*	$600 annual health account deposit maximum per eligible participant

New enrollees within the 2018 calendar year will automatically earn the 2018 health plan premium reduction.

Eligible employees and their spouses/domestic partners who are enrolled in a BNY Mellon sponsored health plan can earn health account deposits for participating in a variety of wellbeing activities throughout the year.

Benefits-eligible employees who waive medical plan coverage may participate in these wellbeing activities but will not be eligible to receive the financial incentives.

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 Health Plan automatically receive the 2018 health plan premium reduction. In addition, those enrolled in the Aetna International, Kaiser and HMSA Hawaii plans through BNY Mellon are eligible to receive a gift card upon completion of applicable point-based activities. Gift cards will be taxed appropriately.

Alternative Means to Earning Incentives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellbeing program are available to all employees and spouses/domestic partners enrolled in a BNY Mellon health plan. If you and/or your spouse/domestic partner think you might be unable to meet a standard for a reward under this program due to health, disability or other concerns, you and/or your spouse/domestic partner may qualify for an opportunity to earn the same reward by different means. Contact WebMD at 1-888-258-9275 and they will work with you and/or spouse/domestic partner (and associated physician, if you wish) to find an alternative means for you to earn the same reward in light of your health status.

More Ways That Pay

You and your covered spouse/domestic partner can each unlock up to $600 in 2018 health account deposits by participating in points-based activities that are right for you between September 12, 2017 and August 31, 2018. For each point you earn, unlock one dollar. Activities include:

– Preventive exams

– Being tobacco-free

– Health coaching

– Aetna or United Healthcare Health Advantage Program

– Add a provider to your Castlight Care team
– Best Doctors InterConsultation
– Emotional Wellbeing Program
– Wellbeing webinars
– Mental Health Screening
– 401(k) participation
– HSA participation (you must be enrolled in Plan HSA for 2018 to participate)
– Ayco financial education and planning services
– Virgin Pulse engagement platform

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

Manage Your Health through Doctor On Demand

You can access a national network of board-certified doctors and licensed professionals all day, every day, at very affordable rates. Through HIPAA-compliant video consultations using your computer or mobile device with a front-facing camera, you can contact board-certified doctors who can diagnose your condition, treat it and write prescriptions to manage common health problems. In addition, behavioral health counseling is available by appointment with licensed professionals.

Use Doctor On Demand for non-emergency care when you need to see a physician and do not need to use an emergency room. In the event of a true medical emergency (such as shortness of breath, chest pains or broken bones) dial 911 or go to your local emergency room. For more information and to register, please visit **www.doctorondemand.com/bnymellon**. You can also download the Doctor On Demand app to your iPhone or iPad (App Store), or Android device (Google Play).

Get Quality Care Fast with a CVS Health MinuteClinic®

If you are enrolled in either Aetna or UnitedHealthcare coverage, you will receive an average discount of 35 percent off standard MinuteClinic fees when you present your CVS ID card. These walk-in medical centers are available across the United States, with on-staff nurse practitioners and physician assistants who specialize in family care (for patients who are 18 months or older). Visit the CVS MinuteClinic locator at **https://www.cvs.com/minuteclinic/clinic-locator** to find a location near you.

2018 IRS Limits Impacting HSA Incentives

Due to IRS maximum limitations on annual contributions to HSAs, you are responsible for adjusting your HSA contributions if any of the incentives outlined above would cause your total contributions (including your own contributions, financial incentives earned and BNY Mellon contributions) to exceed the IRS limit ($3,450 for single Employee Only coverage and $6,850 for non-single coverage; additional $1,000 catch-up contribution permitted for those age 55 or older).

If your total contributions exceed the IRS limit, you may withdraw the excess without penalty until the deadline (including extensions) for filing your tax return for the tax year for which the excess contribution was made. After that time, the excess amounts are subject to both income taxes and an excise tax.

Changing Coverage

The BNY Mellon Flexible Benefits Program is regulated by 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 within 31 days from the date of the qualified event. You may also be permitted to change your benefits elections 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 21, 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/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 benefit costs will change
- **Dependent Eligibility** – An event that causes the gain or loss of a dependent's eligibility for benefits
- **Residence** – A change in where you, your spouse/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

Consistency Rule

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

- the qualified life event affects eligibility for you, your spouse/domestic partner or your dependent under a BNY Mellon plan or a plan maintained by your spouse's/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 > Log on to MyReward > Proceed to My Personal Total Reward Data > MyBenefit Solutions > Life Events), from home at **http://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.

What You Can Change

Any election change you make must satisfy the "consistency rule" explained below, 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 change your medical plan election 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/domestic partner and/or new or existing dependents
	– Spouse/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 domestic partner status, death)***	– Medical – Dental – Vision	Must discontinue coverage for your former spouse/domestic partner Elect coverage for yourself or dependents who lose coverage under your former spouse's/domestic partner's plan
	– Supplemental Life & Accidental Death and Dismemberment (AD&D)	Increase or decrease coverage
	– Spouse/Domestic Partner Life	Discontinue spouse/domestic partner coverage
	– Dependent Care FSA	Elect, increase, decrease or discontinue your contributions
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/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

LIFE EVENT CHANGES		
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/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/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/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.

OTHER EVENTS	ALLOWABLE CHANGES
Changes in Entitlement for Medicare or Medicaid	If you, your spouse/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/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/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/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 domestic partner and your domestic partner's children are not eligible for reimbursement through either of the FSAs.

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 18 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.

When You Have Other Medical Coverage Available

If you enroll in Plan HRA (Health Reimbursement Account) and have other medical coverage available—for example, through your spouse's/domestic partner's employer—you should carefully consider your coverage options. It may not be cost-effective to carry coverage under more than one plan. Note: If you enroll in Plan HSA, 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 (including any part of Medicare Part A, Part B, etc. or Tricare), such as your spouse's/domestic partner's, unless it also meets the IRS definition of a "high-deductible health plan."

When you have other actual coverage available 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 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 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 domestic partner is the patient, your spouse's or 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.

Note: if you enroll in other medical coverage, such as through your spouse's or 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 HSA. (While you can still enroll in Plan HSA, you will not be eligible to open the Health Savings Account.)

Coordination of Medicare and BNY Mellon Medical Coverage

If you or your covered dependent 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 and domestic partner status.

If you are an active employee (regardless of age) and you or your eligible covered dependent (who is not a domestic partner) is enrolled in both Medicare and a BNY Mellon health plan, your BNY Mellon health plan will be the primary payer.

The only exception to this rule is if you or an eligible covered dependent (who is not a domestic partner) is eligible for Medicare coverage due to end-stage renal disease and is also covered by a BNY Mellon health plan. In this case, your BNY Mellon health plan will be the primary payer for the first 30 months of end-stage renal disease Medicare eligibility. After 30 months, Medicare will be the primary payer.

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

- Medicare pays first if a 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 domestic partner.
- Medicare generally pays second:
  - When the 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 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 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.

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.)

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, HRA, 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 the "COBRA Rights Notice – Health and Welfare Benefits" section at the end of this document 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.

Medical and Prescription Drug

For 2018, most eligible employees have a choice between the following two national health plan options, each offered by our carriers, Aetna and UnitedHealthcare, with prescription drug coverage offered through CVS Caremark:

Option 1: Plan HRA Health Reimbursement Account	Option 2: Plan HSA Health Savings Account
See "Plan HRA (Health Reimbursement Account)" on page 38 for details	See "Plan HSA (Health Savings Account)" on page 42 for details

If you are eligible for a regional plan, you will receive more information at the time you enroll. Generally:

– Residents in Southern and Northern California are also eligible for coverage under the Kaiser Permanente California health plan. The Kaiser Plan deductible is $500 for individual coverage/$1,000 for family coverage. After you reach your annual deductible, BNY Mellon will pay 80 percent of the cost of eligible in-network care, and you will pay 20 percent of the cost for services, up to the annual out-of-pocket maximum. The in-network out-of-pocket maximum is $4,000 per person and $8,000 per family. Details about this plan are available on the MyBenefit Solutions website under "Plan Information."

– Hawaii residents will be eligible for coverage under HMSA.

– International expatriates will be eligible for coverage under Aetna International.

Your Medical Coverage Levels

You may select one of the following four levels of coverage:

– Employee Only

– Employee + Child(ren)

– Employee + Spouse/Domestic Partner

– Employee + Family (more than one eligible dependent)

Locating a Provider

With Castlight you can view cost estimates and quality ratings for doctors' and dentists' visits and medical services, understand what's covered by your health plan, view your past health care expenses year-to-date (for periods you were enrolled in a BNY Mellon medical plan) and review simple explanations of past expenses. Visit **http://www.mycastlight.com/bnymellon** or call a Castlight Guide at 1-866-960-0873, Monday through Friday, 8:00 a.m. to 9:00 p.m. Eastern Time.

You can also contact Aetna at 1-855-855-8112 or UnitedHealthcare at 1-800-842-0750 (depending on the health plan carrier you select) to access health and wellbeing advocacy services. Note the "Network Name" associated with the "Health Plan Carrier" options.

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**

How the Plans Work

Plan HRA (Health Reimbursement Account) and Plan HSA (Health Savings Account) are both built on traditional health insurance plans with these features:

– You have access to national networks of doctors and hospitals provided by Aetna or UnitedHealthcare.

– You save through negotiated discounts when 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.

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

Higher Deductible

Both health plan options have a higher deductible than traditional health plans. High-deductible plans make it more important for you to research the price and value of medical services using the price and quality comparison tools that include 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.

The Health Accounts

Whether you choose Plan HSA or Plan HRA with Aetna or UnitedHealthcare, you'll have access to a personal health account. BNY Mellon will contribute to these accounts on or before your first pay following your plan effective date to help you pay your share of eligible health care expenses. These health accounts reward you for effective long-term health care savings, even into retirement, because unused balances generally roll forward from year to year.

– A Health Reimbursement Account will be automatically opened for you if you enroll in Plan HRA. BNY Mellon contributes to your health account to help you pay your portion of eligible health care expenses. You do not contribute to your Health Reimbursement Account.

– A Health Savings Account, regulated by IRS rules, will be automatically opened for you if you enroll in Plan HSA. BNY Mellon contributes to your health account to help you pay your portion of eligible health care expenses. In addition, from your pay, you can contribute pre-tax dollars to your health account up to the annual IRS limits (Individual annual maximum: $3,450; Employee + Child(ren), Employee + Spouse/Domestic Partner or Employee + Family annual maximum: $6,850; Age 55 or older: additional catch-up contributions of up to $1,000 annually). Health account earnings and distributions (for eligible expenses) are also tax-free. To finalize opening your account, you will be required to provide certain information as required by the U.S. Patriot Act (including such items as name, address, date of birth, Social Security number, etc.).

– Your contributions to pay for your health coverage are paid on a "tax-free" basis. As used throughout this Guide, "tax-free" means they are generally exempt from federal income and Social Security taxes, as well as many state income taxes.

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

– The amount BNY Mellon contributes on your behalf to either account is based upon your coverage level and your base pay. As used in this Guide, "base pay" generally means your annualized base pay, or rate of pay based on a normal workweek not exceeding 40 hours, generally excluding commissions, overtime pay, bonuses, payments in lieu of vacation, all non-regular payments and any other special purpose payments. Salary reduction contributions, Code Section 132(f) transportation plan and similar salary reduction contributions, as well as any deferred compensation contributions, are included in your base pay.

Account Basics

– If you enroll in Plan HRA or Plan HSA, your health account will be opened on your plan effective date.

– If you elect Plan HSA, you will be presented with the BenefitWallet HSA terms and conditions after you enroll. Once you agree to the terms and conditions, your electronic signature will be used to activate your HSA on your plan effective date. To finalize opening your account, you will be required to provide certain information, as required by the U.S. Patriot Act (including such items as name, address, date of birth, Social Security number, etc.).

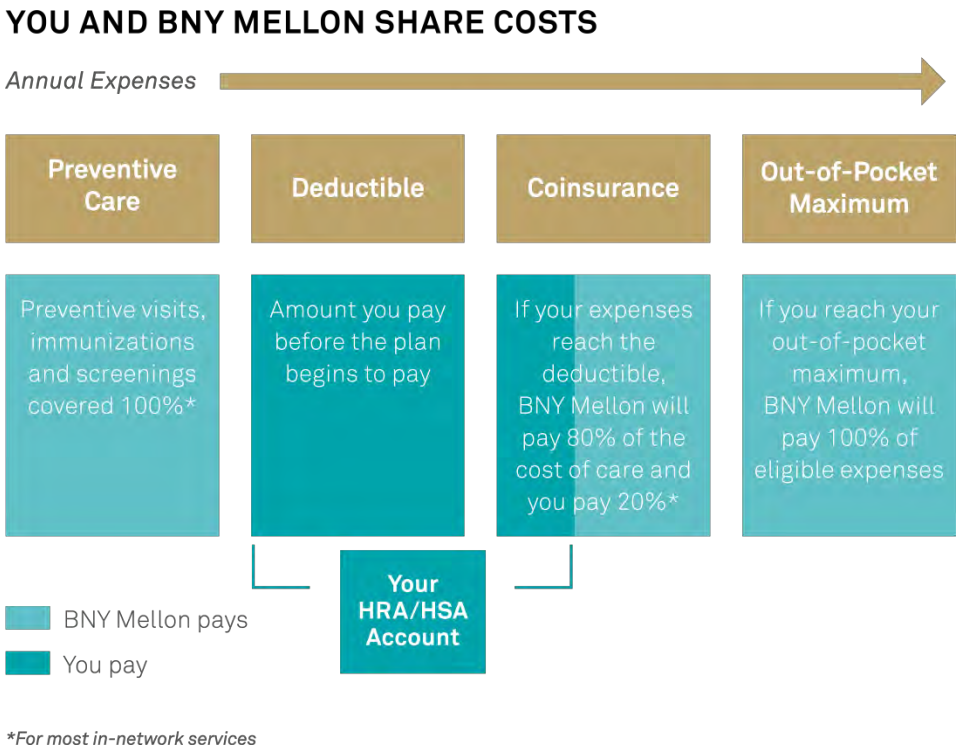
– BNY Mellon will contribute to either your HRA or HSA in one lump sum on or before your first pay following your plan effective date. The BNY Mellon contribution deposited to your health account will be based on your base pay level.

– In addition to receiving BNY Mellon's contribution, you can also make pre-tax contributions to your HSA, up to the annual IRS limits (see "Plan HSA (Health Savings Account)" on page 42 for more information). HSA contributions can only be used for qualified health care expenses, and contributions cannot be withdrawn from your health account to pay non-health-related expenses.
– You decide when to use your health account to pay for qualified health care expenses.
– Participation in the HSA is subject to IRS rules, including limits on other existing health care coverage and certain restrictions that may apply to adult dependents up to age 26.
– Unused balances roll forward from year to year.
– HSA contributions belong to you. If you leave BNY Mellon for any reason and at any age, HSA contributions remaining in your health account will continue to be available for your use.
– HRA contributions remaining in your health account will remain available for your use if you leave BNY Mellon at or following the attainment of age 55, but will be forfeited if you leave BNY Mellon prior to attaining age 55.

Important: If you are currently enrolled in any part of Medicare (Part A, Part B, etc.) or Tricare, you may participate in Plan HSA but neither you nor BNY Mellon may contribute to a Health Savings Account. See "Health Savings Account (HSA) Contributions" on page 42 for more information about IRS regulations on Health Savings Accounts.

You and BNY Mellon Share Costs

Both types of health accounts help you budget and save for your share of health care costs like deductibles and coinsurance.



**For most in-network services*

Cost of Coverage

Your cost of coverage, or your per-pay cost, is what you pay for medical coverage whether or not you use medical services. It is important to consider both your cost of coverage **and** your cost of care (i.e., deductible, coinsurance and out-of-pocket maximum) when comparing your health plan options. Review the "2018 Medical Contributions" on page **32**.

Make sure your health plan election meets your needs for 2018. See "Tools to Help You Choose the Right Health Plan" on page 14 for interactive tools you can use to compare options more carefully.

PLAN HRA (HEALTH REIMBURSEMENT ACCOUNT) MAY BE RIGHT FOR YOU IF YOU…	PLAN HSA (HEALTH SAVINGS ACCOUNT) MAY BE RIGHT FOR YOU IF YOU…
– want a lower deductible and out-of-pocket maximum – want access to a traditional four-tier prescription drug schedule (generic/specialty/formulary/non-formulary) – want to contribute to a Flexible Spending Account – want the convenience of having the HRA and your Flexible Spending Account on the same debit card	– want a lower per-pay cost – don't mind a higher, "true family"* deductible or a higher out-of-pocket maximum and can budget for it – want the potential for tax benefits of the HSA, including tax-free contributions, tax-free earnings on accumulated balances and tax-free distributions if amounts are used for qualified health care expenses – want to contribute to a Limited Purpose Flexible Spending Account

* Under Plan HRA, individual deductibles apply to each family member until the family deductible is met. Under Plan HSA, if an employee elects coverage for dependents, the "true family" deductible must be met before the Plan reimburses for benefits, even if only one family member incurs expenses. Plan HSA out-of-pocket expenses paid for an individual family member are limited to no more than $6,850 for in-network coverage before Plan HSA reimburses 100 percent of eligible expenses.

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

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.

Coverage Includes Mastectomy Benefits

Under the Women's Health and Cancer Rights Act (WHCRA), mastectomy benefits must cover certain reconstructive surgery. 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 a mastectomy has been performed;

– surgery and reconstruction of the other breast to produce a symmetrical appearance;

– the cost of prostheses; and

– the costs of treatment of physical complications at any stage of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For more information on mastectomy benefits, call your health plan carrier.

Healthy Pregnancy Programs

If you are an expectant mother covered under Plan HRA or Plan HSA and you complete either Aetna's or UnitedHealthcare's Healthy Pregnancy program (depending on the BNY Mellon health plan carrier you select) by August 31, 2018, you may be eligible to earn points for the 2018 Wellbeing Rewards Program. These programs help expecting mothers before, during and after pregnancy. Visit **www.webmdhealth.com/bnymellon** for more information about the incentive and requirements.

Aetna's Beginning Right Maternity Program

If you are an expectant mother or father, you can participate in the Beginning Right 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 the Beginning Right 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, the Beginning Right Maternity Program can teach you the signs and symptoms of early labor. You'll also hear about new treatment options.

To enroll in the Beginning Right 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
– 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 **cx.uhc.com/sjsnurse**.

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.

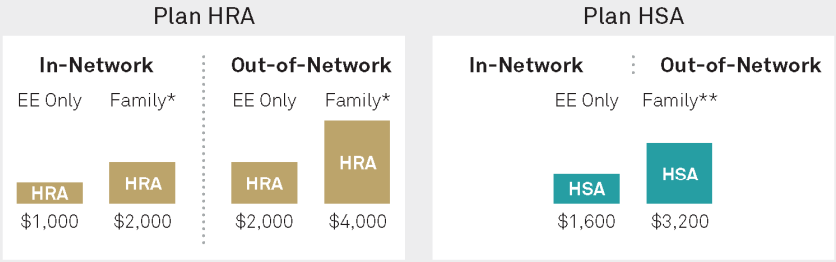
Comparing the Plans

BNY Mellon offers two medical plans—Plan HRA and Plan HSA. Both plans are available through Aetna and UnitedHealthcare and each plan has a health account feature. They both provide comprehensive coverage, provider networks and an opportunity for you to control your health care spending.

PREMIUM:
Plan HRA has a higher premium than Plan HSA

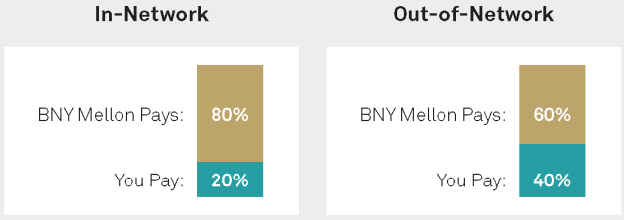
PREVENTIVE CARE:
Covered 100% in-network under both plans

DEDUCTIBLE:
Plan HRA has a lower in-network deductible than Plan HSA but higher out-of-network deductible

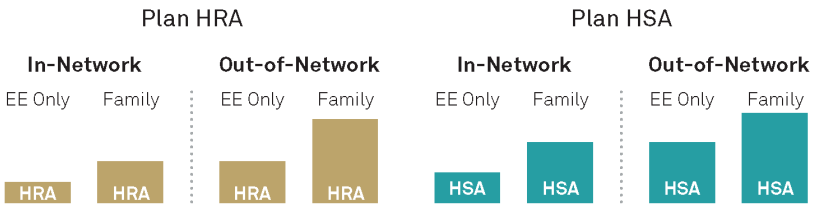


* *For Plan HRA family coverage, each member must meet the individual deductible unless the combined family meets the maximum first.*
** *For Plan HSA family coverage, if only one family member becomes ill or injured, that person must meet the family deductible before the plan reimburses for benefits.*

COINSURANCE:
Both plans have the same coinsurance percentage



OUT-OF-POCKET MAXIMUM:
Plan HRA has lower out-of-pocket maximums



Salary Range: Under $30,000	$2,250	$4,500	$4,500	$9,000	$2, 400	$4,800	$4,800	$9, 600
$30,000 - $49,999	$2,750	$5,500	$6,300	$12,600	$3,900	$7,800*	$7,800	$15,600
$50,000 - $79,999	$3,750	$7,500	$8,300	$16,600	$5,500	$11,000*	$11,000	$22,000
$80,000 - $124,999	$4,750	$9,500	$10,100	$20,200	$6,350	$12,700*	$14,200	$28,400
$125,000 and above	$5,750	$11,500	$11,100	$22,200	$6,350	$12,700*	$15,600	$31,200

* *Note, the Plan HSA out-of-pocket expenses paid for an individual family member is limited to no more than $6,850 for in-network coverage before Plan HSA reimburses 100% of eligible expenses.*

PRESCRIPTION DRUGS[1]:

	PLAN HRA: Drugs are not subject to the deductible and coinsurance and follow the traditional 4-tier prescription drug schedule.	**PLAN HSA:** Non-preventive drugs are subject to the deductible and coinsurance. Preventive drugs are covered under the same traditional 4-tier prescription drug schedule as Plan HRA.
Preventive[2]	Same as Retail/Mail Order below	Same as Retail/Mail Order under Plan HRA (deductible does not apply)
Retail	• Generic: Lesser of $10 or retailer's regular cost • Formulary (Preferred) Brand: 25% coinsurance ($50 minimum; $75 maximum) • Non-Formulary (or Non-Preferred) Brand: 40% coinsurance ($75 minimum; $100 maximum)	• Generic: 20% coinsurance after deductible • Formulary (Preferred) Brand: 20% coinsurance after deductible • Non-Formulary (or Non-Preferred) Brand: 40% coinsurance after deductible
Mail-Order[1]	• Generic: Lesser of $25 or regular discount cost • Formulary (Preferred) Brand: 25% coinsurance ($125 minimum, $187.50 maximum) • Non-Formulary (or Non-Preferred) Brand: 40% coinsurance ($187.50 minimum; $250 maximum)	• Generic: 20% coinsurance after deductible • Formulary (Preferred) Brand: 20% coinsurance after deductible • Non-Formulary (or Non-Preferred) Brand: 40% coinsurance after deductible
Specialty	• Generic: $10 • Formulary (Preferred) Brand: $75 • Non-Formulary (or Non-Preferred) Brand: $100	• Generic: 20% coinsurance after deductible • Formulary (Preferred) Brand: 20% coinsurance after deductible • Non-Formulary (or Non-Preferred) Brand: 40% coinsurance after deductible

[1] Chronic medications restricted to mandatory mail order or CVS pharmacy after the prescription is filled twice at the retail level; mandatory generic; step therapy programs.
[2] Examples of preventive drugs include diabetes medications, cholesterol medications, and high blood pressure medication.

HEALTH REIMBURSEMENT ACCOUNT:
For qualified out-of-pocket medical and pharmacy expenses

Unused money rolls over from year to year as long as you remain employed by BNY Mellon or leave at or following age 55

BNY MELLON CONTRIBUTES:	*Employee Only*	*Family*
Salary Range: Under $30,000	$700	$1,400
$30,000 - $39,999	$600	$1,200
$40,000 - $49,999	$500	$1,000
$50,000 - $79,999	$400	$800
$80,000 and above	$200	$400

EMPLOYEE CONTRIBUTIONS:
Employees cannot contribute.

HEALTH SAVINGS ACCOUNT:
For qualified out-of-pocket medical and pharmacy expenses

Unused money rolls over from year to year even if you leave BNY Mellon for any reason and at any age

BNY MELLON CONTRIBUTES:	*Employee Only*	*Family*
Salary Range: Under $30,000	$700	$1,400
$30,000 - $39,999	$600	$1,200
$40,000 - $49,999	$500	$1,000
$50,000 - $79,999	$400	$800
$80,000 and above	$200	$400

EMPLOYEE CONTRIBUTIONS:
Maximum IRS annual contribution below includes employee and BNY Mellon contributions and health account deposits earned by completing wellbeing activities. No taxes on contributions, interest earned or withdrawals if used for eligible expenses. Employees age 55 or older may contribute an additional $1,000 catch-up contribution annually.

EMPLOYEE: $3,450 FAMILY: $6,850

** BNY Mellon's HSA and HRA contributions will be pro-rated for those who become benefits eligible during 2018. An additional amount of up to $600 each will be added to the HRA or HSA if an employee and/or spouse/domestic partner completes wellbeing activities.*

2018 Medical Contributions

The rates shown in the table below are 2018 semi-monthly health plan contribution 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. This amount includes the $400 health plan premium reduction that newly eligible employees (or $800 if covering an eligible spouse/domestic partner) automatically earn during the first year of coverage. (Your base pay for the 2018 plan year is determined as of September 1, 2017, 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 > Log on to MyReward > Proceed to My Personal Total Reward Data > MyBenefit Solutions. From home: **http://mybenefits.bnymellon.com**.

2018 SEMI-MONTHLY EMPLOYEE CONTRIBUTIONS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAYCHECK) (FIGURES ASSUME EMPLOYEE/SPOUSE/DOMESTIC PARTNER WELLBEING PREMIUM REDUCTION WAS EARNED)						
	PLAN HRA		PLAN HSA			
	PREFERRED CARRIER RATE	NON-PREFERRED CARRIER RATE	PREFERRED CARRIER RATE	NON-PREFERRED CARRIER RATE	KAISER PLAN	AETNA INTER-NATIONAL*
Under $30,000						
Employee	$32.00	$36.00	$9.50	$10.50	$32.50	$34.50
Employee + Child(ren)	$66.00	$74.50	$19.50	$21.50	$67.00	$71.50
Employee + Spouse/Domestic Partner	$78.00	$87.50	$23.00	$25.50	$79.00	$84.00
Employee + Family	$117.50	$132.00	$35.00	$38.50	$119.00	$126.50
$30,000 - $39,999						
Employee	$50.00	$56.00	$17.00	$19.00	$54.00	$56.00
Employee + Child(ren)	$103.50	$115.50	$35.00	$39.50	$111.50	$115.50
Employee + Spouse/Domestic Partner	$121.50	$136.50	$41.50	$46.00	$131.50	$136.50
Employee + Family	$183.50	$205.50	$62.50	$69.50	$198.00	$205.50 s
$40,000 - $49,999						
Employee	$58.50	$65.50	$20.00	$22.50	$67.00	$72.00
Employee + Child(ren)	$121.00	$135.50	$41.50	$46.50	$138.50	$149.00
Employee + Spouse/Domestic Partner	$142.50	$159.50	$48.50	$55.00	$163.00	$175.00
Employee + Family	$214.50	$240.00	$73.50	$82.50	$245.50	$264.00
$50,000 - $79,999						
Employee	$63.50	$71.00	$22.50	$25.00	$83.00	$92.00
Employee + Child(ren)	$131.00	$146.50	$46.50	$51.50	$171.50	$190.00
Employee + Spouse/Domestic Partner	$154.50	$173.00	$55.00	$61.00	$202.00	$224.00
Employee + Family	$233.00	$260.50	$82.50	$91.50	$304.50	$337.50
$80,000 - $99,999						

2018 SEMI-MONTHLY EMPLOYEE CONTRIBUTIONS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAYCHECK) (FIGURES ASSUME EMPLOYEE/SPOUSE/DOMESTIC PARTNER WELLBEING PREMIUM REDUCTION WAS EARNED)						
	PLAN HRA		PLAN HSA			
	PREFERRED CARRIER RATE	NON-PREFERRED CARRIER RATE	PREFERRED CARRIER RATE	NON-PREFERRED CARRIER RATE	KAISER PLAN	AETNA INTER-NATIONAL*
Employee	$74.50	$83.50	$28.50	$32.00	$101.00	$97.50
Employee + Child(ren)	$154.00	$172.50	$59.00	$66.00	$208.50	$201.50
Employee + Spouse/Domestic Partner	$181.50	$203.00	$69.50	$78.00	$246.00	$237.50
Employee + Family	$273.00	$306.00	$104.50	$117.50	$370.50	$357.50
$100,000 - $124,999						
Employee	$95.00	$106.50	$36.50	$41.00	$108.50	$134.00
Employee + Child(ren)	$196.50	$220.00	$75.50	$84.50	$224.00	$277.00
Employee + Spouse/Domestic Partner	$231.00	$259.00	$89.00	$100.00	$264.00	$326.00
Employee + Family	$348.50	$390.50	$134.00	$150.50	$398.00	$491.50
$125,000 -$149,999						
Employee	$102.00	$114.00	$39.50	$44.00	$136.50	$136.50
Employee + Child(ren)	$211.00	$235.50	$81.50	$91.00	$282.00	$282.00
Employee + Spouse/Domestic Partner	$248.00	$277.50	$96.00	$107.00	$332.00	$332.00
Employee + Family	$374.00	$418.00	$145.00	$161.50	$500.50	$500.50
$150,000 - $249,999						
Employee	$113.50	$127.00	$44.00	$49.50	$142.00	$156.50
Employee + Child(ren)	$234.50	$262.50	$91.00	$102.50	$293.50	$323.50
Employee + Spouse/Domestic Partner	$276.00	$309.00	$107.00	$120.50	$345.50	$381.00
Employee + Family	$416.00	$465.50	$161.50	$181.50	$520.50	$574.00
$250,000 and above						
Employee	$124.50	$139.50	$48.00	$54.00	$162.50	$170.00
Employee + Child(ren)	$257.50	$288.50	$99.00	$111.50	$336.00	$351.50
Employee + Spouse/Domestic Partner	$303.00	$339.50	$117.00	$131.50	$395.50	$413.50
Employee + Family	$456.50	$511.50	$176.00	$198.00	$596.00	$623.50

* Employees who are eligible for and enroll in the Aetna International plan automatically earn the health plan premium reduction.

Prescription Drug Benefits

If you elect medical coverage through Plan HRA (including Health Reimbursement Account) or Plan HSA (including Health Savings Account) 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.

Under Plan HRA, all covered prescription drugs are subject to the traditional four-tier prescription drug schedule (generic and specialty copayments, formulary and non-formulary coinsurance).

Under Plan HSA, non-preventive prescription drugs are subject to the deductible/coinsurance provisions, but preventive prescription drugs are covered under the traditional four-tier prescription drug schedule, offering low copayments for generic drugs and coinsurance for formulary, non-formulary and specialty drugs.

As required by the Affordable Care Act, prescription drug expenses under both health plans now count toward the out-of-pocket maximum.

PRESCRIPTION DRUGS		
	PLAN HRA[1] Drugs are not subject to the overall plan deductible and follow the traditional 4-tier prescription drug schedule	**PLAN HSA**[1] Non-preventive drugs are subject to the overall plan deductible. Preventive drugs are not subject to the overall plan deductible and are covered under the same traditional 4-tier prescription drug schedule as Plan HRA.
Preventive[2]	Same as Retail/Mail Order below	Same as Retail/Mail Order under Plan HRA (deductible does not apply)
Retail[3]	**Non-Preventive Drugs** – Generic: Lesser of $10 or retailer's regular cost – Formulary (Preferred) Brand: 25% coinsurance *($50 minimum; $75 maximum)* – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance *($75 minimum; $100 maximum)*	**Non-Preventive Drugs** – Generic: 20% coinsurance after deductible – Formulary (Preferred) Brand: 20% coinsurance after deductible – Non-Formulary (or Non-Preferred) Brand: *40% coinsurance after deductible*[5]
Mail Order[3]	**Non-Preventive Drugs** – Generic: Lesser of $25 or regular discount cost – Formulary (Preferred) Brand: 25% coinsurance *($125 minimum; $187.50 maximum)* – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance *($187.50 minimum; $250 maximum)*	**Non-Preventive Drugs** – Generic: 20% coinsurance after deductible – Formulary (Preferred) Brand: 20% coinsurance after deductible – Non-Formulary (or Non-Preferred) Brand: *40% coinsurance after deductible*[5]
Specialty[4]	– Generic: $10 – Formulary (Preferred) Brand: $75 – Non-Formulary (or Non-Preferred) Brand: $100	– Generic: 20% coinsurance after deductible – Formulary (Preferred) Brand: 20% coinsurance after deductible – Non-Formulary (or Non-Preferred) Brand: *40% coinsurance after deductible*[5]

1 Your costs for preventive and non-preventive drugs count toward the out-of-pocket maximum; mandatory generic and step therapy programs apply.

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

3 Maintenance/preventive medication must be filled through mail order or at a CVS (or Target) retail pharmacy after the prescription is filled twice at a retail location.

4 30-days' supply maximum at Retail and Mail Order.

5 Minimums and maximums do not apply.

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 104.

CVS Caremark Value Formulary

The Prescription Drug Formulary is updated regularly and can be accessed at **http://info.caremark.com/highvalueplan**. If you currently take prescription drugs or need prescription drugs during 2018, 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

Beginning January 1, 2018, CVS will align 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 enhanced program will limit days' supply, limit quantity of opioids and require 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. Please call CVS Caremark at 1-800-685-4130 for more information.

Diabetes Discount Program (Only for Participants in Plan HRA)

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 Plan HRA who have completed an A1C test in the prior 12 months. You will be contacted if this program applies to you.

The discount does not apply to any medications on the CVS Caremark Value Formulary.

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

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. However, 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 104.

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.

New Prescription Drug Card

You will receive a prescription drug card from CVS Caremark in late December. 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.

Questions About Your Prescription Coverage?

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

– About prescription drugs under Plan HRA: BNYMHRATEST1

– About prescription drugs under Plan HSA: BNYMHSATEST

Plan HRA (Health Reimbursement Account)

HRA Contributions

The HRA feature includes a contribution from BNY Mellon to help you pay for qualified health care expenses. BNY Mellon contributions are tax-free. You cannot save your own money in the Health Reimbursement Account; only BNY Mellon can put money in your account. If you don't use all of the money in your HRA, your account balance rolls over from one year to the next.

If you leave BNY Mellon for any reason before the age of 55, your HRA balance is forfeited, unless you continue Plan HRA medical coverage under COBRA. If you terminate employment with BNY Mellon before the age of 55 and do not continue Plan HRA medical coverage under COBRA, you may submit claims for expenses incurred through the end of the month in which you left. In addition, if you change to a BNY Mellon sponsored health plan that does not have the HRA, your HRA becomes a Limited Purpose HRA, which can only be used to pay dental, vision, preventive prescription drugs and out-of-network preventive care expenses, or other qualified health care expenses after you have met your new plan's annual deductible. If you are at or over the age of 55 when you leave BNY Mellon, your HRA balance remains available for reimbursement of eligible dental, vision, preventive prescription drugs and out-of-network preventive care expenses.

BNY MELLON'S ANNUAL CONTRIBUTION (AUTOMATIC)		
ANNUAL BASE PAY	EMPLOYEE ONLY*	EMPLOYEE + CHILD(REN), EMPLOYEE + SPOUSE/DOMESTIC PARTNER OR EMPLOYEE + FAMILY*
Under $30,000	$700	$1,400
$30,000-$39,999	$600	$1,200
$40,000-$49,999	$500	$1,000
$50,000-$79,999	$400	$800
$80,000 and above	$200	$400

* If you join BNY Mellon after the beginning of the 2018 plan year, BNY Mellon's contribution will be pro-rated.

Additionally, if you are enrolled in Plan HRA or Plan HSA in 2018, you and your covered spouse/domestic partner may each earn up to $600 in health account deposits to your 2018 HRA or HSA by participating in certain wellbeing activities. See "Health and Wellbeing" on page 15 for more information.

Proration of BNY Mellon HRA or HSA Contribution

If you join BNY Mellon after the beginning of the 2018 plan year, BNY Mellon's contribution to your HRA or HSA 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 HSA AND HRA ACCOUNTS IN 2018		
HIRE/BENEFIT ELIGIBILITY MONTH	**NUMBER OF MONTHS COUNTED TOWARD CONTRIBUTION AMOUNT**	**PRORATION FACTOR**
November/December 2017	12	1.00
January 2018	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

HRA Debit Card Convenience

The HRA is administered by Alight. When you elect to participate in Plan HRA, you can use the "Your Spending Account" debit card to pay for qualified health care expenses at the point of purchase, or pay out-of-pocket and submit a claim for reimbursement. This is the same debit card as the one used for the Health Care FSA (if you elect the Health Care FSA). If you also have a Health Care FSA and you choose to pay from your account, your Health Care FSA will pay first.

Using the debit card saves you the inconvenience of paying for an expense out-of-pocket, filing a claim and waiting for reimbursement. Because all contributions to your HRA have been made on or before your first pay date following your plan effective date, you can begin using your card starting on your plan effective date.

How the HRA Works

It's easy to use an HRA:

– You enroll in Plan HRA

– All contributions are made by BNY Mellon to your HRA on or before your first pay date following your plan effective date.

– You may use your HRA to reimburse yourself for qualified health care expenses, using tax-free dollars. **Note:** You may use your debit card to pay for qualified health care expenses, or pay out-of-pocket and submit a claim for reimbursement.

– Use MyBenefit Solutions to complete HRA reimbursement requests (via MyReward or **http://mybenefits.bnymellon.com**).

Keep Your Receipts

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

If You Change Your Plan Option Later

If you select Plan HRA and decide the following year to change to Plan HSA, your HRA (to the extent it has any balance remaining) will become a **Limited Purpose HRA**. This means that only dental, vision, preventive drug and out-of-network preventive care expenses will be eligible for reimbursement. Other qualified health care expenses can only be submitted for reimbursement after you meet the Plan HSA deductible. Additionally, you will no longer be able to use your Plan HRA debit card; instead, you will have to submit receipts for reimbursement.

In the Event of Disability

If you become disabled and are receiving either Short-Term or Long-Term Disability benefits, you will continue to receive BNY Mellon's annual contribution to your HRA and amounts in your account will remain available for reimbursement of qualified health care expenses.

In the Event of Your Death

In the event of death, amounts remaining in the HRA are available for reimbursement of qualified health care expenses incurred through the date of death; any remaining amounts are forfeited. Reimbursement requests for 2018 qualified health care expenses must be submitted by the deadline of June 30, 2019.

Plan HRA Details

Plan HRA offers a lower deductible—$1,000 for an individual or $2,000 for a family in-network—and a lower out-of-pocket maximum than Plan HSA, in exchange for a higher per-pay premium cost.

PLAN HRA				
	IN-NETWORK		OUT-OF-NETWORK	
Deductible	$1,000 individual	$2,000 family	$2,000 individual	$4,000 family
Annual Out-of-Pocket Maximum (Includes deductible and coinsurance for medical and prescription drugs. Excludes any amount over UCR[1], non-covered expenses and pre-certification penalties.)				
BASE PAY RANGE	**INDIVIDUAL**	**FAMILY**	**INDIVIDUAL**	**FAMILY**
$0 – $29,999	$2,250	$4,500	$4,500	$9,000
$30,000 – $49,999	$2,750	$5,500	$6,300	$12,600
$50,000 – $79,999	$3,750	$7,500	$8,300	$16,600
$80,000 – $124,999	$4,750	$9,500	$10,100	$20,200
$125,000 and above	$5,750	$11,500	$11,100	$22,200
Services				
Office Visits (Family/General Practice, Internal Medicine, Pediatrician, Ob/Gyn)	80%[2]		60%[2]	
Preventive Care, Routine Physicals (Adult and Child), Mammograms, Well Childcare (immunizations)	100% (no deductible)		60%[2]	
Mental Health, Behavioral Health and Substance Abuse (inpatient and outpatient services)	80%[2]		60%[2]	
Outpatient Surgery	80%[2]		60%[2]	
Hospital Care	80%[2]		60%[2]	
Emergency Room	80%[2]			

PLAN HRA		
	IN-NETWORK	**OUT-OF-NETWORK**
Physical, Speech and Occupational Therapy	80%[2] (Combined in- and out-of-network limit of 60 visits per calendar year for combined therapies)	60%[2] (Combined in- and out-of-network limit of 60 visits per calendar year for combined therapies)
Infertility	Plan pays up to $25,000 lifetime medical maximum benefit (in addition to $10,000 lifetime drug maximum benefit)[3,6]	
Hearing Aid (per member)	Plan pays up to $5,000 every two years	
Bariatric Surgery	80%[2,7] , must be obtained from an Aetna Institute of Quality or a UHC Center of Excellence	
Applied Behavior Analysis (ABA) Therapy	80%[2]	60%[2]
Joint and Spine Surgery	100%[2], if performed at an Aetna Institute of Quality or UHC Center of Excellence 80%[2], if performed at any other in-network facility	60%[2]
Organ Transplant	80%[2], must be obtained from an Aetna Institute of Quality or a UHC Center of Excellence	
Lifetime Maximum Benefit (per member)	Unlimited	
Prescription Drugs (In-Network Only)[4,5]		
Preventive Retail (30-day supply maximum)	– Generic: Lesser of $10 or the retailer's regular cost – Formulary (Preferred) Brand: 25% coinsurance ($50 minimum/$75 maximum) – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance ($75 minimum/$100 maximum)	
Preventive Mail Order (90-day supply maximum)	– Generic: Lesser of $25 or regular discount cost – Formulary (or Preferred) Brand: 25% coinsurance ($125 minimum/$187.50 maximum) – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance ($187.50 minimum/$250 maximum)	
Specialty	– Generic: $10 – Formulary (Preferred) Brand: $75 – Non-Formulary (or Non-Preferred) Brand: $100 30 days' supply maximum at Retail and Mail Order; required to use CVS Caremark Specialty pharmacies after initial fill.	

1 Usual, customary and reasonable (UCR) limits.

2 After deductible.

3 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.

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

5 Mandatory mail order or CVS pharmacy applies after the prescription is filled twice at the retail level; mandatory generic and step therapy programs.

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. 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.

Plan HSA (Health Savings Account)

Health Savings Account (HSA) Contributions

The HSA offers the following:

– **BNY Mellon contributes to your HSA.** BNY Mellon's contribution will be deposited to your HSA on or before your first pay following your plan effective date to help you pay for qualified health care 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.** You can also contribute to your HSA. Please keep in mind that you need to budget for the deductible. The amount you're saving on your premium cost is a great place to start. And, if you don't use all of the money in your HSA, your account balance rolls over from one year to the next.

– **No federal taxes.** You don't pay federal taxes on any money you and BNY Mellon put into your HSA or any money taken out—as long as it is used to pay for qualified health care expenses. In most states, HSA contributions and earnings may also be exempt from state income taxes.

– **It's your money.** The money in your HSA is yours—to pay for qualified health care expenses today or in the future, even if you leave BNY Mellon for any reason at any time.

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

HEALTH SAVINGS ACCOUNT 2018 CONTRIBUTION LIMITS			
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	$3,450	$700	$2,750
Employee + Spouse/Domestic Partner, Employee + Child(ren) or Employee + Family	$6,850	$1,400	$5,450
$30,000 - $39,999			
Employee Only	$3,450	$600	$2,850
Employee + Spouse/Domestic Partner, Employee + Child(ren) or Employee + Family	$6,850	$1,200	$5,650
$40,000 - $49,999			
Employee Only	$3,450	$500	$2,950
Employee + Spouse/Domestic Partner, Employee + Child(ren) or Employee + Family	$6,850	$1,000	$5,850
$50,000 - $79,999			
Employee Only	$3,450	$400	$3,050
Employee + Spouse/Domestic Partner, Employee + Child(ren) or Employee + Family	$6,850	$800	$6,050

HEALTH SAVINGS ACCOUNT 2018 CONTRIBUTION LIMITS			
COVERAGE LEVEL	**IRS COMBINED MAXIMUM ANNUAL CONTRIBUTION**	**BNY MELLON'S ANNUAL CONTRIBUTION (AUTOMATIC)[1]**	**YOUR MAXIMUM ANNUAL CONTRIBUTION (VOLUNTARY)[2]**
$80,000 and above			
Employee Only	$3,450	$200	$3,250
Employee + Spouse/Domestic Partner, Employee + Child(ren) or Employee + Family	$6,850	$400	$6,450

1 If you join BNY Mellon after the beginning of the 2018 plan year, BNY Mellon's HSA contribution will be pro-rated.

2 Maximum contribution should be reduced by any health account deposits earned by completing wellbeing activities by August 31, 2018. Beginning in the year you attain age 55, you may make additional catch-up contributions of up to $1,000 annually.

Additionally, if you are enrolled in Plan HRA or Plan HSA in 2018, you and your covered spouse/domestic partner may each receive financial incentives deposited to your 2018 HRA or HSA by participating in certain wellbeing activities. See "Health and Wellbeing" on page 15 for more information.

Proration of BNY Mellon HRA or HSA Contribution

If you join BNY Mellon after the beginning of the 2018 plan year, BNY Mellon's contribution to your HRA or HSA 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 HSA AND HRA ACCOUNTS IN 2018		
HIRE/BENEFIT ELIGIBILITY MONTH	**NUMBER OF MONTHS COUNTED TOWARD CONTRIBUTION AMOUNT**	**PRORATION FACTOR**
November/December 2017	12	1.00
January 2018	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 HSA Works

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

Your BenefitWallet HSA will not become active until after the date you have completed the enrollment process, your Plan HSA enrollment has been received and your Plan HSA coverage becomes effective. Unless your Plan HSA 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.

Once an HSA checking account balance reaches $1,000, you generally may set up a BenefitWallet Investment Account and begin to diversify your accumulated HSA savings in excess of $1,000 among a selection of investment funds. **Note:** A minimum of $1,000 must remain in your BenefitWallet HSA Checking Account.

A fee of $2.90 per month is charged if you choose to use the BenefitWallet HSA investment platform. There are no additional transaction fees, loads or commissions.

If you participate in Plan HSA and leave BNY Mellon, you will be charged $3.25 per month as an account maintenance fee to keep your checking account open plus $2.90 per month if you continue to invest your HSA.

You must be enrolled in Plan HSA to contribute to a Health Savings Account.

Federal law states that you cannot contribute to an HSA if you:

- are covered by any other health plan (as an individual, spouse or domestic partner) that is not a qualifying high-deductible health plan, 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 (Part A, Part B, etc.) or Tricare; or
- are claimed as a dependent on another individual's federal tax return.

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

If you choose to participate in both Plan HSA and BNY Mellon's Limited Purpose Flexible Spending Account for health care reimbursement, you may use the accounts for eligible dental and vision expenses. Also, once you meet the Plan HSA deductible, you may use the account for other eligible medical expenses.

Activating Your Account

If you elect Plan HSA, you will be given the BenefitWallet HSA terms and conditions. Once you agree to those terms and conditions, your electronic signature will be used to activate your HSA on your plan effective date. You will also receive a packet of information and a Master Signature Card in the mail, as well as additional information on how to use your HSA. To receive a checkbook and provide beneficiary information to BenefitWallet, you will need to sign and return the Master Signature Card by mail. To finalize opening your account, you will also be required to provide certain information as required by the U.S. Patriot Act (including such items as name, address, date of birth, Social Security number, etc.). Separately, you will be mailed two health care payment (debit) cards. Once you reach your plan effective date, as long as your HSA is activated, you can use your HSA checkbook and health care payment card to pay for prescription drugs or other qualified health care expenses up to your available account balance. (When you stay in-network, your provider will file claims for you to ensure that you receive the higher, in-network level of benefits.)

Contributing to Your Account

If you elect Plan HSA, BNY Mellon will contribute to your HSA on or before your first pay following your plan effective date and you can make your own pre-tax contributions through semi-monthly payroll deductions (which you can change monthly). Alternatively, you may make a lump-sum contribution (see "Lump-Sum Contribution" on page 46 for more information).

Additionally, if you are enrolled in a BNY Mellon health plan in 2018, you and/or your covered spouse/domestic partner can each unlock up to $600 in health account deposits to your HSA (up to maximum annual limits) by participating in certain wellbeing activities. Consider this additional contribution when you determine your annual HSA contribution, as this additional amount is included when calculating to the IRS combined maximum annual contribution amount as outlined above. See "Payroll Deductions" on page 45 and "More Ways That Pay" on page 16 for more information.

The maximum annual amount you can contribute to an HSA is shown in "Health Savings Account (HSA) Contributions" on page 42. This amount is determined by subtracting BNY Mellon's contribution and any wellbeing incentives you earn from the maximum annual contribution allowed by the IRS. Depending on how much you choose to contribute, your total annual contributions (plus BNY Mellon contributions) can cover the full cost of your annual deductible. This means you would be able to cover any qualified health care expenses leading up to your deductible using pre-tax money (based on federal taxes).

Please Note: Once you enroll in any part of Medicare, including Part A, Part B and/or Part D coverage, you will no longer be eligible to contribute to an HSA and will not be eligible to receive any BNY Mellon contributions. To the extent that contributions are made to your HSA after your Medicare coverage starts, you may be subject to a tax penalty. If you would like to continue contributing and/or receiving BNY Mellon's automatic contributions to your HSA, you should not apply for any part of Medicare, Social Security or Railroad Retirement Board (RRB) benefits.

Using Your Account

You decide how to spend the money in your HSA. You can use your HSA to help meet your annual deductible or pay other qualified health care expenses that may not be covered by the Plan, such as dental and vision. You also can choose to pay expenses out of your own pocket and save your HSA balance for future expenses, including retiree medical premiums and other qualified health care expenses. For more information about qualified health care expenses, visit **www.mybenefitwallet.com**.

If you use all the money in your Health Savings Account before you meet the annual deductible, you'll be responsible for paying additional health care costs—up to the annual out-of-pocket maximum—out of your own pocket.

If you do not use all the money in your HSA, you can leave it there for future use. After your account balance reaches $1,000, you will generally have access to investment options offered through BenefitWallet. In the event the investment account falls below $1,000, contributions will be deposited to the HSA checking account until the balance again reaches $1,000. If you choose an automatic sweep of your contributions to your investment account, the automatic sweep will not occur unless the balance reaches $1,000. For more information about HSA investment options, visit **www.mybenefitwallet.com**.

Making Your Elections

Here's what you need to do to contribute to the HSA:

1. Choose a coverage level of Individual, Employee + Child(ren), Employee + Spouse/Domestic Partner or Employee + Family.*
2. Decide how much to contribute to your account annually. You may supplement BNY Mellon's HSA contributions with your own pre-tax contributions and earned wellbeing health account deposits. See "Health Savings Account (HSA) Contributions" on page 42 for your maximum permitted contribution amount.
3. Choose how you will contribute to your HSA. 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 HSA. See "How the HSA Works" on page 43 for details.

Payroll Deductions

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 HSA. See "How the HSA Works" on page 43 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, HSA 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 HSA pre-tax payroll contributions and wellbeing health account deposits to assist in ensuring that IRS contribution limits are not exceeded, please note that it is your responsibility to determine whether your total HSA contributions exceed the maximum IRS contribution limits in a particular year. If your total HSA contributions (including your own post-tax contributions, pre-tax payroll contributions, wellbeing health account deposits 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 Contribution

If you wish, you may contribute to your HSA by lump-sum payment, using either a deposit slip from an HSA 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 HSA checkbook.

Note: Lump-sum contributions are made using after-tax money, but you may deduct the after-tax HSA contributions on your 2018 federal income tax return. You also may delay making your lump-sum contribution up to the time you timely file your 2018 federal income tax return.

Roll-overs or Transfers

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

After You Enroll

You will receive:

– an Aetna or UnitedHealthcare medical card(s) to use when you seek health care; you will show this card to get discounts from providers, including doctors and hospitals.

– a CVS Caremark prescription drug card(s) to present when filling prescriptions at a participating pharmacy and when receiving discounted services at a CVS MinuteClinic®;

– an HSA Welcome Kit, which will include instructions on how to manage and use your HSA. Follow account activation instructions in the Welcome Kit to open your HSA and receive two debit cards. If you want to receive a checkbook and/or designate a beneficiary, you will need to fill out and return the signature card included in your Welcome Kit to BenefitWallet. The Welcome Kit also provides instructions on how to access the HSA website at **www.mybenefitwallet.com**, offering more information on how you can manage your HSA.

If You Change Your Plan Option in the Future

If you select Plan HSA and decide in a subsequent year to change to a non-HSA qualified plan, any remaining balance in the HSA continues to be available for your use in covering qualified health care expenses and/or can be saved.

The HSA will remain open. However, you will not be eligible to make contributions into it until you are again covered under Plan HSA or another high-deductible health plan. As long as amounts in the HSA were contributed while you were eligible, you can continue to use the HSA when you are covered by a non-HSA plan. Additionally, you will be charged $2.90 per month if you continue to invest your HSA.

In the Event of Disability

If you become disabled and are receiving Short-Term Disability benefits, you will remain eligible to receive BNY Mellon's annual contribution to your HSA and may continue to make pre-tax contributions to your HSA while receiving pay from BNY Mellon. If your pay ends, your payroll contributions to the HSA will cease at the same time. However, you may make after-tax contributions directly to your HSA. These after-tax contributions will be deductible on your 2018 federal income tax return.

If you transition to Long-Term Disability status, you will no longer be eligible to receive BNY Mellon contributions and can no longer make pre-tax payroll contributions to your HSA because your pay from BNY Mellon ends. However, you may make after-tax contributions directly to your HSA. These after-tax contributions will be deductible on your 2018 federal income tax return.

In the event that you transition to Long-Term Disability status and subsequently become enrolled in any part of Medicare (including Part A, Part B, etc.) or Tricare, you will no longer be eligible to contribute to your HSA. However, your HSA will remain available for your use in paying qualified health care expenses.

Since transition to Long-Term Disability status is considered a qualified life event, you may change your health plan coverage at the time of this status change. If, in doing so, you opt out of the Plan HSA, your HSA will remain open and any remaining balance in that account will continue to be available for your use in paying qualified health care expenses.

Note, however, even if you cease to be eligible to make contributions to your HSA, you will be charged $2.90 per month if you elect to continue to invest your HSA.

In the Event of Your Death

In the event of your death, the disposition of amounts remaining in your HSA depends on whom you name as your beneficiary:

- **Spouse as designated beneficiary.** If your spouse is your designated beneficiary, the account will be treated as your spouse's HSA after your death. Qualified HSA distributions are not subject to federal income tax. If your spouse is covered by a qualified high-deductible health plan, contributions to the account may also not be subject to federal income tax, up to maximum annual contribution limits.
- **Non-spouse as designated beneficiary.** If you designate someone other than your spouse as the beneficiary of your HSA:
  - The savings account stops being an HSA on the date of your death;
  - The fair market value of the HSA becomes taxable (without penalties) to the beneficiary in the year in which you die; and
  - The amount taxable to a beneficiary (other than your estate) is reduced by any qualified health care expenses you incurred prior to your death that are paid from the HSA by the beneficiary within one year after the date of death.
- **Your estate as beneficiary.** If your estate is the beneficiary of your HSA, the value of your HSA is included on your final income tax return.
- **No designated beneficiary on file.** If you do not designate a beneficiary or if your existing beneficiary designation is invalid, your HSA will be paid to your spouse if he or she is living or, if you are not married or your spouse is not living, then your HSA will be paid out according to applicable law of your state of domicile at the time of your death or, if you have no heir then-living, your HSA will be paid to your estate.

Important Notice

The Health Savings Account is offered in conjunction with Plan HSA as a voluntary benefit directly by BenefitWallet. The HSA is not part of The Bank of New York Mellon Health and Welfare Plan and is not governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). BNY Mellon neither endorses BenefitWallet as the HSA vendor, nor is it sponsoring the HSA program. BNY Mellon's role with respect to the HSA is limited to permitting contributions to the HSA on your behalf. For more information about the HSA, we encourage you to contact the BenefitWallet Service Center at 1-877-472-4200 or **www.mybenefitwallet.com**. Please also note, the HSA is neither a COBRA-covered benefit, nor is it funded through a trust arrangement.

Your HSA, once established, will be a checking account and, if certain threshold limits are met, you may be eligible to invest your HSA in certain mutual funds. BenefitWallet determines whether you are eligible, and qualify, for investing your HSA in its pre-determined investment options. Please carefully review the agreement provided by BenefitWallet for your rights and responsibilities when participating in such an arrangement. Each fund has a particular investment objective and, accordingly, the degree of risk involved and the potential for long-term appreciation (or depreciation) will vary. You may call BenefitWallet at 1-877-472-4200 to request written materials, including a current prospectus, for each of the funds. You may also obtain written materials, including a current prospectus, by accessing the BenefitWallet website at **www.mybenefitwallet.com**. Please refer to the prospectus for each fund for detailed information and financial data pertaining to that fund. BenefitWallet, in its sole and absolute discretion, selects the investment funds and may in the future change the available funds and the procedures for investing your HSA in one or more of these funds.

Plan HSA Details

With Plan HSA, you pay a lower per-pay cost. In exchange, you have a higher deductible—$1,600 for an individual or $3,200 for a family in and out-of-network—if you need care. Also, the out-of-pocket maximum is higher.

PLAN HSA				
	IN-NETWORK		OUT-OF-NETWORK	
Deductible	$1,600 individual	$3,200 family[1] *true family deductible*[2]	$1,600 individual	$3,200 family[1] *true family deductible*[2]
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**
$0 – $29,999	$2,400	$4,800	$4,800	$9,600
$30,000 – $49,999	$3,900	$7,800[4]	$7,800	$15,600
$50,000 – $79,999	$5,500	$11,000[4]	$11,000	$22,000
$80,000 – $124,999	$6,350	$12,700[4]	$14,200	$28,400
$125,000 and above	$6,350	$12,700[4]	$15,600	$31,200
Services				
Office Visits (Family/General Practice, Internal Medicine, Pediatrician, Ob/Gyn)	80%[5]		60%[5]	
Preventive Care, Routine Physicals (Adult and Child), Mammograms, Well Childcare (immunizations)	100% (no deductible)		60%[5]	
Mental Health, Behavioral Health and Substance Abuse (inpatient and outpatient t services)	80%[5]		60%[5]	
Outpatient Surgery	80%[5]		60%[5]	
Hospital Care	80%[5]		60%[5]	
Emergency Room	80%[5]			
Physical, Speech and Occupational Therapy	80%[5] (Combined in- and out-of-network limit of 60 visits per calendar year for combined therapies)		60%[5] (Combined in- and out-of-network limit of 60 visits per calendar year for combined therapies)	
Infertility	Plan pays up to $25,000 lifetime medical maximum benefit (in addition to $10,000 lifetime drug maximum benefit)[6,9]			
Hearing Aid (per member)	Plan pays up to $5,000 every two years			
Bariatric Services	80%[2,5,10], must be obtained from an Aetna Institute of Quality or a UHC Center of Excellence			
Joint and Spine Surgery	100%[2], if performed at an Aetna Institute of Quality or UHC Center of Excellence 80%[2], if performed at any other in-network facility		60%[2]	
Organ Transplant	80%[2], must be obtained from an Aetna Institute of Quality or a UHC Center of Excellence			
Applied Behavior Analysis (ABA) Therapy	80%[5]		60%[5]	
Lifetime Maximum Benefit (per member)	Unlimited			

PLAN HSA		
	IN-NETWORK	**OUT-OF-NETWORK**
Prescription Drugs (In-Network Only)		
Retail	**Preventive Drugs** – Generic: Lesser of $10 or retailer's regular cost – Formulary (Preferred) Brand: 25% coinsurance ($50 minimum; $75 maximum) – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance ($75 minimum; $100 maximum) **Non-Preventive Drugs** – Generic: 20% coinsurance after deductible – Formulary (Preferred) Brand: 20% coinsurance after deductible – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance after deductible	
Mail Order[7]	**Preventive Drugs** – Generic: Lesser of $25 or regular discount cost – Formulary (Preferred) Brand: 25% coinsurance ($125 minimum; $187.50 maximum) – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance ($187.50 minimum; $250 maximum) **Non-Preventive Drugs** – Generic: 20% coinsurance after deductible – Formulary (Preferred) Brand: 20% coinsurance after deductible – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance after deductible	
Specialty	– Generic: 20% coinsurance after deductible[8] – Formulary (Preferred) Brand: 20% coinsurance after deductible[8] – Non-Formulary (or Non-Preferred) Brand: 40% coinsurance after deductible	

[1] Family applies to the Employee + Child(ren), Employee + Spouse,/Domestic Partner or 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 a $3,200 deductible before any coinsurance will be paid.

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

[4] Plan HSA out-of-pocket expenses paid for an individual family member are limited to no more than $6,850 for in-network coverage before Plan HSA reimburses 100 percent of eligible expenses.

[5] After deductible.

[6] 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.

[7] 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.

[8] Drugs filled outside of the CVS Caremark network will initially be denied, and you will 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.

[9] 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. Contact your medical plan provider for more information.

[10] 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.

How the Health Accounts Compare

	HEALTH SAVINGS ACCOUNT	HEALTH REIMBURSEMENT ACCOUNT	LIMITED PURPOSE HEALTH REIMBURSEMENT ACCOUNT*	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT
Who owns it?	Employee	BNY Mellon	BNY Mellon	BNY Mellon	BNY Mellon
Who contributes to the account?	BNY Mellon and employee	BNY Mellon	BNY Mellon	Employee	Employee
Can unused amounts carry or roll over?	Yes	Yes	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	No	No
Is the account subject to COBRA continuation?	No	Yes	Yes	Yes	Yes
How are contributions made?	Through BNY Mellon and employee contributions	Through BNY Mellon contributions	Through BNY Mellon contributions while covered by Plan HRA	Employee contributions	Employee contributions
Is there a contribution limit?	Yes. The 2018 limits are $3,450 for individual coverage and $6,850 for dependent coverage, as established by the IRS.	BNY Mellon contributions based on base pay while covered under Plan HRA	BNY Mellon contributions based on base pay while covered under Plan HRA	Yes. The 2017 limit is $2,600 for Health Care FSA as established by the IRS.	Yes. The 2017 limit is $2,600, 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	No	No
What are the tax benefits for employees?	BNY Mellon and employee contributions are tax-free. Withdrawals/reimbursements for qualified health care expenses are tax-free.	BNY Mellon contributions are tax-free. Reimbursements for qualified health care expenses are tax-free.	BNY Mellon contributions are tax-free. Reimbursements for qualified health care expenses are tax-free.	Employee contributions are tax-free, which reduces annual taxable income. Reimbursements for qualified health care expenses are tax-free.	Employee contributions are tax-free, which reduces annual taxable income. Reimbursements for qualified health care expenses are tax-free.

	HEALTH SAVINGS ACCOUNT	HEALTH REIMBURSEMENT ACCOUNT	LIMITED PURPOSE HEALTH REIMBURSEMENT ACCOUNT*	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT
What health care expenses can be paid from the account?	Any qualified health care 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, including health insurance and long-term care insurance premiums. Long-term care services and premiums under employer pre-tax plans 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 HRA deductible has been satisfied.	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 HSA deductible has been satisfied.
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	No	No
Can COBRA premiums be reimbursed from the account?	Yes. Distributions to pay premiums reimbursed for COBRA are tax-free.	Yes. COBRA premiums may be reimbursed from the account.	Yes. COBRA premiums may be reimbursed from the account.	No	No
Must a qualified health care expense occur during the plan year the contribution is made?	No. You cannot use HSA contributions to pay for expenses incurred prior to establishing the HSA; however, you can use contributions to pay for eligible expenses incurred after establishing the HSA even if you are no longer covered under an HSA.	No. You cannot use HRA contributions to pay for expenses incurred prior to establishing the HRA; however, you can use contributions to pay for eligible expenses incurred after establishing the HRA even if you are no longer covered under the HRA.	No. You cannot use Limited Purpose HRA contributions to pay for expenses incurred prior to establishing the HRA; however, you can use contributions to pay for eligible expenses incurred after establishing the HRA even if you are no longer covered under the HRA.	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	Yes	No
Are other accounts available at the same time?	Only with a Limited Purpose FSA	Only with a traditional FSA	Only with an HSA and Limited Purpose FSA	Only with an HRA	Only with an HSA

* If you select Plan HRA and decide the following year to change to Plan HSA, your Health Reimbursement Account will become a Limited Purpose Health Reimbursement 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 domestic partner's plan, including a general purpose Health Care FSA or HRA, or are covered by any part of Medicare (including Part A, Part B, etc.) or Tricare, by federal law, you aren't eligible for the HSA. (This is an IRS rule.)

New Health Plan ID Card

You will receive a new 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.

Castlight: Make Informed Health Care Choices

If you participate in BNY Mellon sponsored Plan HRA or Plan HSA 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/domestic partner or your parents/parents-in-law:

– **InterConsultation** 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 or 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 InterConsultation 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.

Illustrated Plan Comparisons

Review the hypothetical examples on the following pages to understand how these plans might work for your situation. You can review a year of health care plan use by:

– John, a relatively healthy 25-year-old who takes a daily medication to treat gastro esophageal reflux disease.

– Megan and Matt, a relatively healthy couple in their 50s. Matt takes a daily medication to treat his chronic thyroid condition.

– The Smiths have been a relatively healthy family, but now Alice has learned that she has breast cancer.

John is a relatively healthy 25 year old and enrolled in Employee Only coverage. He takes a daily medication to treat gastroesophageal reflux disease. John's annual base salary is $60,000 – see how both options work for him.

	Plan HRA (Health Reimbursement Account)				Plan HSA (Health Savings Account)			
	Cost of Coverage	Plan Coverage			Cost of Coverage	Plan Coverage		
2018 health plan premium[1]:	$1,924				$940			
Premium reduction for completing biometric screening and WBA:	($400)	DEDUCTIBLE	OUT-OF-POCKET MAXIMUM		($400)	DEDUCTIBLE	OUT-OF-POCKET MAXIMUM	
TOTAL 2018 HEALTH PLAN PREMIUM:	**$1,524**	John pays 100% of $1,000 deductible[2]	John pays 20% coinsurance[2] up to $3,750 out-of-pocket maximum[1]	After out-of-pocket maximum is met, BNY Mellon covers 100%[2,3]	**$540**	John pays 100% of $1,600 deductible[2]	John pays 20% coinsurance[2] up to $5,500 out-of-pocket maximum[1]	After out-of-pocket max is met, BNY Mellon covers 100%[2,3]
2018 Account contributions[1]:	$400				$400			
Health account deposits for participating in wellbeing activities:	$600		**$1,000** HRA		$600		**$1,000** HSA	
TOTAL 2018 ACCOUNT:	**$1,000**				**$1,000**			

PAYING FOR CARE[2]	**From the HRA, John pays...**	**Out-of-pocket, John pays…**	**BNY Mellon pays…**	**From the HSA, John pays...**	**Out-of-pocket, John pays…**	**BNY Mellon pays…**
1/1: John purchases 90-day mail order Omeprazole (non-preventive, generic) – **$30**	**$25** generic mail order copay counts towards the out-of-pocket maximum **$975 HRA**	**$0**	the remaining **$5**	$30 toward the $1,600 deductible and the out-of-pocket maximum **$970 HSA**	$0	$0
3/13: John tears his ACL playing hockey. His treatment includes a visit to the ER, an MRI, surgery and physical therapy – **$6,570**	**$975** toward the $1,000 deductible and the out of-pocket maximum **$0 HRA**	**$1,139** ($25 to meet the $1,000 deductible and $1,114 or 20% coinsurance on the remaining $5,570)	the remaining **$4,456** (80% coinsurance, after the deductible)	$970 toward the $1,600 deductible and the out-of-pocket maximum **$0 HSA**	**$1,600** ($600 to meet the $1,600 deductible and $1,000 or 20% coinsurance on the remaining $5,000)	the remaining **$4,000** (80% coinsurance, after the deductible)
4/1: John purchases 90-day mail order Omeprazole (non-preventive, generic) – **$30**		the **$25** generic mail order copay counts towards the out-of-pocket maximum	the remaining **$5**		**$6** (20% coinsurance)	the remaining **$24** (80% coinsurance, after the deductible)
6/10: John gets a Preventive Care Physical – **$150**		**$0**	**$150**		**$0**	**$150**
7/1: John purchases 90-day mail order Omeprazole (non-preventive, generic) – **$30**		the **$25** generic mail order copay counts towards the out-of-pocket maximum	the remaining **$5**		**$6** (20% coinsurance)	the remaining **$24** (80% coinsurance, after the deductible)
10/1: John purchases 90-day mail order Omeprazole (non-preventive, generic) – **$30**		the **$25** generic mail order copay counts towards the out-of-pocket maximum	the remaining **$5**		**$6** (20% coinsurance)	the remaining **$24** (80% coinsurance, after the deductible)
11/28: John gets a Preventive Care Flu Shot – **$15**		**$0**	**$15**		**$0**	**$15**

For the year, John …	**spent $3,738 on his total cost of care.** • $1,524 health plan premium • $1,000 paid from HRA (BNY Mellon-funded) • $1,214 out-of-pocket medical and prescription drug expenses	**spent $3,158 on his total cost of care.** • $540 health plan premium • $1,000 paid from HSA (BNY Mellon-funded) • $1,618 out-of-pocket medical and prescription drug expenses (John would have saved money if he had contributed to his HSA and paid for these expenses with pre-tax dollars)

[1] Based on salary and preferred carrier premium
[2] In-network only
[3] Includes deductible

Note: The people and circumstances depicted in these example are fictional, not actual BNY Mellon employees or plan participants.

Megan and Matt Jones are a relatively healthy couple in their 50s and enrolled in Employee + Spouse coverage. Matt takes a daily medication to treat his chronic thyroid condition. Megan's annual base salary is $120,000 — see how both options work for them.

	Plan HRA (Health Reimbursement Account)				Plan HSA (Health Savings Account)			
	Cost of Coverage	Plan Coverage			Cost of Coverage	Plan Coverage		
2018 health plan premium[1]:	$6,344				$2,936			
Premium reduction for completing biometric screening and WBA:	($800)				($800)			
		DEDUCTIBLE	OUT-OF-POCKET MAXIMUM			DEDUCTIBLE	OUT-OF-POCKET MAXIMUM	
TOTAL 2018 HEALTH PLAN PREMIUM:	**$5,544**	They pay 100% of $2,000 deductible[2]	They pay 20% coinsurance[2] up to $9,500 out-of-pocket maximum[1]	After out-of-pocket maximum is met, BNY Mellon covers 100%[2,3]	**$2,136**	They pay 100% of $3,200 deductible[2,4]	They pay 20% coinsurance[2] up to $12,700 out-of-pocket maximum[1] for the family, but $6,850 per person	After out-of-pocket max is met, BNY Mellon covers 100%[2,3]
2018 Account contributions[1]:	$400				$400			
Health account deposits for participating in wellbeing activities:	$1,200		**$1,600** HRA		$1,200		**$1,600** HSA	
TOTAL 2018 ACCOUNT:	**$1,600**				**$1,600**			

PAYING FOR CARE[2]	**From the HRA, the Joneses pay...**	**Out-of-pocket, the Joneses pay…**	**BNY Mellon pays…**	**From the HSA, the Joneses pay...**	**Out-of-pocket, the Joneses pay…**	**BNY Mellon pays…**
1/1: Matt purchases 90-day mail order Levothyroxine (non-preventive, generic) – **$15**	**$15** cost (lesser of drug cost or $25 copay) counts towards the out-of-pocket maximum **$1,585 HRA**	**$0**	**$0**	**$15** toward the $3,200 deductible and the out-of-pocket maximum **$1,585 HSA**	**$0**	**$0**
2/17: Megan gets Well Woman Exam, including mammogram – **$300**	**$0**	**$0**	**$300**	**$0**	**$0**	**$300**
4/1: Matt purchases 90-day mail order Levothyroxine (non-preventive, generic) – **$15**	**$15** cost (lesser of drug cost or $25 copay) counts towards the out-of-pocket maximum **$1,570 HRA**	**$0**	**$0**	**$15** toward the $3,200 deductible and the out-of-pocket maximum **$1,570 HSA**	**$0**	**$0**
4/11: Matt gets a Preventive Care Physical – **$150**	**$0**	**$0**	**$150**	**$0**	**$0**	**$150**
7/1: Matt purchases 90-day mail order Levothyroxine (non-preventive, generic) – **$15**	**$15** cost (lesser of drug cost or $25 copay) counts towards the out-of-pocket maximum **$1,555 HRA**	**$0**	**$0**	**$15** toward the $3,200 deductible and the out-of-pocket maximum **$1,555 HSA**	**$0**	**$0**
10/1: Matt purchases 90-day mail order Levothyroxine (non-preventive, generic) –**$15**	**$15** cost (lesser of drug cost or $25 copay) counts towards the out-of-pocket maximum **$1,540 HRA**	**$0**	**$0**	**$15** toward the $3,200 deductible and the out-of-pocket maximum **$1,540 HSA**	**$0**	**$0**
11/28: Megan and Matt both have age-recommended cancer-screening colonoscopies – **$5,000**	**$0**	**$0**	**$5,000**	**$0**	**$0**	**$5,000**

For the year, Megan and Matt…	**spent $5,604 on their total cost of care.**	**spent $2,196 on their total cost of care.**
	• $5,544 health plan premium • $60 paid from HRA (BNY Mellon-funded) • $0 out-of-pocket medical and prescription drug expenses	• $2,136 health plan premium • $60 paid from HSA (BNY Mellon-funded) • $0 out-of-pocket medical and prescription drug expenses

[1] Based on salary and preferred carrier premium
[2] In-network only
[3] Includes deductible
[4] 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 a $3,200 deductible before any coinsurance will be paid.

Note: The people and circumstances depicted in these example are fictional, not actual BNY Mellon employees or plan participants.

The Smiths have been a relatively healthy family and are enrolled in Employee + Family coverage, but now Alice has learned that she has breast cancer. Nick's annual base salary is $60,000 – see how both options work for them.

	Plan HRA (Health Reimbursement Account)				Plan HSA (Health Savings Account)			
	Cost of Coverage	Plan Coverage			Cost of Coverage	Plan Coverage		
2018 health plan premium[1]:	$6,392				$2,780			
Premium reduction for completing biometric screening and WBA:	($800)				($800)			
		DEDUCTIBLE	OUT-OF-POCKET MAXIMUM			DEDUCTIBLE	OUT-OF-POCKET MAXIMUM	
TOTAL 2018 HEALTH PLAN PREMIUM:	**$5,592**	They pay 100% of $2,000 deductible[2]	They pay 20% coinsurance[2] up to $7,500 out-of-pocket maximum[1]	After out-of-pocket maximum is met, BNY Mellon covers 100%[2,3]	**$1,980**	They pay 100% of $3,200 deductible[2,4]	They pay 20% coinsurance[2] up to $11,000 out-of-pocket maximum,[1] for the family, but $6,850 per person	After out-of-pocket max is met, BNY Mellon covers 100%[2,3]
2018 Account contributions[1]:	$800				$800			
Health account deposits for participating in wellbeing activities:	$1,200		**$2,000** HRA		$1,200		**$2,000** HSA	
TOTAL 2018 ACCOUNT:	**$2,000**				**$2,000**			

PAYING FOR CARE[2]	**From the HRA, the Smiths pay...**	**Out-of-pocket, the Smiths pay…**	**BNY Mellon pays…**	**From the HSA, the Smiths pay...**	**Out-of-pocket, the Smiths pay…**	**BNY Mellon pays…**
1/1: Nick and Alive get annual physicals – **$300**	**$0**	**$0**	**$300**	**$0**	**$0**	**$300**
2/17: Alice gets a mammogram and discovers she has breast cancer. Her treatment includes chemotherapy – **$22,100** (including $100 mammogram)	**$1,000** toward Alice's $1,000 individual deductible and $1,000 toward Alice's coinsurance liability **$0 HRA**	**$1,750** toward Alice's coinsurance liability, capped at the $3,750 individual out-of-pocket maximum	the remaining **$18,350** ($100 for the mammogram and $18,250 after Alice hits her individual out-of-pocket maximum)	**$2,000** toward the $3,200 deductible[4] and the out-of-pocket maximum **$0 HSA**	**$4,850** ($1,200 to meet the $3,200 deductible and coinsurance of $3,650. After meeting the deductible, Alice would be responsible for 20% of the remaining $18,000 until the individual out-of-pocket maximum of $6,850 is met)	the remaining **$15,250** (80% coinsurance after deductible and $100 for the mammogram and 100% coinsurance after the individual out-of-pocket maximum)
4/6: Nick is diagnosed with a bacterial sinus infection. The office visit costs **$150**, and amoxicillin (non-preventive, generic) costs **$10**		**$150** toward Nick's $1,000 individual deductible (or the Smith's $2,000 family deductible) and the $10 generic retail copay counts towards the out-of-pocket maximum	$0		**$32** (20% coinsurance)	the remaining $128 (80% coinsurance, after deductible)
7/10: Sally, Tim and Joe get Well-Child exams – **$600**		**$0**	**$600**		**$0**	**$600**
10/15: Tim is diagnosed with strep throat. The office visit and lab work costs **$180**, and amoxicillin (non-preventive, generic) costs **$10**		**$180** toward Tim's $1,000 individual deductible (or the Smith's $2,000 family deductible) and the $10 generic retail copay counts towards the out-of-pocket maximum	$0		**$38** (20% coinsurance)	the remaining **$152** (80% coinsurance, after deductible)

For the year, the Smiths…	**spent $9,692 on their total cost of care.** • $5,592 health plan premium • $2,000 paid from HRA (BNY Mellon-funded) • $2,100 out-of-pocket medical and prescription drug expenses	**spent $8,900 on their total cost of care.** • $1,980 health plan premium • $2,000 paid from HSA (BNY Mellon-funded) • $4,920 out-of-pocket medical and prescription drug expenses (Nick would have saved money if he had contributed to his HSA and paid for these expenses with pre-tax dollars)

[1] Based on salary and preferred carrier premium
[2] In-network only
[3] Includes deductible
[4] 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 a $3,200 deductible before any coinsurance will be paid.

Note: The people and circumstances depicted in these example are fictional, not actual BNY Mellon employees or plan participants.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside money from your pay before it is taxable. 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.

YOUR FSA OPTIONS	
Health Care FSA	***Dependent Care FSA***
No participation	No participation
Contribute up to $2,600 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 health care and eligible dependent care expenses that are incurred from January 1, 2018, through December 31, 2018, as an active employee. You must submit all claims by the reimbursement deadline of **June 30, 2019**. Please note that you may carry over $500 each year from your Health Care FSA for use in the following year.

Important Reminders

- You must re-enroll each year to participate in either of the FSAs.
- Expenses for your domestic partner and your domestic partner's children generally are not eligible for reimbursement through either of the FSAs.
- By law, if you enroll in Plan HSA, you may not participate in the Health Care FSA; however, you may participate in the Limited Purpose FSA that will allow you to pay for non-medical health care expenses, like dental, vision, preventive prescription drugs and out-of-network preventive care benefits.
- If you enroll in Plan HSA, you may submit for reimbursement from the Limited Purpose FSA medical expenses you incur after satisfying the Plan HSA deductible. You must submit documentation showing that the deductible has been met, along with your first post-deductible expense reimbursement submission to "Your Spending Account."
- 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

It's easy to use FSAs. Here's how they 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 most 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 health care expenses and eligible dependent care expenses, using tax-free dollars. Except for the $500 Health Care FSA carryover from your 2018 health care FSA for use in the 2019 plan year, claims against your 2018 FSAs must be submitted by the reimbursement deadline of June 30, 2019. Note: If you have a Health Care FSA, you may use your FSA debit card to pay for qualified health care expenses, or pay out-of-pocket and submit a claim for reimbursement.
4. Use MyBenefit Solutions (via MyReward or at **http://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

When you elect to contribute to a Health Care FSA, you can use a debit card to pay for qualified health care expenses at the point of purchase. Your Spending Account 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 a Your Spending Account 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 **http://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 **http://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 **http://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 **http://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 **http://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 health care expenses include deductibles, copayments, prescriptions and certain over-the-counter items (insulin, over-the-counter drugs for which you have a valid prescription and 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 health care 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, 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 18 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, 2019, to claim reimbursement for eligible expenses incurred during 2018.
– 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 an HRA or HSA, nor deduct those expenses on your federal income tax return. Similarly, 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, if you participate in a high-deductible health plan like Plan HSA, you may not participate in a traditional Health Care FSA. Your HSA will help you pay for qualified health care expenses not covered by Plan HSA and for eligible dental and vision expenses not paid by your dental and vision plans.

To also help you pay eligible health care expenses, you can enroll in the Limited Purpose FSA. (Unlike the HSA, though, participation in the Limited Purpose FSA is not automatic when you enroll in Plan HSA). For 2018, you can contribute up to $2,600 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 HSA annual deductible, other qualified health care 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) you will lose any Limited Purpose FSA contributions you do not use—so plan carefully.

Things to Consider

Here are some things to consider as you make your Health Care FSA decision.

– How much do you think you (and your family) will spend out of pocket on medical and dental plan expenses?
– How much of your own money will you (and your family) be spending in 2018 on non-covered expenses like prescription sunglasses?
– Do you (and your family) regularly take medication for which you can predict costs for the year?
– How much have you (and your family) spent from your own pocket on health care needs in the past?

Here are some things to consider as you make your Dependent Care FSA decision.

– How much do you spend on childcare or eldercare during the year?
– Are there changes ahead that are likely to require daycare for a dependent?
– Have you estimated your taxes using both the Dependent Care Tax Credit and the Dependent Care FSA to see which provides a better tax break for you?

Dental and Vision

BNY Mellon provides a choice of dental and vision plans. For 2018, you'll have a choice of three dental plans and one vision plan.

All of 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.

Dental Coverage

Dental coverage helps with the cost of routine dental care and major services for 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/Domestic Partner

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

2018 Dental Contributions

The rates shown in the table below are 2018 semi-monthly dental plan contribution amounts. This is the amount that will be withheld from each paycheck per pay period for eligible full-time and part-time employees.

2018 SEMI-MONTHLY EMPLOYEE CONTRIBUTIONS (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/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 issue 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).

MetLife 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.

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.

	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]

	METLIFE PDP OPTION 1		METLIFE PDP OPTION 2	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
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
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, Employee + Spouse/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 only receive a benefit 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 primary dentist, 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

AETNA DMO[1]	
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 primary dentist 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.

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 56) 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 Coverage

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/Domestic Partner

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

2018 Vision Contributions

The rates shown in the table below are 2018 semi-monthly vision plan contribution amounts. This is the amount that will be withheld from each paycheck per pay period for eligible full-time and part-time employees.

2018 SEMI-MONTHLY EMPLOYEE CONTRIBUTIONS (THE AMOUNT BELOW WILL BE WITHHELD FROM EACH PAYCHECK)	
Employee	$3.48
Employee + Child(ren)	$6.95
Employee + Spouse/Domestic Partner	$7.65
Employee + Family	$11.82

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.**

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.

Financial Protection

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, which can help you make comprehensive, integrated financial decisions.

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 long-term disability coverage through Liberty Mutual 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). For commissioned employees, the LTD payment is determined using a percentage of your Annual Benefits Base Rate (ABBR). In addition, your base pay or ABBR used in determining LTD benefits will be capped at $300,000.

Note: Liberty Mutual became the LTD administrator as of July 1, 2017. Prudential will continue to administer LTD claims that were effective before July 1, 2017.

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.

– Does your spouse/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 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/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 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.

DESCRIPTION AND CHOICES		
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.
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/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, 2018, the level of coverage you select and your base pay as of September 1, 2017, 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 and supplemental 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 on which you must pay taxes (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.

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 (7) 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/Domestic Partner Life Insurance

This benefit provides life insurance coverage for your spouse or 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 Reimbursement Accounts, 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.

Because Ayco's financial coaches have been specially trained in BNY Mellon's benefit programs, they can help you make comprehensive and integrated financial decisions, when you enroll and all year long.

Ayco financial coaches provide confidential, unlimited, personalized, one-on-one financial counseling over the phone, including:

– Counseling for everyday financial decisions, like balancing a budget, saving for a major purchase or handling credit card debt;

– Help planning for big decisions and life events, such as enrolling in benefits, purchasing a home or planning for college; and

– Tax planning strategies, investment planning, estate planning, retirement planning and more.

The Aycofn® website offers a powerful suite of interactive tools, including:

– **Ayco360:** Navigate the personal dashboard that allows you to see your financial life all in one place. You can choose to link your bank account, credit cards, investments and other accounts into Ayco360. The dashboard is refreshed daily with current account information.

– **MyLearning Center:** Find videos, articles and interactive content.

– **5 Minute Financial Checkup:** Take a quick assessment of your financial strengths and challenges.

If you participate in a telephonic coaching session with an Ayco financial counselor by August 31, 2018, you may be eligible to earn points for the 2018 Wellbeing Rewards Program. Learn more at **www.webmdhealth.com/bnymellon**.

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Time Off & 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 to give you greater flexibility.

Your flex vacation choices (if hired prior to November 30, 2017):

– 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 base pay. The annual cost of each vacation day is your annual base pay (as of September 1, 2017, 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

Here is something to consider as you make your flex vacation decision. **Additional vacation days can be helpful if you know you'll definitely use them.** Perhaps you anticipate getting married, expecting a child, attending a family reunion or are planning a move. Consider whether you have an upcoming event that you know will require extra time away from work.

How Flex Vacation Works

Provided you are hired on or before November 30, 2017, you can purchase additional vacation days for 2018 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 2018. 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

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:

– **Mental Health Parity and Addiction Equity Act**—This law generally requires that annual or lifetime dollar limits on mental health and substance use disorder benefits be at least as generous as any comparable dollar limits for medical and surgical benefits offered under a group health plan.

– **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 enrollments. This SBC will help you better understand your coverage by summarizing the key features of BNY Mellon's health plans 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 **http://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 care benefits received in the immediately preceding year will be reported in Box 12 on your 2018 W-2 statement. This reporting requirement will not affect your taxable income. The value of health benefits reported in Box 12 on the W-2 statement you receive in January 2018 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.

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. If you would like more information on WHCRA benefits, 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.

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).

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

If you take a 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 **http://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.

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 August 10, 2017. Contact your state for more eligibility information.

STATE	SERVICE	WEBSITE	PHONE NUMBER
Alabama	Medicaid	**http://myalhipp.com/**	1-855-692-5447
Alaska	Medicaid	**http://myakhipp.com/** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	1-866-251-4861
Arkansas	Medicaid	**http://myarhipp.com/**	1-855-692-7447
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/ime/members/medicaid-a-to-z/hipp**	1-888-346-9562
Kansas	Medicaid	**http://www.kdheks.gov/hcf/**	1-785-296-3512
Kentucky	Medicaid	**http://chfs.ky.gov/dms/default.htm**	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/medical-assistance.jsp**	1-800-657-3739
Missouri	Medicaid	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	1-573-751-2005
Montana	Medicaid	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**	1-800-694-3084
Nebraska	Medicaid	**http://www.ACCESSNebraska.ne.gov**	Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
Nevada	Medicaid	**https://dwss.nv.gov/**	1-800-992-0900
New Hampshire	Medicaid	**http://www.dhhs.nh.gov/oii/documents/hippapp.pdf**	1-603-271-5218
New Jersey	Medicaid	**http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**	1-609-631-2392
	CHIP	**http://www.njfamilycare.org/index.html**	1-800-701-0710
New York	Medicaid	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina	Medicaid	**https://www.dma.ncdhhs.gov/**	1-919-855-4100
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

STATE	SERVICE	WEBSITE	PHONE NUMBER
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/**	1-307-777-7531

To see if any more states have added a premium assistance program since August 10, 2017, 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

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, 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 9.5 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 employee 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
Email address	Not available

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

– As your employer, we offer a health plan to all active 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 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.

Information Regarding Termination of Health Plan Coverage for Cause

Your (and/or your dependents') coverage under the medical plan may be rescinded (i.e., canceled or discontinued with a retroactive effective date) if you (and/or your dependent) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material information as prohibited under the terms of this Plan (i.e., in enrollment materials, a claim or appeal for benefits or in response to a question from the Plan Sponsor or Plan Administrator or each of their delegates). Failure to inform the Plan Sponsor or Plan Administrator that you or your dependent is covered under another group health plan or providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation of material information.

You will receive a thirty (30) calendar-day written notice prior to any coverage being rescinded.

Self-Insured Plans

Most of BNY Mellon's health plans are self-insured, which generally means that BNY Mellon pays benefit claims rather than an insurance company.

BNY Mellon national health plans are self-insured as described below.

– **Self-insured.** When a plan or plan option is self-insured, it means the sponsor (in this case, BNY Mellon) assumes the financial risk of the claims incurred by participants/employees and eligible dependents. Claims are paid from sponsor and participant contributions (premiums). A plan sponsor may also hire an administrator to process claims, manage provider networks and handle other administrative tasks.

– **Fully Insured.** When a plan or plan option is fully insured, the sponsor pays premiums (consisting of both sponsor and participant contributions) to an insurance carrier, which assumes the financial risk of paying for claims, as well as the responsibility for all of the administrative duties listed above. Fully insured health plans include Kaiser California, HMSA Hawaii and Aetna International.

Self-insured plans and programs include the 2018 health plans available through Aetna and UnitedHealthcare, dental through MetLife, vision through VSP, the Flexible Spending Accounts, the wellbeing programs (i.e., WebMD Health Services, Best Doctors, onsite Health Centers, Virgin Pulse, AccessSolutions EAP & Work/Life Program, and Castlight), and flex vacation purchase. Self-insured health plans give BNY Mellon the flexibility to create customized plan designs and benefits for our eligible employees and their eligible dependents and to help manage plan costs. Unlike fully insured health plans, self-insured health plans are not subject to state insurance laws, which typically govern fully insured health plans. State insurance laws may require fully insured plans to provide benefits that may not be offered under the self-insured health plans.

For example, some state laws extend medical coverage for dependent children under certain fully insured plans. If you have a dependent age 26 or older and you have coverage in one of the fully insured plans listed above, you should contact that plan directly to find out if your dependent qualifies for the extended coverage. For more information, see “Contact Information” on page 100.

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 Plan HRA (Health Reimbursement Account)
– Aetna Plan HSA (Health Savings Account)
– UnitedHealthcare Plan HRA (Health Reimbursement Account)
– UnitedHealthcare Plan HSA (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 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 2017). 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 2017). 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.socialsecurity.gov** or call 1-800-772-1213 (TTY: 1-800-325-0778).

Remember: Keep this 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 2017

BNY Mellon
Benefits Department
500 Grant Street, Room3118
Pittsburgh, PA15258
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

From: Monique Herena, Chief Human Resources Officer

Date: January 1, 2018

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 Plan HRA – Aetna Plan HSA – Best Doctors® – Castlight – CVS/Caremark Prescription Program – CVS/Caremark Pharmacy Advisor Counseling – Doctor On Demand – Premise Health	– UnitedHealthcare Plan HRA – UnitedHealthcare Plan HSA – Beacon Health AccessSolutions Employee Assistance & Work/Life Program – MetLife Preferred Dental Program – Vision Service Plan (VSP) – WebMD Health Services	– Aetna International (international expatriates only) – HMSA (Hawaii only) – Kaiser Permanente California (Los Angeles) – Kaiser Permanente California (San Francisco) – Aetna DMO

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 Plan HRA (Health Reimbursement Account)

– Aetna Plan HSA (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 Plan HRA

– UnitedHealthcare Plan HSA

– Beacon Health AccessSolutions Employee Assistance & Work/Life Program

– 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 regulations permit us to use and disclose your PHI. It also describes your rights to access and control your PHI.

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, 8:00 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. No one can retaliate against you 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 2018.

COBRA Rights Notice – Health and Welfare Benefits

You are receiving this notice because you have recently become covered under BNY Mellon group health 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. 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 doesn't 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. 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 31days 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 described on the previous pages. 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 on behalf of the plan administrator, BNY Mellon. 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

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Privacy Notice for Wellbeing Program

Your Privacy Is Important

Your participation in the BNY Mellon Wellbeing Program (the “Program”) is voluntary. The Wellness Program is available to all eligible employees and their eligible family members. The Wellness 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 Wellness Program you will be asked to complete a voluntary Wellbeing Assessment (“WBA”) that asks a series of questions about your health-related activities, behaviors and history. You will also be asked to 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 other medical examinations. However, if you choose not to complete the WBA you will not be eligible to receive any of the incentives offered by the Wellness Program (biometric screening must also be completed to receive health premium reductions).

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 Wellness 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 Wellness 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 Wellness 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., AccessSolutions, WebMD Health Services, Castlight, Doctor on Demand, Virgin Pulse, 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 Wellness 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 Wellness 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 Wellness Program, we will notify you immediately.

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, 2017, 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. See “True Family Deductible” on page 99 of this section.

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 Reimbursement Account (HRA)

An account paid for solely by BNY Mellon and designated for qualified health care expenses. The level of contribution is based on your annual base pay. At the end of the year, any unused contributions roll over for you to use in the future, so long as you stay employed by BNY Mellon. If you leave BNY Mellon for any reason before reaching age 55, your HRA balance is forfeited unless you continue medical coverage under COBRA. If you elect COBRA coverage, your medical coverage continues as long as you pay the required COBRA premiums by the due date. To participate in a Health Reimbursement Account, you must enroll in Plan HRA (Health Reimbursement Account) under Aetna or UnitedHealthcare.

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. In addition to BNY Mellon contributions based on your annual salary, you can also contribute to this account. Your contributions and BNY Mellon contributions cannot exceed the annual IRS maximum contribution. You can use an HSA 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 Plan HSA 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 Plan HSA 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
- 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 Contribution

Contributions to pay for your health care coverage 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 **http://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.

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 Health Care Expenses

Qualified health care expenses are "qualified medical 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.

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.

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.

AccessSolutions, 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.

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	**http://mybenefits.bnymellon.com**	
HEALTH PLANS			
Aetna Plan HRA ***Aetna Plan HSA***	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 Plan HRA ***UnitedHealthcare Plan HSA***	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 Log in ID and Password If not registered, click “Not Registered” and enter required fields Click “Member Quick Links” to learn about the plan
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	**http://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” 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 (formerly Aon Hewitt)	1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time	**http://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	**http://mybenefits.bnymellon.com**	
FLEXIBLE SPENDING AND HEALTH REIMBURSEMENT ACCOUNTS			
Alight (formerly Aon Hewitt)	1-800-947-4748, option 2, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time	**http://mybenefits.bnymellon.com**	
HEALTH SAVINGS ACCOUNTS			
Benefit Wallet	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	**https://members.bestdoctors.com**	Find a specialist Request a consultation Ask The Expert™

PERSONAL WELLBEING			
AccessSolutions (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	**http://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.minuteclinic.com**	Quickly and easily get the care you need at affordable prices
Virgin Pulse	1-888-671-9395	**http://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**	2018 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 www.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
NOXAFIL

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
verapamil 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

§ 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
RANEXA

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
paroxetine HCl ext-rel
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**
GILENYA **PA, SP, QL**
OCREVUS **PA, SP, QL**
REBIF **PA, SP, QL**
TECFIDERA **PA, SP, QL**
TYSABRI **PA, SP, QL**

ENDOCRINE AND METABOLIC

ANTIDIABETICS

§ BIGUANIDES
metformin
metformin ext-rel

§ BIGUANIDE / SULFONYLUREA COMBINATIONS
glipizide-metformin

DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS
JANUVIA **ST, PA**
TRADJENTA **ST, PA**

DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR/BIGUANIDE COMBINATIONS
JANUMET **ST, PA**
JANUMET XR **ST, PA**
JENTADUETO **ST, PA**
JENTADUETO XR **ST, PA**

INCRETIN MIMETIC AGENTS
OZEMPIC **ST, PA**
TRULICITY **ST, PA**
VICTOZA **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**
INVOKANA **ST, PA**

SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITOR / BIGUANIDE COMBINATIONS
INVOKAMET **ST, PA**
INVOKAMET XR **ST, PA**
XIGDUO XR **ST, PA**

§ SULFONYLUREAS
glimepiride
glipizide
glipizide ext-rel
glyburide
glyburide, micronized

SUPPLIES
BD INSULIN SYRINGES AND NEEDLES
LANCETS
ONETOUCH STRIPS AND KITS [1]

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
mestranol-norethindrone

§ 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
levonorgestrel 0.75 mg
levonorgestrel - Next Choice One Dose
ELLA

§ INJECTABLE
medroxyprogesterone acetate 150 mg/mL

§ TRANSDERMAL
norelgestromin/ethinyl estradiol - Xulane

VAGINAL
NUVARING

ESTROGENS

§ ORAL
estradiol
estropipate

§ 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

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
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

CIMZIA **#, PA, SP, QL**
HUMIRA **PA, SP, QL**

After failure of HUMIRA

PSORIASIS

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

After failure of HUMIRA

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**

ULCERATIVE COLITIS

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

After failure of HUMIRA

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
INCRUSE ELLIPTA **QL**

ANTICHOLINERGIC / BETA AGONIST COMBINATIONS

§ SHORT ACTING

ipratropium-albuterol inhalation solution
COMBIVENT RESPIMAT

LONG ACTING

BEVESPI AEROSPHERE **QL**

BETA AGONISTS, INHALANTS

§ SHORT ACTING

albuterol inhalation solution
levalbuterol nebulizer solution concentrate
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**
SYMBICORT **QL**

§ STEROID INHALANTS

budesonide inhalation suspension **QL**
ARNUITY ELLIPTA **QL**
FLOVENT DISKUS **QL**
FLOVENT HFA **QL**
QVAR **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%

FOR YOUR INFORMATION: This drug list represents a summary of prescription coverage. It is not all-inclusive and does not guarantee coverage. In most instances, a brand-name drug for which a generic product becomes available will require prior authorization or will no longer be covered upon release of the generic product to the market. Unless specifically indicated, drug list products will include all oral dosage forms, except for orally disintegrating formulations. This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*. Listed products may be available generically in certain strengths or dosage forms. Dosage forms on this list will be consistent with the category and use where listed. Log in to www.caremark.com to check coverage.

An exception process may exist for specific clinical or regulatory circumstances that require coverage of a removed medication.

§ Generics are available in this class and should be considered the first line of prescribing.

* For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).

[1] A ONETOUCH blood glucose meter may be provided at no charge by the manufacturer to those individuals currently using a meter other than ONETOUCH. For more information on how to obtain a blood glucose meter, call: 1-800-588-4456.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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