At Bank of America, we believe employees are the foundation of our success.

To support you during the moments that matter most, we offer a wide range of benefits, programs and resources that are competitive, diverse and flexible to meet your needs. It’s one of the most important things we do as a company, and part of our commitment to making Bank of America a great place to work. To help you know more about all the programs available to you, we’ve included an employee benefits and programs guide in the packet with your enrollment information.

We offer a variety of health and insurance benefits to meet your needs.

This enrollment guide is designed to help you understand the comprehensive medical, prescription, dental and vision coverage available for you and your family. You’ll also learn about the available life and accident insurance options, including what’s provided automatically by the bank. You’ll see that wellness is a key component of our medical plans, as we’re committed to helping you learn more about your health and save money in the long run. You can keep a credit toward your annual medical premium by completing two voluntary wellness activities, and you’ll have access to personal health coaches and nurses to help you improve your health, manage chronic conditions and more.
How do I use this guide?

Get ready to make your benefit elections for 2016.

You can find a range of tools on My Benefits Resources® (mybenefitsresources.bankofamerica.com) 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 less than $100,000 in performance year cash compensation. See page 28 for details.

For more information about plans described in this guide, go to Flagscape® > HR Connect > Benefits > Health > Medical plans and click Resources.

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 do I need to consider during enrollment?

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

- Decide which medical carrier fits your needs.
- 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 selecting your medical coverage, there are a few more actions to think about...

**Determine what additional coverage you need**
- Do you and your family need dental and vision coverage?
- Do you want to purchase supplemental life or disability insurance?
- Do you want to enroll in prepaid legal services?

**Add family members**
- Do you need to cover eligible family members under your health or insurance benefits?
- Who should be your beneficiary for life insurance?
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.

Call 866.777.8187 Monday through Friday, 9 a.m. to 8 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 your enrollment period, log on to mybenefitsresources.bankofamerica.com and click Enroll in Your Benefits > Compare Medical Plan Details.

Note: If you are based in Guam, Hawaii, Puerto Rico or the U.S. Virgin Islands, you will be eligible for plans that are not described in this guide. Refer to your Enrollment Worksheet for information about the plans available to you.
We offer a choice among three medical carriers, each with the same medical plans, similar services and national networks.

- **Anthem BlueCross BlueShield**
- **UnitedHealthcare**
- **aetna**

Your per-pay-period costs will vary based on which medical carrier you choose. Kaiser Permanente is also an option as a carrier for 2016 in select markets.

**Tip**

You must enroll by your enrollment deadline if you want coverage under our plans.

If you don’t do anything during your enrollment period, you will have the coverage indicated on your Enrollment Worksheet, which in most cases is no coverage for 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>Doctors and facilities</th>
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<tbody>
<tr>
<td>Check if your doctor is in a carrier network</td>
<td><a href="http://antheme.com/bankofamerica">anthem.com/bankofamerica</a></td>
<td><a href="http://welcometouhc.com/findmydoc">welcometouhc.com/findmydoc</a></td>
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<thead>
<tr>
<th>Medical plans</th>
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<tbody>
<tr>
<td>(Comprehensive PPO, Consumer Directed, Consumer Directed High Deductible)</td>
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<th>Teladoc™</th>
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<tr>
<td>24/7 access to board-certified doctors by phone or online video</td>
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<th>24-hour nurse line</th>
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<th>Maternity programs</th>
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<th>Health coaches (phone/online)</th>
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<td></td>
<td>Phone</td>
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<tr>
<th>Call center hours</th>
<th>Mon–Fri: 8 a.m. to 11 p.m. Eastern</th>
<th>Mon–Fri: 8 a.m. to 8 p.m. local time</th>
<th>Mon–Fri: 8 a.m. to 8 p.m. local time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sat: 8 a.m. to 5 p.m. Eastern</td>
<td>Welcometouhc.com</td>
<td>Welcometouhc.com</td>
<td>Welcometouhc.com</td>
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</table>

Kaiser Permanente is also a medical carrier option for 2016 in select markets.

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.
We’ve designed our medical plans to meet the diverse needs of our employees.

We offer medical plans that provide quality health care and 100% coverage for in-network preventive care. Each of these plans has the predictability of an annual deductible and the security of an out-of-pocket maximum.

The medical plan you choose determines:

- The amount of coverage you receive
- When you pay for care (For example, in the Comprehensive PPO, you’ll pay more every pay period than you would in either of the consumer-directed plans. In the consumer-directed plans, you have lower per-pay-period costs and pay more when you receive care.)
- The type of health care account(s) available to you
- Your prescription drug coverage

Which is the right medical plan for me in 2016?
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 then pays the rest.

What will I pay when I begin receiving medical care?

**Annual deductible**
You won’t pay for in-network preventive care covered under health care reform, such as your annual check-up. Generally, for all other covered care, including visits to the doctor, you’ll pay the amount of your annual deductible before the plan starts to pay.

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 4 for contact information and availability.
## What are my medical plan options?

<table>
<thead>
<tr>
<th>Comprehensive PPO</th>
<th>Consumer Directed Plan</th>
<th>Consumer Directed High Deductible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong>&lt;br&gt;In network: $500 per individual, $1,000 per family&lt;br&gt;Out of network: $1,000 per individual, $2,000 per family</td>
<td><strong>$1,200 per individual, $2,400 per family</strong>&lt;br&gt;The in-network and out-of-network annual deductibles are the same under this plan.</td>
<td><strong>$2,250 employee only, $4,500 per family</strong>&lt;br&gt;The in-network and out-of-network annual deductibles are the same under this plan.</td>
</tr>
<tr>
<td><strong>Coinsurance</strong>&lt;br&gt;In network: You pay 20%&lt;br&gt;Out of network: You pay 40%</td>
<td><strong>In network: You pay 20%, Out of network: You pay 40%</strong>&lt;br&gt;In network: $3,500 per individual, $7,000 per family&lt;br&gt;Out of network: $5,000 per individual, $10,000 per family</td>
<td><strong>In network: You pay 20%, Out of network: You pay 40%</strong>&lt;br&gt;In network: $4,000 employee only, $6,850 per individual, up to $8,000 per family*&lt;br&gt;Out of network: $5,500 employee only, $11,000 per family</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong>&lt;br&gt;In network: $2,000 per individual, $4,000 per family&lt;br&gt;Out of network: $4,000 per individual, $8,000 per family</td>
<td><strong>In network: $2,000 per individual, $4,000 per family&lt;br&gt;Out of network: $4,000 per individual, $8,000 per family</strong>&lt;br&gt;You pay the full negotiated rate until you meet the deductible, then you pay coinsurance.</td>
<td><strong>In network: $2,250 employee only, $4,500 per family&lt;br&gt;Out of network: $4,500 per individual, $9,000 per family</strong>&lt;br&gt;You pay the full negotiated rate until you meet the deductible, then you pay coinsurance.</td>
</tr>
<tr>
<td><strong>Preventive services</strong>&lt;br&gt;In network: No cost to you, according to government guidelines</td>
<td><strong>In network: No cost to you, according to government guidelines</strong>&lt;br&gt;You pay the full negotiated rate until the annual deductible, then you pay coinsurance.</td>
<td><strong>In network: No cost to you, according to government guidelines</strong>&lt;br&gt;You pay the full negotiated rate until you meet the deductible, then you pay coinsurance.</td>
</tr>
<tr>
<td><strong>Office visits</strong>&lt;br&gt;In network: $15 copayment for primary care, $25 copayment for specialist</td>
<td><strong>In network: You pay the full negotiated rate until you meet the deductible, then you pay coinsurance.</strong></td>
<td><strong>In network: You pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance.</strong></td>
</tr>
<tr>
<td><strong>Prescription drugs (30-day supply)</strong>&lt;br&gt;Generic: $5 copayment&lt;br&gt;Preferred brand: $25 copayment&lt;br&gt;Non-preferred brand: $50 copayment</td>
<td><strong>In network: Generic: $5 copayment&lt;br&gt;Preferred brand: $25 copayment&lt;br&gt;Non-preferred brand: $50 copayment&lt;br&gt;Other drugs (non-preventive): You pay the full negotiated price until you meet the annual deductible, then you pay coinsurance.</strong></td>
<td><strong>Preventive drugs: You pay 20% coinsurance. Other drugs (non-preventive): You pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance.</strong></td>
</tr>
<tr>
<td><strong>Health care account</strong>&lt;br&gt;Health Flexible Spending Account (Health FSA)</td>
<td><strong>Health Flexible Spending Account (Health FSA)</strong>&lt;br&gt;Health Reimbursement Arrangement (HRA)</td>
<td><strong>Health Savings Account (HSA)</strong>&lt;br&gt;Limited Purpose Health Flexible Spending Account (Limited Purpose FSA)</td>
</tr>
</tbody>
</table>

### 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 10.

*The out-of-pocket maximum is $6,850 for family coverage under Kaiser Permanente.
Can family members be covered under my benefits?

During your enrollment period, you can add an eligible child, spouse or partner to 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.

At any time during the year, you must provide notice 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 an 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 plan features work. See page 4 for contact information and availability.

### Understanding how deductibles and maximums work with family coverage

#### Under the Comprehensive PPO or 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.
- 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.
How can I save on prescriptions?

**Take advantage of the 90-Day Refill Program**

When you enroll in a medical plan with Aetna, Anthem Blue Cross Blue Shield or UnitedHealthcare, your prescription drug coverage is provided through CVS Caremark. With this coverage, you can save money on maintenance medications that treat ongoing conditions, such as high blood pressure, by receiving your prescription through the 90-Day Refill Program. It’s actually less expensive than receiving three 30-day supplies.

### Comprehensive PPO

**Prescription drugs (90-day supply)**

- Generic: $10 copayment
- Preferred brand: $50 copayment
- Non-preferred brand: $100 copayment

### Consumer Directed Plan

**Prescription drugs (90-day supply)**

- Generic: $10 copayment
- Preferred brand: 30% coinsurance ($200 max)
- Non-preferred brand: 45% coinsurance ($300 max)

### Consumer Directed High Deductible Plan

**Prescription drugs (90-day supply)**

- Generic: 20% coinsurance
- Preferred brand: Full negotiated cost until you reach the deductible

### Consumer Directed High Deductible Plan

- Preventive drugs: 20% coinsurance
- Non-preventive drugs: Full negotiated cost until you reach the deductible

#### You have two ways to save

You can pick up your maintenance medication and receive this discount at one of 60,000 pharmacies or merchants, including many retail pharmacy chains, grocery stores and big-box retailers in our expanded network or through home delivery to save you time. You can save even more money on prescription drugs by using CVS Caremark’s Mail Order Pharmacy. Receiving your prescription drugs by mail generally can save you more than if you pick up your 90-day supplies at a network pharmacy.

#### It’s easy to get started

You can avoid interruptions in your maintenance medications by participating in the 90-Day Refill Program as soon as possible. Ask your doctor to write a 90-day prescription for your maintenance medication and take it to your network pharmacy to see if your pharmacy is in the 90-Day Retail Network or log on to caremark.com and click Find a Pharmacy under the Order Prescriptions tab.

Ask CVS Caremark to contact your doctor directly, or you can visit caremark.com or call 800.701.5833 to confirm your prescription is eligible and set it up. If you pick up your prescriptions at a CVS/pharmacy®, ask the pharmacist about filling a 90-day supply.

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**Tip**

Keep in mind, the first time you fill a 30-day supply of your maintenance medications, CVS Caremark will remind you to switch to a 90-day prescription. The third time you try to fill a 30-day supply of a maintenance medication, you’ll have to pay the full negotiated cost until you enroll in the 90-Day Refill Program. Those costs won’t count toward your annual deductible or out-of-pocket maximum.
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.
### 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 plan is this account available for?</strong></td>
<td>Comprehensive PPO</td>
<td>Consumer Directed Plan</td>
<td>Consumer Directed High Deductible Plan</td>
</tr>
<tr>
<td><strong>What would I use this account for?</strong></td>
<td>Any eligible health care expense</td>
<td>Any eligible health care expense</td>
<td>To save for future health care expenses, but also to pay for eligible health care expenses now</td>
</tr>
<tr>
<td><strong>What is the maximum amount that the bank and I combined can put in this account?</strong></td>
<td>$2,550 The IRS pretax contribution limit</td>
<td>The IRS does not allow employee contributions to an HRA.</td>
<td>$3,350 Employee-only coverage</td>
</tr>
<tr>
<td><strong>What does the bank put in?</strong></td>
<td>$250 For employees making less than $50K in cash compensation and who enroll in a medical plan paired with a Health FSA</td>
<td>Cash compensation is less than $50K</td>
<td>$6,750 Family coverage</td>
</tr>
<tr>
<td></td>
<td>This amount does not count against the IRS limit of $2,550.</td>
<td>$500 Employee-only coverage</td>
<td>If you'll be 55 or older in 2016, you can make an additional $1,000 catch-up contribution.</td>
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<td>$750 Employee plus spouse/partner OR Employee plus child(ren) coverage</td>
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<td>$1,000 Family coverage</td>
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<td>Cash compensation is $50K to less than $100K</td>
<td>$2,550 The IRS pretax contribution limit</td>
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<td>$400 Employee-only coverage</td>
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<td>$600 Employee plus spouse/partner OR Employee plus child(ren) coverage</td>
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<td>$800 Family coverage</td>
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<tr>
<td></td>
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<td>Bank contributions count against the IRS limits. If your benefits begin on or after July 1, 2016, you will receive 50% of the amounts above.</td>
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<tr>
<td><strong>When are the funds available?</strong></td>
<td>Your entire contribution amount, and any bank contribution, is available at the beginning of the year or when your coverage begins.</td>
<td>Any bank contribution is available at the beginning of the year or when your coverage begins.</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 or when your coverage begins.</td>
</tr>
<tr>
<td><strong>What happens if I don’t use the money during the year?</strong></td>
<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>
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</tbody>
</table>

**Medical**

2016 benefits enrollment guide — Understanding your benefits
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 can keep up to a $500 credit toward your 2016 annual medical premium by completing both wellness activities or up to $1,000 if your spouse or partner also completes them. If you enroll in benefits later in the year, we’ll prorate the credit based on when your medical plan coverage takes effect.

Tip
You have approximately 60 days from when your medical plan coverage becomes effective to complete your wellness activities. You can find your exact wellness activities deadline when you enroll in your benefits on mybenefitsresources.bankofamerica.com. Your health screening results and your health questionnaire must be submitted by the deadline to be considered completed.
How can wellness activities help me save money?

Together, these voluntary steps are a great way to get more information about your overall health so you can address potential risks earlier and save money in the long run.

When you're ready to complete your wellness activities, log on to mybenefitsresources.bankofamerica.com and select the Wellness tab.

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

1. **Complete your health screening**
   - Height, weight, waist, blood pressure and total cholesterol measurements
   - Up to $500

2. **Complete your health questionnaire**
   - Online questionnaire takes just a few minutes and measures your overall health and lifestyle risks
   - Up to $500

3. **You complete both wellness activities**
   - Total credit toward your annual medical plan premium
   - Up to $1,000

If you enroll in benefits later in the year, we’ll prorate the credit based on when your medical plan coverage takes effect. If you and your spouse or 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).

**Tip**

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.
What is covered under the dental plans?

Our primary dental plan is the MetLife Dental PPO Plan.

Visit metlife.com/mydentalppo to see if your dentist is in-network for the Dental PPO Plan.

In select markets, the Aetna Dental DMO Plan is available. When you participate in the Aetna DMO, you choose a primary care dentist who provides most of your care and referrals to specialists. Visit aetna.com/bankofamerica to check if your dentist is in the Aetna DMO network.

If you elect the Triple-S Salud Plan in Puerto Rico or the Aetna International Health Plan in Guam or the U.S. Virgin Islands, dental coverage is provided through that plan.
What is covered under the dental plans?

**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

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**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.

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**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.

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**Aetna DMO (limited markets)**

**General dental expenses**

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

---

**Preventive care**

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.

---

**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; uncomplicated, non-bony impactions.

Oral surgery
- You pay 20% of covered services for basic surgery; 50% of covered major surgery.

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

The bank offers one vision plan with a choice between two vision carriers: Aetna and VSP.

Both carriers will offer the same services and coverage with only a slight difference in per-pay-period costs.

Visit [aetna.com/bankofamerica](http://aetna.com/bankofamerica) or [vsp.com/bankofamerica](http://vsp.com/bankofamerica) to see if your eye care provider is in-network.

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.
## What are my vision plan options?

<table>
<thead>
<tr>
<th></th>
<th>Aetna</th>
<th>VSP</th>
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<tr>
<td></td>
<td>In network</td>
<td>Out of network</td>
</tr>
<tr>
<td><strong>Routine vision exams</strong> (once per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10 copayment</td>
<td>Plan pays a reimbursement, up to $40.</td>
<td>$10 copayment</td>
</tr>
<tr>
<td><strong>Single vision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses (once per calendar year)</td>
<td>Plan pays 100% of covered services, limited to standard uncoated plastic lenses.</td>
<td>Plan pays 100% of covered services.</td>
</tr>
<tr>
<td>Frames (once every other calendar year)</td>
<td>Plan provides a $130 allowance, 20% discount thereafter.</td>
<td>Plan pays a reimbursement, up to $40.</td>
</tr>
<tr>
<td><strong>Bifocal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses (once per calendar year)</td>
<td>Plan pays 100% of covered services for standard uncoated plastic lenses.</td>
<td>Plan pays a reimbursement, up to $60.</td>
</tr>
<tr>
<td>Frames (once every other calendar year)</td>
<td>Plan provides a $130 frame allowance, 20% discount thereafter.</td>
<td>Plan pays a reimbursement, up to $50.</td>
</tr>
<tr>
<td><strong>Contact lenses</strong></td>
<td>$0 copayment</td>
<td>Plan pays a reimbursement, up to $40.</td>
</tr>
<tr>
<td>Standard lens fit and follow-up (once per calendar year)</td>
<td>Plan provides up to $55 allowance, then 10% discount.</td>
<td>Not covered</td>
</tr>
<tr>
<td>Premium contact fit and follow-up (once per calendar year)</td>
<td>Plan pays 100% of covered services.</td>
<td>Plan pays a reimbursement, up to $210.</td>
</tr>
<tr>
<td>Medically necessary prescription lenses for specific eye conditions that would prohibit the use of glasses (once per calendar year; prior approval is needed)</td>
<td>Plan provides a $125 allowance in lieu of eyeglasses; a 15% discount is applied to conventional contacts over the $125 allowance.</td>
<td>Plan provides a $125 allowance in lieu of eyeglasses.</td>
</tr>
<tr>
<td>Elective prescription lenses (once per calendar year)</td>
<td>Plan provides a $125 allowance in lieu of eyeglasses.</td>
<td>Plan provides a $125 allowance in lieu of eyeglasses.</td>
</tr>
</tbody>
</table>
What are my life and disability insurance options?

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?

Yes No

Do others depend on your income?

Yes No

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

Yes No

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

Yes No

If you answer “yes” to any of the questions above, you may want to consider the life and disability insurance options available to you.
What insurance benefits are available at no cost to me?

**Associate life insurance**
For 2016, our company-paid associate life insurance is provided by MetLife.

Annual base pay (or ABBR) × 1
Rounded up to the next $1,000, up to a maximum of $2 million.
See information about ABBR on page 28.

**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 enrollment on mybenefitsresources.bankofamerica.com.

**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 × 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**
Log on to mybenefitsresources.bankofamerica.com to designate a beneficiary for all of your life insurance coverage. After you log on, go to Your Profile and click Beneficiaries to make and confirm your elections.
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 child or spouse/partner 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
- $20,000/child
- $25,000/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 may be right for you. See page 4 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)

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

**Family AD&D insurance**
You also may elect family AD&D coverage for your children and spouse/partner, 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 your enrollment period:

- Dependent Care Flexible Spending Account (Dependent Care FSA)
- Purchased Time Off (PTO)
- Prepaid Legal
### Beneficiaries

**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.

**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.

**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 are eligible, except those in bands 0–3, commissioned employees or employees working in Puerto Rico.

### Eligibility

**Who's eligible**
- 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 is eligible.
- 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.

### Actions you can take

**Actions you can take**
- 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.
- Receive permission from your manager before you purchase time off.
- If your coverage starts Jan. 1, 2016, you can purchase time off from work. If your coverage starts later, you can purchase time off during the next Annual Enrollment.
- You are only able to enroll in Prepaid Legal during your enrollment period and must remain in the plan for the calendar year.
How do I enroll?

Find your exact enrollment date on your Enrollment Worksheet.

**Important reminders:**

- Your elections will last for the 2016 calendar year unless you experience a qualified status change during the year.
- Any health care account contributions you receive from the bank will not change, even if you have a qualified status change that changes the number of people you cover on your plan.
- If you decline coverage during your enrollment period, but need to enroll following a qualified status change, you may be eligible for a prorated health care account contribution.

**Tip**

You must enroll by your enrollment deadline if you want coverage under our plans. If you don’t do anything during your enrollment period, you will have the coverage indicated on your Enrollment Worksheet, which in most cases is no coverage for 2016.
How do I enroll?

The fastest and easiest way to enroll is online.

**When you’re logged on to the bank’s network:**

1. Click **Essential Links** on Flagscape, then select **My Benefits Resources**.
2. Log on using your Standard ID and Password.
3. From the **Home** tab on **mybenefitsresources.bankofamerica.com**, click **Make Your 2016 Enrollment Choices**.
4. 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 need more information, go to **HR Connect > Benefits > Health > Eligibility & enrollment**.

**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 **mybenefitsresources.bankofamerica.com**, click **Enroll in Your Benefits**.
3. 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.

**Tip**

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

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 “Health and Insurance” 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.
A few additional notes about your benefits

For more information about plans described in this guide, go to Flagscape > HR Connect > Benefits > Health > Medical plans and click Resources.

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 still will 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 mybenefitsresources.bankofamerica.com

Medical

Performance year cash compensation (PYCC)
If you were newly hired by the bank or became benefits-eligible for the first time after June 30, 2015, your performance year cash compensation (PYCC) for 2016 is your base salary as of your date of hire, or the date you became benefits-eligible.
If you rejoined the bank after June 30, 2015:
• If you were rehired within 180 days of leaving the bank, your previous PYCC amount will be used again.
• If you were rehired more than 180 days after leaving the bank, your PYCC is your base salary as of your date of rehire.
Any changes to your base salary in 2015 or 2016 will not impact 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 (see next section).

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 bonus 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.

Find your PYCC or ABBR
1. Log on to mybenefitsresources.bankofamerica.com using your Person Number and the password you create 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.
3. Select the Personal Details tab.
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 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 your enrollment period.

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) include the participant’s birth, adopted or placed-for-adoption, step and foster children under the age of 26, among other eligible dependents.
However, per IRS requirements, the definition of an eligible dependent under a Health Savings Account (HSA) only includes family members whom you can claim as dependents on your federal income tax return. If you are uncertain if a child or other individual qualifies as your eligible dependent, call the Global HR Service Center.
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 re-enroll in an HRA-eligible plan or leave the bank after meeting the Rule of 60. HRA-eligible plans include the Comprehensive PPO Plan and the Consumer Directed Plan. For more information, refer to the summary plan document and any SMMs on Flagscape > HR Connect > Benefits > Health > Health Care Accounts and click Resources.

Tax considerations
Some circumstances could result in your 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 non-tax-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)
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, go to Flagscape > HR Connect > Benefits > Health > Eligibility & enrollment. If you 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 mybenefitresources.bankofamerica.com 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 information on what’s considered a qualified status change, go to Flagscape > HR Connect > Benefits > Health > Eligibility & enrollment and click Enrolling or making changes.
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 a coverage amount more than three times your annual base salary (or ABBR) plus eligible bonus amount, or elect coverage that is greater than or equal to $500,000, you can become insured for this amount only if you submit a Statement of Health. 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.

A Statement of Health will be required if you elect spouse or partner life insurance coverage of $75,000 or more during your enrollment period. 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 your enrollment period 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 your effective date of 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 full- or part-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
- A normal sick 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 summary plan document, which is available on Flagscape > HR Connect > Benefits > Health > Medical plans and click Resources.

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, log on to mybenefitsresources.bankofamerica.com and go to Enroll in Your Benefits > 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 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.

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.

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.

Important notes

• 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 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 re-enrollment 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 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 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 mybenefitsresources.bankofamerica.com for deductibles 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 mybenefitsresources.bankofamerica.com 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 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
TTY: 800.628.3323

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
TTY: Dial 711, then 877.240.4075

Prescription coverage
CVS Caremark
caremark.com
800.701.5833
TTY: 800.231.4403

Dental
Aetna (limited availability)
aetna.com/bankofamerica
877.444.1012

MetLife
metlife.com/mydentalppo
888.245.2920
TTY: Dial 711, then 888.245.2920

Vision
Aetna
aetna.com/bankofamerica
877.444.1012

VSP
vsp.com/bankofamerica
877.814.8967
TTY: 800.428.4833

Health care and dependent care accounts
Health Benefit Solutions
bankofamerica.com/benefitslogin
866.791.0254
TTY: 800.305.5109

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
TTY: Dial 711, then 800.556.6044

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