How do I use this guide?

Annual Enrollment for your 2016 health and insurance benefits is Oct. 2–16.

When Annual Enrollment begins, you’ll find a range of helpful tools on My Benefits Resources that can help you:

- See which plans are available to you
- Know the per-pay-period costs for each option
- Use the medical expense estimator to plan for 2016 out-of-pocket expenses

See page 27 for details.

This guide is for employees who earn $100,000 or more in performance year cash compensation. See page 28 for details.

For more information about plans described in this guide, visit the Health and insurance plan summaries page in the Reference library on Flagscape® > HR, Benefits & Career > Compensation and benefits > Health and insurance.

If you and/or your family members have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. See page 32 for information.
What’s new and what’s staying the same in 2016?

What’s new?

As part of our continued efforts to listen to your feedback and stay ahead of U.S. health care trends, we’re adding new medical carrier choices for 2016.

If you choose Anthem BlueCross BlueShield, you’ll have a 0% increase in your per-pay-period costs, which means they will stay the same for a second year in a row.* See page 7 for information on medical premiums for each carrier.

We’ll continue to offer Kaiser Permanente in 2016 as a carrier in the select markets where it’s currently an option.

We’re also adding new carriers for dental, vision and life insurance plans. Depending on what you choose, you may pay less overall for your benefits.

What’s staying the same?

We’re offering the same medical plans as we did in 2015 and the key features of our medical plans — such as annual deductibles, coinsurance and prescription coverage — aren’t changing.

You’ll still be able to keep a credit toward your annual medical plan premiums by completing wellness activities.

We’ll also continue to contribute the same amount to health care accounts for eligible employees as in 2015.

*Assumes you’re in the same pay tier, choose the same plan that covers the same family members, complete wellness activities, didn’t start using tobacco and still live in the same ZIP code.
What do I need to consider for Annual Enrollment?

When choosing your medical coverage for 2016, you have some important decisions to consider...

- Decide if you want to keep your current medical carrier or choose a new carrier for 2016.
- Understand which medical plan will work best for you and your family for 2016.
- Calculate how much you want to contribute to the health care account that works with your plan.
- Complete your voluntary wellness activities so you can keep the credit toward your annual medical plan premium.

In addition to your medical coverage, there are a few more actions to think about...

**Make changes to your current benefit elections**
- Do you want to change your dental or vision plan?
- Do you want to purchase supplemental life or disability insurance?
- Are you eligible to purchase time off in 2016?
- Do you want to enroll in prepaid legal services?

**Add or remove family members**
- Do you need to change which family members are covered under your health or insurance benefits?
- Do you need to add or change beneficiary designations for life insurance?
What’s inside this guide?

Have questions?

Financial counselors at the Benefits Education & Planning Center (BEPC) can help answer any questions you may have on the topics covered in this guide.

To fit your schedule, the BEPC has added extra hours during Annual Enrollment. Call 866.777.8187 Monday through Friday, 8 a.m. to 9 p.m. Eastern, and Saturdays, 9 a.m. to 4 p.m. Eastern.

To help you compare your medical plan choices, take a look at the Summaries of Benefits and Coverage. To view them during Annual Enrollment, log on to mybenefitsresources.bankofamerica.com and click Make Your 2016 Annual Enrollment Choices > Compare Medical Plan Details.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>6</td>
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<tr>
<td>Carriers</td>
<td>6</td>
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<td>Plans</td>
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<td>Health care accounts</td>
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<td>Wellness</td>
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<td>Dental</td>
<td>16</td>
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<tr>
<td>Life and disability insurance</td>
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<td>Family care and other benefits</td>
<td>24</td>
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<td>How to enroll</td>
<td>26</td>
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<tr>
<td>Important notes</td>
<td>28</td>
</tr>
<tr>
<td>Helpful contact information</td>
<td>34</td>
</tr>
</tbody>
</table>
All three medical carriers offer the same medical plans and are strong, high-quality options with similar services and networks.

Your per-pay-period costs will vary based on which you choose. If you choose Anthem BlueCross BlueShield, you’ll have a **0% increase** in your per-pay-period costs for a second year in a row.

We’ll continue to offer Kaiser Permanente in 2016 as a carrier in the select markets where it’s currently an option.

**Tip**

If Aetna is currently your medical carrier and you don’t make elections during Annual Enrollment, you will remain with Aetna in 2016.
What’s important to know about the medical carriers?

Evaluate your medical carrier options and choose what’s best for you and your family:

<table>
<thead>
<tr>
<th>Medical Carrier</th>
<th>Increase in per-pay-period costs for 2016*</th>
<th>Doctors and facilities</th>
<th>Same medical plans as 2015 (Consumer Directed, Consumer Directed High Deductible)</th>
<th>Teladoc™</th>
<th>24-hour nurse line</th>
<th>Maternity programs</th>
<th>Health coaches (phone/online)</th>
<th>Call center hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Blue Cross Blue Shield</td>
<td>0%</td>
<td>anthem.com/bankofamerica</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Mon–Fri: 8 a.m. to 11 p.m. Eastern Sat: 8 a.m. to 5 p.m. Eastern</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>5%</td>
<td>welcometouhc.com/findmydoc</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Mon–Fri: 8 a.m. to 8 p.m. local time</td>
</tr>
<tr>
<td>aetna</td>
<td>15%</td>
<td>aetna.com/bankofamerica</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Mon–Fri: 8 a.m. to 8 p.m. local time</td>
</tr>
</tbody>
</table>

**What does a medical carrier do?**

Our largest plans are self-insured, which means the medical carriers are administrators of our medical plans. They negotiate rates with hospitals and doctors on your behalf and offer a variety of wellness benefits and resources, while the bank and you cover the bills.

**Tip**

If you're being treated for an ongoing condition and wish to change medical carriers, check the new carriers' websites to see if your doctor or provider is in-network with the carrier of your choice.

If your doctors and providers aren’t in-network, you may request that your doctor or treatment continues to be covered at the in-network rate under the new carrier. This standard industry practice is called transition of care. You can call the carriers for additional information on transition of care.

We’ll continue to offer Kaiser Permanente in 2016 as a carrier in the select markets where it’s currently an option, and per-pay-period costs will increase 3.7% for 2016.*

*Assumes you're in the same pay tier, choose the same plan that covers the same family members, complete wellness activities, didn't start using tobacco and still live in the same ZIP code.

2016 benefits enrollment guide — Understanding your options
Should I consider changing my medical plan?

It’s important to consider which plan best meets your needs and preferences.

Quick quiz

Did your pay increase and possibly change your pay tier?

- [ ] Yes
- [x] No

Do you need to update which family members are covered under your plan?

- [ ] Yes
- [x] No

Do you expect to need more or less medical care in 2016 than you did in 2015?

- [x] Yes
- [ ] No

If you answer “yes” to any of the questions above, you may want to make a change to your medical plan.

Tip

Anthem BlueCross BlueShield, UnitedHealthcare, Aetna and Kaiser Permanente offer the same plans with the same key features.
What’s important to know about the medical plans?

What comes out of my pay?

**Annual premium**
The annual cost to purchase medical coverage is spread across the year, so you pay a portion of it in each pay period. Annual premiums differ based on your pay tier, the plan you elect, the carrier you choose and the number of people you cover. Your premium also will be based on whether or not you complete the wellness activities and use tobacco.

What will I pay after I meet my annual deductible?

**Coinsurance**
After you meet the annual deductible, generally, you’ll continue to pay 20% of the cost for in-network covered medical services until you meet the out-of-pocket maximum. The plan pays the rest.

What’s the most I’d have to pay out of my own pocket?

**Out-of-pocket maximum**
This is the most you’d pay for covered medical services in a calendar year. Think of it as your financial safety net. Once you meet it, the plan pays the full cost of additional covered care.

What is performance year cash compensation?

**Performance year cash compensation**
Per-pay-period costs for medical coverage are determined by tiers that use your performance year cash compensation (see page 28).

Those pay tiers are:
- Less than $50,000
- $50,000 to less than $100,000
- $100,000 to less than $250,000
- $250,000 to less than $500,000
- $500,000 or more

A financial counselor at the Benefits Education & Planning Center can help you understand and evaluate your options. See page 5 for contact information and availability.
What are my medical plan options?

### Consumer Directed Plan

- **Annual deductible**: $1,200 per individual, $2,400 per family
- **Out-of-pocket maximum**: $3,500 per individual, $7,000 per family
- **Coinsurance**: In network, you pay 20%; Out of network, you pay 40%
- **Preventive services**: No cost to you, according to government guidelines.
- **Office visits**: You pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance.
- **Prescription drugs (30-day supply)**:
  - Generic: $5 copayment
  - Preferred brand: 30% coinsurance ($100 max)
  - Non-preferred brand: 45% coinsurance ($150 max)
- **Health care account**: More details on page 13

- **Consumer Directed High Deductible Plan**

- **Annual deductible**: $2,250 employee only, $4,500 per family
- **Out-of-pocket maximum**: $4,000 employee only, $6,850 per individual, up to $8,000 per family*
- **Coinsurance**: In network, you pay 20%; Out of network, you pay 40%
- **Preventive services**: No cost to you, according to government guidelines.
- **Office visits**: You pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance.
- **Prescription drugs (30-day supply)**:
  - Generic: $5 copayment
  - Preferred brand: 30% coinsurance ($100 max)
  - Non-preferred brand: 45% coinsurance ($150 max)
- **Health care account**: More details on page 13

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**Tip**

For 2016, the Consumer Directed High Deductible Plan includes an individual out-of-pocket maximum embedded within the family out-of-pocket maximum. See how this works on page 11.

*The out-of-pocket maximum is $6,850 for family coverage under Kaiser Permanente.*
Do I need to change which family members are covered under my benefits?

During Annual Enrollment, you can add or drop an eligible child, spouse or partner from your coverage.

If you add an adult to your coverage, you’ll need to verify that he or she is eligible to be on your plan. You’ll be asked to provide a marriage certificate, federal tax return or other documents. Some of your benefits, including when bank contributions to your health care account are available, may be affected if there’s a delay in providing documents.

Understanding how deductibles and maximums work with family coverage

Under the **Consumer Directed Plan:**

- **Annual deductible**
  - Coinsurance begins if:
    - You or your family member meets the individual annual deductible, just for that person.
    - Two people on the plan have costs that combine to meet the family deductible. In this situation, coinsurance begins for everyone on the plan.

- **Out-of-pocket maximum**
  - The same applies to the out-of-pocket maximum:
    - If you or a family member meets the individual out-of-pocket maximum, 100% of eligible costs are covered for that person.
    - If two people on the plan combine to reach the family out-of-pocket maximum, 100% of the costs for eligible services are covered for everyone on the plan.

The **Consumer Directed High Deductible Plan** works differently:

- **Annual deductible**
  - If anyone covered on the plan meets the family annual deductible, or two or more family members combine to reach it, coinsurance begins for everyone on the plan.

- **Out-of-pocket maximum**
  - The in-network out-of-pocket maximum for this plan is $8,000 per family.
  - Beginning in 2016, if one person covered under the plan meets the individual out-of-pocket maximum of $6,850, 100% of the costs for eligible services are covered for that person.
  - If another family member adds $1,150 (for a total of $8,000) in covered expenses, 100% of the costs for covered services for everyone on the plan are covered.

At any time during the year, you must provide notification to the Global HR Service Center within 31 calendar days of the date of a qualified status change, such as the birth of a child or marriage, to add a new eligible family member to your coverage.

For more information about who’s eligible to be on your plans, see page 29.

A financial counselor at the **Benefits Education & Planning Center** can help you understand how these work. See page 5 for contact information and availability.
Which health care account works best for me, and how much can I contribute to it?

Health care accounts can help you pay for certain health expenses with pretax dollars.

The amount the bank will contribute to your health care account is based on your performance year cash compensation. Depending on the type of health care account that is paired with your medical plan, you and the bank may be able to contribute to the account.

Tip

If you contributed to a health care account in 2015, that election will carry over to 2016 if you don’t make a change.
## What are my health care account options?

<table>
<thead>
<tr>
<th>Health Flexible Spending Account (Health FSA)</th>
<th>Health Reimbursement Arrangement (HRA)</th>
<th>Health Savings Account (HSA)</th>
<th>Limited Purpose Flexible Spending Account (Limited Purpose FSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Which plans is this account available for?</strong></td>
<td><strong>Which plans is this account available for?</strong></td>
<td><strong>Which plans is this account available for?</strong></td>
<td><strong>Which plans is this account available for?</strong></td>
</tr>
<tr>
<td>Consumer Directed Plan</td>
<td>Consumer Directed Plan</td>
<td>Consumer Directed High Deductible Plan</td>
<td>Consumer Directed High Deductible Plan</td>
</tr>
<tr>
<td><strong>What would I use this account for?</strong></td>
<td><strong>What would I use this account for?</strong></td>
<td><strong>What would I use this account for?</strong></td>
<td><strong>What would I use this account for?</strong></td>
</tr>
<tr>
<td>Any eligible health care expense</td>
<td>Any eligible health care expense</td>
<td>Any eligible health care expense</td>
<td>Any eligible health care expense</td>
</tr>
<tr>
<td><strong>What is the maximum amount that the bank and I combined can put in this account?</strong></td>
<td><strong>What is the maximum amount that the bank and I combined can put in this account?</strong></td>
<td><strong>What is the maximum amount that the bank and I combined can put in this account?</strong></td>
<td><strong>What is the maximum amount that the bank and I combined can put in this account?</strong></td>
</tr>
<tr>
<td>$2,550 The IRS pretax contribution limit</td>
<td>The IRS does not allow employee contributions to an HRA.</td>
<td>$3,550 Employee-only coverage $6,750 Family coverage</td>
<td>$2,550 The IRS pretax contribution limit</td>
</tr>
<tr>
<td><strong>What does the company put in?</strong></td>
<td><strong>What does the company put in?</strong></td>
<td><strong>What does the company put in?</strong></td>
<td><strong>What does the company put in?</strong></td>
</tr>
<tr>
<td>The bank contributes to the HRA.</td>
<td>Cash compensation is $100k to less than $250k $300 Employee-only coverage $450 Employee plus spouse/partner OR Employee plus child(ren) coverage $600 Family coverage</td>
<td>Cash compensation is $100k to less than $250k $300 Employee-only coverage $450 Employee plus spouse/partner OR Employee plus child(ren) coverage $600 Family coverage</td>
<td>The bank does not contribute to this account.</td>
</tr>
<tr>
<td><strong>When are the funds available?</strong></td>
<td><strong>When are the funds available?</strong></td>
<td><strong>When are the funds available?</strong></td>
<td><strong>When are the funds available?</strong></td>
</tr>
<tr>
<td>Your entire contribution amount is available at the beginning of the year.</td>
<td>Any bank contribution is available at the beginning of the year.</td>
<td>Your contribution amount is available as it comes out of your paycheck each pay period — so your entire contribution amount is not available at the beginning of the year or when coverage starts. The entire bank contribution is available at the beginning of the year.</td>
<td>Your entire contribution amount is available at the beginning of the year.</td>
</tr>
<tr>
<td><strong>What happens if I don’t use the money during the year?</strong></td>
<td><strong>What happens if I don’t use the money during the year?</strong></td>
<td><strong>What happens if I don’t use the money during the year?</strong></td>
<td><strong>What happens if I don’t use the money during the year?</strong></td>
</tr>
<tr>
<td>Up to $500 in unused funds will roll over automatically to pay for eligible expenses in the following year.</td>
<td>Unused funds will automatically roll over to the next year, and you generally will have access to the funds as long as you stay in a medical plan that works with the HRA.</td>
<td>Unused funds will roll over to the next year. Also, if you have more than $1,000 in your HSA, you can invest it, and any growth is generally tax-free. You can take HSA funds with you when you leave the company or retire.</td>
<td>Up to $500 in unused funds will roll over automatically to pay for eligible expenses in the following year.</td>
</tr>
</tbody>
</table>
How can wellness activities help me stay in touch with my health?

Completing the voluntary 2016 wellness activities is a two-step process involving both a health screening and a health questionnaire.

You keep a $500 credit toward your 2016 annual medical premium by completing both wellness activities or $1,000 if your spouse or partner also completes them.

If you’re already enrolled in one of our medical plans, you can start submitting your health screening results and your health questionnaire for 2016 when Annual Enrollment begins on Oct. 2. Both wellness activities must be completed and submitted by **Feb. 29, 2016** to keep the credit.
How can wellness activities help me save money?

Same wellness activities, improved completion process.

For 2016, the wellness activities will remain the same. To make it more convenient, we’ve simplified how you access physician forms, submit your information and check your completion status. When you’re ready to complete your wellness activities, log on to My Benefits Resources and select the Wellness tab.

Here’s how you can keep the credit toward your annual medical plan premium:

<table>
<thead>
<tr>
<th></th>
<th>Complete your health screening</th>
<th>Complete your health questionnaire</th>
<th>$500 + $500 = $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Height, weight, waist, blood pressure and total cholesterol measurements</td>
<td>Online questionnaire takes just a few minutes and measures your overall health and lifestyle risks</td>
<td>Total credit to your annual medical plan premium</td>
</tr>
<tr>
<td>2</td>
<td>You complete both wellness activities by Feb. 29, 2016</td>
<td>Your spouse/partner completes both wellness activities by Feb. 29, 2016</td>
<td></td>
</tr>
</tbody>
</table>

The results of the health screening and health questionnaire won’t affect your per-pay-period costs, coverage or eligibility. Bank of America will not have access to individual results. Screening results will only be shared with your medical carrier and be used to provide you with important information about your health.

Tip

If you and your spouse/partner choose not to complete the wellness activities, your per-pay-period costs for medical plan coverage will go up by about $40 (or about $20 per adult), beginning in April 2016.
What are my dental plan options?

For 2016, MetLife will be the carrier for our Dental PPO Plan.

MetLife will offer the same Dental PPO Plan as in 2015, and with lower per-pay-period costs. Visit metlife.com/mydentalppo to see if your dentist is in-network for the Dental PPO Plan.

Dental plan costs will be available on My Benefits Resources when Annual Enrollment begins on Oct. 2, 2015.

Tip

If you are enrolled in the Aetna Dental PPO for 2015 and don’t make a change, you will be enrolled in the MetLife Dental PPO for 2016.
### MetLife Dental PPO

**General dental expenses**

- **Annual deductible**
  - $50 individual, $150 family
  - The deductible is waived for preventive/diagnostic care and applies to basic and major expenses.

- **Annual maximum coverage per person (excludes orthodontia)**
  - $1,500

- **Lifetime maximum for orthodontia**
  - (children starting treatment before age 20)
  - $1,500

- **Office visit copayment**
  - None

**Preventive care**

- **Exams**
  - Plan pays 100% of covered services, limited to two routine visits and two problem-focused visits per calendar year.

- **Cleaning**
  - Plan pays 100% of covered services, limited to two visits per calendar year.

**Basic services**

- **Amalgam (silver) fillings**
  - You pay 20% of covered services.

- **Composite fillings**
  - You pay 20% of covered services; limitations may apply.

- **Extractions**
  - You pay 20% of covered services.

- **Oral surgery**
  - You pay 20% of covered services.

- **Orthodontia**
  - You pay 50% of covered services.

### Aetna DMO (limited markets)

**Annual deductible**

- None

**Annual maximum coverage per person (excludes orthodontia)**

- There is no annual maximum.

**Lifetime maximum for orthodontia**

- (children starting treatment before age 20)
  - 24 months active treatment plus 24 months retention per lifetime

**Office visit copayment**

- $5 per visit

**Exams**

- Plan pays 100% of covered services, limited to four visits per calendar year.

**Cleaning**

- Plan pays 100% of covered services, limited to two visits per calendar year.

**Amalgam (silver) fillings**

- You pay 20% of covered services.

**Composite fillings**

- You pay 20% of covered services; limitations may apply.

**Extractions**

- You pay 20% of covered services; uncomplicated, non-bony impactions.

**Oral surgery**

- You pay 50% of covered services for basic surgery.

- You pay 50% of covered services for major surgery.

**Orthodontia**

- You pay 50% of covered services.
What are my vision plan options?

For 2016, we are offering you one vision plan with a choice between two vision carriers: Aetna and VSP.

The per-pay-period costs under each carrier will be lower than in 2015, and both carriers will offer the same services and coverage.

Visit aetna.com/bankofamerica or vsp.com/bankofamerica to see if your eye care provider is in-network.

Vision plan costs will be available on My Benefits Resources when Annual Enrollment begins on Oct. 2, 2015.

Tip

If you are enrolled with Aetna as your vision carrier for 2015 and don’t change your election, you will remain with Aetna under your current vision plan.
### What is covered under the vision plan?

<table>
<thead>
<tr>
<th>Exams and other services</th>
<th>In network</th>
<th>Out of network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine vision exams</strong></td>
<td>$10 copayment, limited to one exam per calendar year</td>
<td>Up to $40 reimbursement, limited to one exam per calendar year</td>
</tr>
<tr>
<td>• Standard contact lens fit and follow-up: $50 copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Premium contact lens fit and follow-up: 10% discount off retail price, then apply $55 allowance per calendar year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lenses and frames</th>
<th>Single vision</th>
<th>Bifocal</th>
<th>Medically necessary prescription lenses for specific eye conditions that would prohibit the use of glasses</th>
<th>Elective prescription lenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single vision</strong></td>
<td>Plan pays 100% of covered services, limited to standard uncoated plastic lenses once per calendar year.</td>
<td>Plan pays up to $60 lens reimbursement, limited to once per calendar year.</td>
<td>Plan provides up to $210 reimbursement, limited to once per calendar year; prior approval is needed for medically necessary contacts.</td>
<td>Plan provides $125 allowance for contact lenses in lieu of eyeglasses, once per calendar year; members may use their $125 allowance either in-network or out-of-network in a single claim; a 15% discount is applied to conventional contacts.</td>
</tr>
<tr>
<td>• Plan pays up to $130 frame allowance, limited to once every other calendar year, 20% discount thereafter.</td>
<td>• Plan provides $50 frame reimbursement, limited to once every other calendar year.</td>
<td>• Plan provides $50 frame reimbursement, limited to once every other calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bifocal</strong></td>
<td>Plan pays 100% of covered services, limited to standard uncoated plastic lenses once per calendar year.</td>
<td>Plan pays up to $60 lens reimbursement, limited to once per calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Plan provides $130 frame allowance, limited to once every other calendar year, 20% discount thereafter.</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact lenses</th>
<th>Medically necessary prescription lenses for specific eye conditions that would prohibit the use of glasses</th>
<th>Elective prescription lenses</th>
</tr>
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<tbody>
<tr>
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</tr>
<tr>
<td><strong>Elective prescription lenses</strong></td>
<td>Plan provides $125 allowance for contact lenses in lieu of eyeglasses, once per calendar year; members may use their $125 allowance either in-network or out-of-network in a single claim; a 15% discount is applied to conventional contacts.</td>
<td></td>
</tr>
</tbody>
</table>

**Tip**

You automatically have access at no cost to the Aetna Vision Discount Program as an alternative to the vision plan under Aetna or VSP. This offers discounts for routine eye exams, eyeglasses, LASIK surgery, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories.
Life and disability insurance can provide income protection for you and your family if you can no longer earn a living.

Some coverage is provided automatically to you at no cost; other supplemental coverage is available for you to purchase based on the needs of you and your family.

**Quick quiz**

Will you need more than the company-paid basic life insurance to meet your survivors' needs?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Do others depend on your income?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Would you have significant additional expenses if your spouse/partner were to die?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Would your survivors lack financial resources if you were to die?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If you answer "yes" to any of the questions above, you may want to consider the life and disability insurance options available to you.

**Tip**  
Supplemental coverage will carry over if you don’t make any elections during Annual Enrollment.
**Associate life insurance**
For 2016, our company-paid associate life insurance will be provided by MetLife, and the plan is staying the same.

**Short- and long-term disability insurance**
The company provides you:
- Short-term disability benefits for up to 26 weeks from the date of your disability after you’ve worked one continuous year
- Long-term disability benefits if you are unable to work for an extended period of time due to a qualifying illness or injury

**Short-term disability (STD)**
Up to 100% weekly base pay (or ABBR)
For up to eight weeks of benefits. Coverage is 70% for the remainder.

**Long-term disability (LTD)**
50% weekly base pay (or ABBR) up to $360,000 per year ($30,000 a month)
For full-time employees only. Part-time employees also can see rates and purchase LTD coverage during Annual Enrollment on My Benefits Resources.

**Business travel accident insurance**
Business travel accident insurance protects you in the event of death or serious covered injury caused by an accident that occurs while traveling on business for the bank. Everyday commuting is excluded.

Annual base pay $ \times 5$
Rounded up to the next $1,000, up to a maximum of $3 million.

For family members who travel with you on an authorized trip or relocation, we provide:
- $150,000 coverage for your spouse or partner
- $50,000 coverage for each child

**Tip**
During Annual Enrollment, ensure you’ve designated a beneficiary for all of your insurance benefits.
What insurance benefits can I purchase?

**Associate supplemental life insurance**
You may elect to purchase associate supplemental life insurance on a post-tax basis.

Eligible compensation \( \times 1-8 \)
(annual base pay + eligible bonus or ABBR)

Rounded up to the next $1,000, up to a maximum of $3 million.

A Statement of Health may be required.

**Dependent life insurance**
Dependent life insurance is paid for on a post-tax basis and assists you with the additional expenses you might have if your spouse/partner or child dies. You need to decide which coverage level, if any, is right for you.

**Child life insurance**
Coverage options available:
- $5,000/child
- $10,000/child
- $15,000/child

**Spouse/partner life insurance**
Coverage options available:
- $10,000
- $25,000
- $50,000
- $75,000
- $100,000
- $125,000
- $150,000

A Statement of Health may be required.

**Tip**
A financial counselor at the **Benefits Education & Planning Center** can help you understand these coverage amounts and which ones may be right for you. See page 5 for contact information.
What insurance benefits can I purchase?

**Long-term disability (LTD) insurance**
You may elect to purchase additional coverage on top of the bank-provided 50% on a post-tax basis, up to a maximum of $360,000 per year ($30,000 per month).

- **60% eligible compensation** (annual base pay + eligible bonus)
- **60% annual base pay**
- **50% annual base pay** (part-time employees)

The amount of benefits you would receive while on LTD is based on your election and the amount of salary or wages you were receiving from the company on the day before your disability period began, known as your pre-disability earnings.

**Accidental death and dismemberment (AD&D) insurance**
AD&D insurance provides you with additional financial protection in the event of a serious accidental injury or death. You pay for this coverage on a pretax basis.

Eligible compensation x 1-8
(annual base pay + eligible bonus)

**Family AD&D insurance**
You also may elect family AD&D coverage for your spouse/partner and children, so long as they are more than seven days old, not full-time military and under age 65. You pay for this coverage on a pretax basis. You must have employee AD&D coverage to elect coverage for your dependents.

- **Each child**
  - 20% of your coverage amount, up to $50,000

- **Spouse/partner**
  - 60% of your coverage amount, up to $600,000
What are my family care and other benefit options?

We offer several benefit options for you and your family.

**Familiarize yourself with what’s available and the elections you can make during Annual Enrollment:**

- Dependent care flexible spending account (Dependent Care FSA)
- Purchased time off (PTO)
- Prepaid Legal
<table>
<thead>
<tr>
<th>Benefits</th>
<th>What we offer</th>
<th>Who's eligible</th>
<th>Actions you can take</th>
</tr>
</thead>
</table>
| Dependent care flexible spending account (Dependent Care FSA) | • You can pay for eligible dependent care expenses with pretax dollars, including:  
  • Adult day care centers  
  • Babysitters and nannies  
  • Summer day camp  
  • Before- and after-school programs  
  • Child day care  
  • You can use this account for dependent care expenses incurred so you and your spouse can work, or so your spouse can attend school full time. If your spouse stays home full time, you are not eligible for the tax benefit. | • Employees with children under age 13 and anyone who is a dependent under IRS rules, or is mentally or physically incapable of taking care of himself or herself.  
  • Employees in New Jersey and Pennsylvania can’t make pretax contributions, per state regulations.  
  • Employees in Puerto Rico, Guam and the U.S. Virgin Islands are not eligible.  
  • Employees scheduled to work less than 20 hours per week are not eligible. | • Contribute up to $5,000 per year to the account (or $2,500 if you are married and filing separate tax returns).  
  • Keep track of your expenses through the year. Back-up care, child care reimbursements and Dependent Care FSA contributions are added together for tax purposes, and any amount over $5,000 is considered taxable income. |
| Purchased time off (PTO) | • You may purchase time off from work beyond your annual vacation allotment.  
  • You can pay for a minimum of four whole hours and a maximum of your weekly scheduled hours, up to 40, shown as weekly scheduled hours on the payroll system. | • All U.S.-based employees who are scheduled to work at least 20 hours per week, except those in bands 0–3, commissioned employees or employees working in Puerto Rico. | • Receive permission from your manager before you purchase time off.  
  • If you have PTO for 2015, your 2015 election will not continue into 2016, so you’ll need to make a new election for 2016 during Annual Enrollment. |
| Prepaid Legal | • You have access to experienced attorneys for many personal legal services and unlimited advice through Hyatt Legal Plans. The plan covers:  
  • Wills  
  • Real estate matters  
  • Small claims  
  • Family services  
  • Most network attorney fees are covered by the plan. | • All active, U.S.-based full- and part-time employees (scheduled to work at least 20 hours a week). | • You are only able to enroll in Prepaid Legal during Annual Enrollment and must remain in the plan for the full year. |
When do I enroll?

Annual Enrollment is open Oct. 2–16, 2015.

**Important reminders:**

- Once you choose a medical or vision carrier for 2016, you will remain with that carrier through the year, even if you experience a qualified status change.

- Any health care account contributions you receive from the bank will not change in 2016 once Annual Enrollment ends, even if you have a qualified status change that changes the number of people you cover on your plan.

- If you decline coverage during Annual Enrollment, but need to enroll following a qualified status change, you may be eligible for prorated health care account contributions.
How do I enroll from Oct. 2–16?

The fastest and easiest way to enroll is online, through My Benefits Resources, available from anywhere you have Internet access.

**When you’re logged on to the bank’s network:**
1. Log on to myHR® and enter your Standard ID and password.
2. Click on the My Benefits & Pay tab.
3. To launch My Benefits Resources, click on Launch (located within the Health and insurance box).
4. From the Home tab on My Benefits Resources, click Make Your 2016 Annual Enrollment Choices.
5. When you’re finished, confirm your choices by clicking Complete Enrollment. Your elections will not be saved unless you complete this step. You will see a Confirmation Statement, which you should print for your records.

**If you’re not logged on to the bank’s network:**
1. Log on to mybenefitsresources.bankofamerica.com using your Person Number and password. If you don’t know your Person Number, you can use the Person Number Lookup tool on Flagscape.
2. From the Home tab on My Benefits Resources, click Make Your 2016 Annual Enrollment Choices.
3. When you’re finished, confirm your choices by clicking Complete Enrollment. Your elections will not be saved unless you click Complete Enrollment. You will see a Confirmation Statement, which you should print for your records.

**Tip**
If you need assistance, use the online chat option, available on the Contact Us page.

**By phone**
If you don’t have Internet access, call the Global HR Service Center at 800.556.6044 to enroll. Representatives are available Monday through Friday (excluding certain holidays) 8 a.m. to 8 p.m. Eastern. Have your enrollment elections ready when you call and enter your Person Number. Once authenticated, say “Annual Enrollment” to speak to a Global HR Service Center representative, who will take your benefit elections and validate your dependent information.

**Special service phone numbers:**
- Hearing-impaired access: Dial 711, then call 800.556.6044.
- Overseas access: Dial your country’s toll-free AT&T USADirect® access number, then enter 800.556.6044. In the U.S., call 800.331.1140 to obtain AT&T USADirect access numbers. From anywhere in the world, access numbers are available online at att.com/traveler or from your local operator.
For more information about plans described in this guide, visit the Health and insurance summaries page in the Reference library on Flagscape > HR, Benefits & Career > Compensation and benefits > Health and insurance.

A few additional notes about your benefits

Wellness

Health screening and health questionnaire

If you are pregnant, or it is medically inadvisable or unreasonably difficult for you to participate in the health screening and/or health questionnaire based on a medical condition, you may submit a Health Care Provider Medical Waiver Form (2016 Wellness Program) signed by your health care provider in place of completing one or both steps of the wellness activities. Your physician will indicate which activities the waiver covers. If your waiver doesn’t cover both steps of the wellness activities, you will still need to complete the step that is not covered by the deadline in order to maintain the wellness credit. The form is available on the online wellness guide on My Benefits Resources.

Medical

Performance year cash compensation (PYCC)

Your 2016 performance year cash compensation (or cash compensation) is your base salary as of Dec. 31, 2014 (or your date of hire, if later), plus any benefits-eligible cash incentives such as most cash commissions and any annual cash bonus, earned for 2014 and paid by June 30, 2015. Your performance year cash compensation is used to determine your pay tier for medical benefits. This amount also is used to determine how much the bank will contribute to your health care account.

Annual Benefits Base Rate (ABBR)

For employees in all lines of business except Global Wealth & Investment Management (GWIM): ABBR is based on your annual base salary as of Dec. 31, 2014, draw paid in 2014 and any benefits-eligible cash incentives, which include most commission pay and annual bonuses earned for 2014 and paid before July 2015. For employees in the GWIM line of business: ABBR is based on your benefits-eligible compensation earned in 2014, plus any benefits-eligible cash incentives, which include most commission pay and annual incentives earned for 2014 and paid before July 2015.

Beginning Oct. 2, you can find your 2016 PYCC or ABBR

1. Log on to My Benefits Resources using your Person Number and the password you created for the site.

2. Click Your Profile in the top right-hand corner of the screen and select Personal Information from the drop-down list.

Any changes to your base salary after Dec. 31, 2014, will not change the PYCC amount used to determine your pay tier.

For some commission-based employees, we calculate an annual benefits base rate (ABBR), which is used as your PYCC, to determine your pay tier for medical benefits.

Tobacco users pay more

For 2016, adults who have used tobacco in the last 12 months and are covered under Bank of America medical plans will continue to pay a tobacco-user rate for their coverage. This rate is $50 per month higher ($600 annually) than the rate for adults who don’t use tobacco.

To qualify for the lower rate, the covered adult must certify during his or her enrollment period that he or she has not used tobacco products during the prior 12 months, including, but not limited to cigarettes, cigars, pipes, chewing tobacco, snuff, dip and loose tobacco smoked by pipe.

If you have acknowledged previously that you’re a tobacco user when electing medical coverage or associate supplemental life insurance coverage, your acknowledgment for 2016 will be set to “yes” automatically.

This means your per-pay-period costs for medical coverage in 2016 will reflect the tobacco-user rate. You can change your acknowledgment to “no” if you have quit using tobacco since your last enrollment and have not used any tobacco products in the past 12 months. During Annual Enrollment, you’ll be asked to provide your tobacco-user status separately from the tobacco-user status of your spouse or partner.

Note for medical coverage only: Tobacco users may still have the option of paying the lower rate. If you or your covered spouse, partner or other adult dependent use tobacco and are unable to meet the non-tobacco user standard, you may still qualify for the lower non-tobacco user medical rates. Contact the Global HR Service Center to discuss an alternative standard that will provide the same non-tobacco user medical rates in light of your health status.

You must contact the Global HR Service Center and complete certain steps prior to the end of Annual Enrollment.

Health care accounts

Depending on your enrollment choices, you may receive a new Visa* debit card for your health care account.

Bank contributions

Your performance year cash compensation, the plan and the coverage level you elect are used to determine how much the bank will contribute to your health care account.

Eligible dependents

For health care accounts, eligible dependents under the Health Reimbursement Arrangement (HRA), the Health Flexible Spending Account (Health FSA) and the Limited Purpose Health Flexible Spending Account (Limited Purpose FSA) also include the participant’s dependent, child or other individual whom you can claim as dependents on your federal income tax return. However, per IRS requirements, the definition of an eligible dependent under a Health Savings Account (HSA) only includes family members who can claim as dependents on your federal income tax return.

Maintaining access to your HRA balance

If you have an existing HRA, you can maintain access to any balance in that account by enrolling in an HRA-eligible plan and remaining employed by the bank. If you’re still employed by the bank and choose a plan that’s not HRA-eligible or choose not to enroll in a health plan, your HRA balance will continue to roll over. The balance won’t be accessible until you reenroll in an HRA-eligible plan or leave the bank after meeting the Rule of 60. HRA-eligible plans include the Consumer Directed Plan. For more information, refer to the 2013...
SPD and subsequent SMMs on Flagscape > HR, Benefits & Career > Compensation and benefits > Health and insurance

Tax considerations
Some circumstances could result in you being taxed on all or part of the contribution to your health care account, including:

- Debit card transactions, so be sure to keep receipts and documentation for health care account purchases. You may need to verify that your debit card transactions were for eligible health care expenses. If you don’t verify them, your Visa debit card may be deactivated and/or you may be taxed on the value of the transaction. For the HSA, there can also be a 20% penalty from the IRS for ineligible expenses.

- If you receive bank contributions in an HRA for a family member who is considered to be a nontax qualified dependent, you must pay taxes on the value of the contribution. This is included in your imputed income calculation, if applicable.

- If your contribution to an HSA, combined with any bank contribution to your HSA, exceeds the IRS limit, you will pay taxes on the amount of the contribution that exceeds the limit.

- California and New Jersey tax employer contributions to health care accounts and don’t allow employees to make pretax contributions.

Health Flexible Spending Account (Health FSA) and Limited Purpose Flexible Spending Account (Limited Purpose FSA)
Your account is credited in full on Jan. 1 (or the date you become benefits eligible). Eligible expenses must be incurred during the period in which you actively contribute to your Health FSA or Limited Purpose FSA. An expense is incurred when you actually receive a service or make a purchase, not when you receive or pay a bill.

Health Savings Account (HSA)
Verifying your information
If you enroll in an HSA, the federal government may require you to verify certain information, such as your name or address, before your HSA can be opened. If you don’t provide this information, your account won’t be opened, which may result in forfeiture of any bank contributions. The contributions you make would be returned during the year.

Who is eligible for our plans?
For detailed information about dependent eligibility, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Compensation and benefits > Health and insurance.
If you already cover a dependent or add a dependent to your coverage for 2016, take time to verify their eligibility and confirm their personal information.

Benefits eligibility
Employees who were previously not eligible for benefits and work 30 hours or more per week over a 12-month “look back” period will be eligible for medical benefits and health care accounts.

Children
Generally, your child or children are eligible to be covered under our plans until age 26, regardless of whether they attend school full or part time.

Spouse or partner
Generally, your spouse or partner is eligible to be covered under our plans.

The U.S. Treasury and IRS guidance state that all same-sex couples who are legally married are treated as married for federal tax purposes, where marriage is a factor, including personal and dependent exemptions and deductions, IRA contributions, tax credits and eligibility for coverage under employee benefit plans.

Other adult dependent
For an individual to qualify as your other adult dependent, he or she must:
- Be under age 65

- Be your dependent for federal income tax purposes (To qualify for coverage in a given year, the individual must have been your tax dependent for the previous tax year and must continue to be your tax dependent for the current tax year.)

- Live with you and be considered a member of your family

- Not be eligible for, and not have declined or deferred, coverage through the Bank of America employee or retiree health care program

For information regarding health and insurance coverage for adult family members, visit My Benefits Resources or call the Global HR Service Center. If you’re uncertain if an adult family member qualifies as your eligible dependent, call the Global HR Service Center.

When a dependent loses eligibility
You have up to 31 calendar days to call the Global HR Service Center and let us know that one of your dependents should be dropped from the plan, for example upon divorce. If your dependent receives benefits from a plan after the date coverage ends, you’re responsible for reimbursing the plan for benefits provided during that period. Changes to your contribution amounts will take effect on the first day of the month after you notify the Global HR Service Center that your dependent is no longer eligible. You will not be refunded premiums if you do not call within 31 days.

Qualified status change
For details on what’s considered a qualified status change, visit the Health and insurance plan summaries page in the Reference library on Flagscape > HR, Benefits & Career > Compensation and benefits > Health and insurance.
Life and disability insurance

**Associate supplemental life insurance**
Tobacco users pay a higher rate. If you have acknowledged previously that you’re a tobacco user when electing associate supplemental life insurance or medical coverage, your acknowledgment for 2016 will be set to “yes” automatically. This means your per-pay-period cost for associate supplemental life insurance coverage in 2016 will reflect the tobacco-user rate. You can change your acknowledgment to “no” if you have quit using tobacco since your last enrollment and have not used any tobacco products in the past 12 months.

If you elect coverage for the first time, increase coverage by more than one level, or elect coverage that is greater than or equal to $500,000, you must provide a Statement of Health. A Statement of Health is not required for a coverage amount change that is greater than or equal to $500,000 if the change is a result of a change in salary and not an increase in option.

If a Statement of Health is required, the increased coverage does not begin until after your Statement of Health is approved by the insurance company. If you fail to provide a Statement of Health when required, you will be assigned the highest coverage available without a Statement of Health. Once the Statement of Health is approved, coverage is effective the first of the month following the date the Statement of Health was approved by the insurance company.

**Dependent life insurance**
Tobacco users pay a higher rate for spouse/partner dependent life insurance coverage. If your spouse or partner has acknowledged previously that he or she is a tobacco user when electing spouse/partner life insurance or medical coverage, the acknowledgment for 2016 will be set to “yes” automatically. This means your per-pay-period costs for spouse/partner dependent life insurance coverage in 2016 will reflect the tobacco-user rate. You can change his or her acknowledgment to “no” if he or she has quit using tobacco since his or her last enrollment and has not used any tobacco products in the past 12 months.

During Annual Enrollment if you elect coverage for the first time, increase coverage by more than one level or elect coverage over $50,000, your spouse or partner must provide a Statement of Health. If a Statement of Health is required, the increased coverage begins the first of the month following the date your spouse’s or partner’s Statement of Health is approved by the insurance company. Until a Statement of Health is approved, or if your spouse or partner fails to provide a Statement of Health when required, coverage defaults to the highest level that does not require a Statement of Health.

**Long-term disability insurance (LTD)**
The amount that you pay for LTD coverage depends on your age, the level of coverage you elect when you are first eligible during Annual Enrollment or through a qualified status change, and whether you are a full- or part-time employee.

If your pre-disability earnings pay rate changes during the year, your LTD coverage amount and the premium charged will be adjusted accordingly. If you are not actively at work on the date your pay rate changes, the new monthly benefit amount will take effect on the date you are again actively at work.

No benefit is payable for any disability that is caused by or contributed to by a pre-existing condition and that starts before the end of the first 12 months following the effective date of your increased coverage. A disease or injury is a pre-existing condition if during the three months before your effective date of coverage:
- It was diagnosed or treated
- Services were received for the diagnosis or treatment of the disease or injury
- You took drugs or medicines prescribed or recommended by a physician for that condition

If you happen to be ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until the date you return to work to your regular part- or full-time schedule. You will be considered to be active at work on any of your scheduled work days if on that day you are performing the regular duties of your job for the number of hours you are normally scheduled to work. In addition, you will be considered to be active at work on the following days:
- Any day which is not one of your employer’s scheduled work days if you were active at work on the preceding scheduled work day
- A normal vacation day

These pre-existing conditions and actively-at-work provisions also apply to an increase in your coverage. No increased benefit is payable for any disability that is caused by or contributed to by a pre-existing condition that starts before the end of the first 12 months following the effective date of your increased coverage. And, if you are not actively at work on the date your coverage increases, your increased coverage will take effect on the date you are again actively at work. The maximum monthly benefit, together with all other income benefits, is $30,000.

**Imputed income**
The value of certain benefits is considered imputed income, which means that you pay taxes on the value of that coverage. If imputed income affects you, you will see it on the first payroll statement you receive after electing your benefits or, if later, your coverage start date. For more information about imputed income, please refer to the 2013 SPD, which is available on Flagscape > HR, Benefits & Career > Compensation and benefits > Health and insurance.

**Eligible bonus amount**
For associate supplemental life, AD&D and LTD insurance coverage amounts for 2016, your eligible bonus amount consists of any performance-based, benefits-eligible cash incentives and special equity awards earned for 2014 and paid by June 30, 2015. Your eligible bonus amount remains fixed for the plan year.
Summary of Benefits and Coverage — Availability Notice

As a result of the Patient Protection and Affordable Care Act, Bank of America is required to provide standardized Summaries of Benefits and Coverage (SBCs). The SBCs summarize, in a standard format, important information about the bank’s health plans. This is another resource to help you compare your plan choices. To take a look at the SBCs during Annual Enrollment, log on to mybenefitsresources.bankofamerica.com and go to Make Your 2016 Annual Enrollment Choices > Compare Medical Plan Details. If you have specific questions about what’s covered, call your medical carrier to ask about coverage for specific health conditions.

For a paper copy, call the Global HR Service Center at 800.556.6044.

When you enroll or continue participation in the Bank of America plans, you are acknowledging that the benefits you have elected are subject to the provisions of the Bank of America Group Benefits Program and the terms and conditions of the benefit plans, and you are authorizing the bank to withhold from your pay any employee contributions required for such benefits. You acknowledge that if you enroll in a plan that provides for binding arbitration of any controversy between a plan member or beneficiary and a plan, including, as applicable, its agents, associates, providers and staff physicians, then any such controversy is subject to binding arbitration.

This communication provides information about certain Bank of America benefits. Receipt of this document does not automatically entitle you to benefits offered by Bank of America. Every effort has been made to ensure the accuracy of the contents of this communication. However, if there are discrepancies between this communication and the official plan documents, the plan documents always will govern.

While the term “premium” is used in this guide (including, but not limited to, the description of the wellness activities and the wellness credit) in reference to certain costs associated with plan benefits, it should be noted that “premium” generally refers to fully insured benefit plans, and not all plans discussed are fully insured.

Bank of America reserves the right to amend or terminate any benefit plan in its sole discretion at any time and for any reason. The bank also retains the discretion to interpret any terms or language used in this guide. For convenience, we use the name Bank of America in this communication because it is used at companies with different names within the Bank of America Corporation family of companies. However, by using the terms Bank of America or bank, it does not mean that you are employed by Bank of America Corporation; you are employed by the entity that directly pays your wages.
Important notice from Bank of America about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bank of America 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 are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current 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 join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. For 2016, Bank of America has determined that the prescription drug coverage offered by your Bank of America-sponsored medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore 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.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current Bank of America coverage will not be affected. However, your current Bank of America coverage may pay secondary to a Medicare drug plan in certain situations as described below.

Bank of America provides medical plans for Medicare-eligible employees and retirees that include prescription drug coverage. Before you decide whether to enroll in Medicare Part D or to continue your Bank of America prescription drug coverage, carefully compare the plans and costs, including which drugs are covered under each plan. Keep these points in mind:

- If you just want medical coverage through Bank of America, without drug coverage, you may be eligible to enroll in the Medical Only Medicare Supplement plan if you become Medicare-eligible while receiving LTD benefits or a Medicare-eligible retiree.
- If you do not elect a Bank of America medical plan that includes prescription drug coverage, and do not enroll in a Medicare prescription drug plan when first eligible, you may pay more for Medicare prescription drug coverage later.
- If you enroll in a Bank of America medical plan that covers prescription drugs, you probably should not enroll in a Medicare prescription drug plan as well. However, if you do enroll in both a Bank of America medical plan that covers prescription drugs and a Medicare prescription drug plan, you will have prescription drug coverage through two plans. It is important that you understand:

- If you are an active employee, your prescription drug coverage through Bank of America will pay primary on prescriptions covered through Medicare. This means that if the Bank of America plan is less generous than your Medicare prescription drug plan, your Medicare prescription drug plan will pay an additional amount. However, if the Bank of America plan is just as generous, the Medicare prescription drug plan will not provide any additional prescription drug coverage.
- If you are not an active employee (if you are on long-term disability [LTD] or are a retiree, for example), your prescription drug coverage through Bank of America will pay secondary on prescriptions covered through Medicare. This means that if the Medicare plan is less generous than your Bank of America prescription drug plan, your Bank of America prescription drug plan will pay an additional amount. However, if the Medicare plan is just as generous, the Bank of America prescription drug plan will not provide any additional prescription drug coverage.
- Your monthly contributions for coverage under the Bank of America plan will not be reduced if you enroll in a Medicare Part D prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Bank of America coverage, be aware that you and your dependents generally will be able to get this coverage back within 31 days of a qualified status change or during Annual Enrollment. Please call the Global HR Service Center at 800.556.6044 for information about applicable reenrollment rules and restrictions.
When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Bank of America and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage, contact the Global HR Service Center at 800.556.6044. Note: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Bank of America changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800 MEDICARE (800.633.4227).
- TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY: 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).

Women’s Health and Cancer Rights Act

As required by the Women’s Health and Cancer Rights Act of 1998, each medical plan provides the following medical and surgical benefits with respect to a mastectomy:
- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles and copayment provisions applicable to other such medical and surgical benefits provided under the plan.

Please refer to your Health Plan Comparison Charts on My Benefits Resources for deductible and copayment information applicable to the plan in which you choose to enroll.

Availability of Notice of Privacy Practices

The Bank of America Group Benefits Program (the “Plan”) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan.

If you would like a copy of the plan’s Notice of Privacy Practices, visit My Benefits Resources or call the Global HR Service Center at 800.556.6044.

Marketplace special enrollment windows related to COBRA

Under the Affordable Care Act, you can enroll in a medical plan through your state’s health care exchange during an open enrollment period or designated special enrollment periods. A special enrollment period will be available when you become eligible for COBRA, or after you are no longer eligible for COBRA. There is no special enrollment period if you voluntarily end your COBRA coverage.

For more information about specific enrollment rules or plans offered through health care exchanges, please visit www.healthcare.gov or call 800.318.2596 (TTY: 855.889.4325).

Fully insured medical plans

Aetna International, Kaiser Permanente, HMSA Hawaii and Triple-S Salud medical plans may have other changes in coverage for 2016. Please contact these carriers with any questions.

For convenience, the term “Bank of America” is used to refer to Bank of America Corporation, the plan sponsor, as well as all companies in the Bank of America-controlled group of corporations. The use of this term does not mean you are an employee of Bank of America Corporation. You remain solely an employee of the company that directly pays your wages.

The Group Benefits Program is subject to applicable limitations and restrictions under the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that governs employee benefit plans. Bank of America Corporation may modify, suspend or terminate the component plans under the Group Benefits Program at any time, without prior notice (except as required by law). Bank of America also retains the discretion to interpret any terms or language used in the Group Benefits Program documents.
Helpful contact information

### Medical plans
- Aetna
  - aetna.com/bankofamerica
  - 877.444.1012
- Anthem BlueCross BlueShield
  - anthem.com/bankofamerica
  - 844.412.2976
- Kaiser Permanente
  - kp.org
  - Please refer to the number on the back of your ID Card.
- UnitedHealthcare
  - welcometouhc.com/findmydoc
  - 877.240.4075

### Prescription coverage
- CVS Caremark
  - caremark.com
  - 800.701.5833
  - Hearing-impaired access: 800.231.4403
- DentaCare
  - Aetna (limited availability)
  - aetna.com/bankofamerica
  - 877.444.1012
  - MetLife
  - metlife.com/mydentalppo
  - 888.245.2920

### Vision
- Aetna
  - aetna.com/bankofamerica
  - 877.444.1012
- VSP
  - vsp.com/bankofamerica
  - 877.814.8967

### Dental
- Aetna
  - aetna.com/bankofamerica
  - 877.444.1012
- MetLife
  - metlife.com/mydentalppo
  - 888.245.2920

### Health care and dependent care accounts
- Health Benefit Solutions
  - bankofamerica.com/benefitslogin
  - 866.791.0254

### Prepaid legal
- Hyatt Legal Plans
  - info.legalplans.com/bofa
  - 800.821.6400

### Additional questions
- Benefits Education & Planning Center
  - 866.777.8187
  - TTY: 888.896.6708
- Global HR Service Center
  - mybenefitsresources.bankofamerica.com
  - 800.556.6044

Contact information for other programs can be found on Flagscape and on Employee Resources at Home bankofamerica.com/employee