2017 benefits enrollment guide
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.

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.
Get ready to make your health and insurance benefit elections for 2017.

This guide is for employees who earn $100,000 or more in performance year cash compensation (PYCC). See page 20 for details.

For more information about plans described in this guide, visit HR Connect > Benefits > Health > Medical plans > 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 medication coverage. See page 24 for information.

Important reminders:

• 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 2017.

• If you decline coverage during your benefits enrollment period but need to enroll following a qualified status change, you may be eligible for prorated health care account contributions.
What do I need to consider for Annual Benefits Enrollment?

When choosing your health and insurance coverage for 2017, review the benefit options available to you and make the elections that are right for you and your family.

- Which medical plan will work best for you and your family?
- Which medical carrier fits your needs?
- How much do you want to contribute to the health care account that works with your medical plan?
- Do you and your family need dental or vision coverage?
- Do you need to cover eligible family members under your health or insurance benefits?
- Do you want to purchase supplemental life or disability insurance?
- Do you have upcoming legal issues (such as, purchasing or selling a house or estate planning) where the prepaid legal program can help?
- Who should be your beneficiary for life insurance and your Health Savings Account (HSA), if applicable?

Important reminder:

Learn more about the voluntary wellness activities through which you can keep a $500 credit toward your annual medical plan premium. Keep an additional $500 if your covered spouse/partner completes theirs as well. If your benefits coverage begins after Jan. 1, we'll prorate the credit based on when your medical plan coverage takes effect.
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 (excluding certain holidays).

To help you compare your medical, dental and vision plan choices, access the compare tools available on My Benefits Resources (mybenefitsresources.bankofamerica.com)
What are my medical options?

You have two medical choices to make during benefits enrollment: your medical carrier and your medical plan.

All three national medical carriers, Aetna, Anthem and UnitedHealthcare, offer the same medical plans and are high-quality options with similar services and networks. We also offer Kaiser Permanente as a carrier in select markets. Please refer to the Compare Medical Options tool on My Benefits Resources for specific Kaiser Permanente plan information.

Your medical premiums will be based on your pay tier, the plan you choose, the number of people you cover and the carrier you select, the zip code you live in and whether or not you complete wellness activities or use tobacco.
What’s important to know about the medical carriers?

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

### 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.

<table>
<thead>
<tr>
<th>Per-pay-period differences between carriers</th>
<th>Anthem</th>
<th>UnitedHealthcare</th>
<th>Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest cost</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctors and facilities</th>
<th>anthem.com/bankofamerica</th>
<th>welcometouhc.com/findmydoc</th>
<th>aetna.com/bankofamerica</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check if your doctor is in a carrier network</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Medical plans                               | ✔ | ✔ | ✔ |
| (Comprehensive PPO, Consumer Directed, Consumer Directed High Deductible) | anthem.com/bankofamerica | welcometouhc.com/findmydoc | aetna.com/bankofamerica |

| Teladoc™                                   | ✔ | ✔ | ✔ |
| 24/7 access to board-certified doctors by phone or online video | anthem.com/bankofamerica | welcometouhc.com/findmydoc | aetna.com/bankofamerica |

| 24-hour nurse line                         | ✔ | ✔ | ✔ |
|                                          | anthem.com/bankofamerica | welcometouhc.com/findmydoc | aetna.com/bankofamerica |

| Maternity programs                         | ✔ | ✔ | ✔ |
|                                          | anthem.com/bankofamerica | welcometouhc.com/findmydoc | aetna.com/bankofamerica |

| Health coaches                             | Phone | Phone | Phone and online |
| (phone/online)                             | anthem.com/bankofamerica | welcometouhc.com/findmydoc | aetna.com/bankofamerica |

| Call center hours                          | Mon–Fri: 8 a.m. to 11 p.m. Eastern Sat: 8 a.m. to 5 p.m. Eastern | Mon–Fri: 8 a.m. to 8 p.m. local time | Mon–Fri: 8 a.m. to 8 p.m. local time |
|                                          | anthem.com/bankofamerica | welcometouhc.com/findmydoc | aetna.com/bankofamerica |
Which is the right medical plan for me in 2017?

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 plan 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
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 on a pretax basis. Medical premiums are based on your pay tier, the plan you choose, the number of people you cover, the carrier you select, the zip code you live in and whether or not you've completed wellness activities or use tobacco.

What will I pay when I begin receiving medical care?

**Annual deductible**
You won’t pay for in-network preventive care defined by the U.S. Preventive Services Task Force, such as your annual checkup. Generally, for all other covered care, you’ll pay the amount of your annual deductible before the plan starts to pay.

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. Once you meet it, the plan pays the full cost of additional covered care. Think of it as your safety net.

How is my annual premium determined?

**PYCC**
Your premiums for medical coverage are determined by tiers that use your PYCC. See page 20 for more information.

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
Here’s how deductibles and maximums for employees with family coverage compare across plans.

**Consumer Directed Plan**

**Annual deductible/coinsurance**

Coinsurance begins:
- For any family member who meets his/her individual annual deductible.
- For everyone on the plan once two people have costs that combine to meet the family deductible.

**Out-of-pocket maximum**

100% of eligible costs are covered:
- For any family member who meets his/her individual out-of-pocket maximum.
- For everyone on the plan once two people combine to reach the out-of-pocket maximum.

**Consumer Directed High Deductible Plan**

**Annual deductible/coinsurance**

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.

*Kaiser California plans have a different deductible and out-of-pocket-maximum for employees choosing family coverage. Please contact Kaiser Permanente for further information.

During your benefits enrollment period, you can add a spouse/partner or eligible child to your coverage.

If you add an adult to your coverage, you’ll be required to verify his or her eligibility. You’ll receive a Dependent Verification letter at your home address on file with more information about deadlines and the documents required to verify the eligibility of your newly added adult family member(s).

Some of your benefits, including when bank contributions to your health care account are available, may be affected if there’s a delay verifying the eligibility of your adult family member(s). If you don’t provide all the required documentation by the deadline provided to you, he or she will be dropped from your health and insurance coverage. This means they will no longer be covered under the plans you elected during enrollment.

**Important reminder:**
If you get married, have a baby, get a divorce, or another event occurs that qualifies as a qualified status change, you must notify the Global HR Service Center **within 31 calendar days** of the date of the change. For more information about who’s eligible to be on your plans, see page 21.

Tip

Don’t forget to take a look at the Medical Expense Estimator on My Benefits Resources to compare your premiums and estimated out-of-pocket costs across the plans and carriers.
### What are my medical plan options?

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Annual Deductible</th>
<th>Coinsurance</th>
<th>Out-of-Pocket Maximum</th>
<th>Preventive Services</th>
<th>Office Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consumer Directed Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In network</td>
<td>You pay up to</td>
<td>$1,200 per individual</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of network</td>
<td>You pay up to</td>
<td>$2,400 per individual</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consumer Directed High Deductible Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In network</td>
<td>You pay up to</td>
<td>$2,250 per individual</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of network</td>
<td>You pay up to</td>
<td>$4,500 per individual</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preventive Services**
- In network: You pay $0, according to government guidelines.
- Out of network: You pay the full negotiated rate until you meet the deductible, then you pay coinsurance.

**Office Visits**
- You pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance.

**Prescription Medication at Retail** *(30-day supply)*
- In network, you pay:
  - Generic: $5 copayment
  - Preferred brand: 30% coinsurance ($100 max)
  - Non-preferred brand: 45% coinsurance ($150 max)
- Out of network, you pay 40% coinsurance.

**Health Care Account** *(More details on page 11)*
- Health Reimbursement Arrangement (HRA)
- Health Flexible Spending Account (Health FSA)
- Health Savings Account (HSA)
- Limited Purpose Flexible Spending Account (Limited Purpose FSA)
Health care accounts can be used to help offset your out-of-pocket health care expenses, such as copayments, prescription medications, eye glasses and lab work.

The amount the bank will contribute to your health care account is based on your PYCC and the family members you cover. 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.

Any health care account contributions you receive from the bank will not change in 2017, even if you have a qualified status change that changes the number of people you cover on your plan.

**Important note**

The health care account contribution you elect will be divided by the number of pay periods remaining once your benefits start. For example, if your benefits start on July 1, the contribution amount you elect will be deducted from your pay between July and December.

**Tip**

If you have selected the Consumer Directed medical plan with the HRA, you may only submit claims for reimbursement from your HRA for yourself and those dependents covered under your Bank of America medical plan, per IRS rules.
<table>
<thead>
<tr>
<th>Which plans is this account available for?</th>
<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>Comprehensive PPO</strong></td>
<td><strong>Consumer Directed Plan</strong></td>
<td><strong>Consumer Directed Plan</strong></td>
<td><strong>Consumer Directed High Deductible Plan</strong></td>
<td><strong>Consumer Directed High Deductible Plan</strong></td>
</tr>
<tr>
<td><strong>Consumer Directed Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**You don't need to be enrolled in a medical plan.**

| What would I use this account for?       | Eligible health care expenses, including dental, vision and prescription medication. | Eligible health care expenses, including dental, vision and prescription medication. | To save for future health care expenses, but also to pay for eligible health care expenses, including dental, vision and prescription medication, now. | This health care account has to be paired with an HSA, and you can only use it for eligible vision and dental expenses. |

| What is the maximum amount that the bank and I combined can put in this account? | $2,600 The IRS pretax contribution limit | The IRS does not allow employee contributions to an HRA. | $3,400 Employee-only coverage $6,750 Family coverage If you'll be at least 55 years old in 2017, you can make an additional $1,000 catch-up contribution | $2,600 The IRS pretax contribution limit |

| What does the company put in?            | The bank does not contribute to this account. | Cash compensation is less than $50K $500 Employee-only coverage $750 Employee plus spouse/partner OR Employee plus child(ren) coverage $1,000 Family coverage Cash compensation is $50K to less than $100K $400 Employee-only coverage $600 Employee plus spouse/partner OR Employee plus child(ren) coverage $800 Family coverage Bank contributions count against the IRS limits. If your benefits begin on or after July 1, 2017, you will receive 50% of the amounts above. | Cash compensation is less than $50K $500 Employee-only coverage $750 Employee plus spouse/partner OR Employee plus child(ren) coverage $1,000 Family coverage Cash compensation is $50K to less than $100K $400 Employee-only coverage $600 Employee plus spouse/partner OR Employee plus child(ren) coverage $800 Family coverage Bank contributions count against the IRS limits. If your benefits begin on or after July 1, 2017, you will receive 50% of the amounts above. | The bank does not contribute to this account. |

| When are the funds available?             | Your entire contribution amount, and any bank contribution, is available at the beginning of the year. | Any bank contribution is available at the beginning of the year. | 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. | Your entire contribution amount is available at the beginning of the year. |

| What happens if I don't use the money during the year? | Up to $500 in unused funds will roll over automatically to pay for eligible expenses in the following year. | All unused funds will 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. Please note that if you leave the bank with a balance and have not met the Rule of 60, it will be forfeited. See page 21 for more information. | All 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. | Up to $500 in unused funds will roll over automatically to pay for eligible expenses in the following year. |
MetLife is the carrier for our 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. Visit aetna.com/bankofamerica to check if your dentist is in the Aetna DMO network. If you choose this plan, your primary care dentist must be in the Aetna DMO network and accepting new DMO patients. Be sure to confirm this before you elect this plan.

Out-of-network coverage.

A dentist who is “out-of-network” means the provider hasn’t agreed to negotiated rates. The plan pays benefits based on the usual and customary charge for a particular service. If the out-of-network provider charges more, you’ll be responsible for paying the amount that exceeds the usual and customary limit plus the applicable coinsurance and deductible. Aetna DMO does not have out-of-network coverage.
We offer two options for vision plans: Aetna and VSP.

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.

<table>
<thead>
<tr>
<th></th>
<th>Aetna</th>
<th>VSP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine vision exams</strong></td>
<td>$10 copayment</td>
<td>$10 copayment</td>
</tr>
<tr>
<td><strong>Eye glasses</strong></td>
<td><strong>In network</strong></td>
<td><strong>Out of network</strong></td>
</tr>
<tr>
<td>Single vision lenses</td>
<td>Plan pays 100% of covered services, limited to standard uncoated plastic lenses.</td>
<td>Plan pays a reimbursement, up to $40.</td>
</tr>
<tr>
<td>Bifocal lenses</td>
<td>Plan pays 100% of covered services for standard uncoated plastic lenses.</td>
<td>Plan pays a reimbursement, up to $40.</td>
</tr>
<tr>
<td>Frame allowance</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>$30 copayment</td>
</tr>
<tr>
<td>Standard lens fit and follow-up</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</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 insurance benefits are available at no cost to me?

**Associate life insurance**

Our company-paid associate life insurance is provided by MetLife.

Annual base pay (or ABBR) \(\times 1\)

Rounded up to the next $1,000, up to a maximum of $2 million.

See information about ABBR on page 20.

**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)**

100% / 70% weekly base pay (or ABBR)

One week notification period.
- 100% for eight weeks.
- 70% for up to 17 additional weeks.

**Long-term disability (LTD)**

50% weekly base pay* (or ABBR)

For full-time employees only. Part-time employees can purchase LTD coverage during Annual Benefits Enrollment on My Benefits Resources.

*Or pre-disability earnings. See page 22 for more information.

**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/partner
- $50,000 coverage for each child

Tip: During your benefits enrollment, ensure you’ve designated a beneficiary for all of your insurance benefits.

Life and disability insurance can provide income protection for you and your family.

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

Life and disability insurance can provide income protection for you and your family.

Some coverage is provided automatically to you at no cost; other supplemental coverage is available to purchase based on your needs.
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. See page 22 for more information.

**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.

**Spouse/partner life insurance**
Coverage options available:
$10,000 $100,000
$25,000 $125,000
$50,000 $150,000
$75,000
A Statement of Health may be required. See page 22 for more information.

**Child life insurance**
Coverage options available:
$5,000/child $20,000/child
$10,000/child $25,000/child
$15,000/child
A Statement of Health may be required.

**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 a month).

60% annual base pay* (or ABBR)

60% eligible compensation
(annual base pay* + eligible bonus)

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**
You may elect additional financial protection in the event of a serious accidental injury or death on a pretax basis.

Eligible compensation $\times 1-8$
(annual base pay + eligible bonus) or ABBR
up to a maximum of $3$ million

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

**Spouse/partner**
60% of your coverage amount, up to $600,000

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

*A financial counselor at the BEPC can help you understand these coverage amounts and which ones may be right for you. See page 4 for contact information.

*Or pre-disability earnings. See page 22 for more information.
### Benefits

<table>
<thead>
<tr>
<th>What we offer</th>
<th>Who's eligible</th>
<th>Actions you can take</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Care Flexible Spending Account</strong> (Dependent Care FSA)</td>
<td>• Employees with children under age 13 and anyone who is a dependent under IRS rules, or who is mentally or physically incapable of taking care of himself or herself.</td>
<td>• Contribute up to $5,000 per year to the account (or $2,500 if you are married and filing separate tax returns).</td>
</tr>
<tr>
<td>• You can pay for eligible dependent care expenses with pretax dollars, including:</td>
<td>• Employees in New Jersey and Pennsylvania can’t make pretax contributions, per state regulations.</td>
<td>• 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.</td>
</tr>
<tr>
<td>– Adult day care centers</td>
<td>• Employees in Puerto Rico, Guam and the U.S. Virgin Islands are not eligible.</td>
<td>• Receive permission from your manager before you purchase time off.</td>
</tr>
<tr>
<td>– Babysitters and nannies</td>
<td>• Employees scheduled to work less than 20 hours per week are not eligible.</td>
<td>• If your benefits coverage starts Jan. 1, 2017, you can purchase time off from work. If your coverage starts later, you can purchase time off during the next Annual Benefits Enrollment.</td>
</tr>
<tr>
<td>– Summer day camp</td>
<td>• 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.</td>
<td>• You are only able to enroll in Prepaid Legal during your enrollment period and must remain in the plan for the calendar year.</td>
</tr>
<tr>
<td>– Before- and after-school programs</td>
<td>• Active, U.S.-based full- and part-time employees.</td>
<td></td>
</tr>
<tr>
<td>– Child day care</td>
<td>• Employees scheduled to work less than 20 hours per week are not eligible.</td>
<td></td>
</tr>
<tr>
<td>• You can use this account for dependent care expenses incurred so you and your spouse/partner can attend school full time. If your spouse/partner stays home full time, you are not eligible for the tax benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Employees with children under age 13 and anyone who is a dependent under IRS rules, or who is mentally or physically incapable of taking care of himself or herself.</td>
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</tr>
</tbody>
</table>

#### Purchased time off (PTO)

- You may purchase time off from work above 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.

#### 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.

- Active, U.S.-based full- and part-time employees.
- Employees scheduled to work less than 20 hours per week are not eligible.

- You are only able to enroll in Prepaid Legal during your enrollment period and must remain in the plan for the calendar year.
Focusing on wellness is an investment in your health, which can save you money in the long run.

When you’re in good health and feel well, you can be your best at home and at work. To help you understand your health, take advantage of the voluntary wellness activities—a health screening and health questionnaire. You’ll get to know your numbers, and keep a $500 credit toward your annual medical plan premium (or a $1,000 credit if your covered spouse or partner completes them as well).*

Once you know about your health, you can take advantage of the benefits and programs available to support your wellness. You have access to:

- Free one-on-one health coach sessions
- Wellness challenges with your teammates
- Programs that can help you quit using tobacco
- A hypertension management program to help you manage your blood pressure

**Important reminder**

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 My Benefits Resources. Your health and screening results and your health questionnaire must be submitted by the deadline to be considered complete.

*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).

**Learn about the two wellness activities and how the $500 credit works.**

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

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

$500 + $500 = $1,000

- You complete both wellness activities
- Your spouse/partner completes both wellness activities
- Total credit to your annual medical plan premium

When you’re ready to complete your wellness activities, log on to My Benefits Resources and select the Wellness tab.

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 your individual results.
When and how do I enroll?

The fastest and easiest way to enroll is online, through My Benefits Resources.

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

1. Log on to My Benefits Resources (Flagscape > Essential links) using your standard ID and password.
2. From the Home tab on My Benefits Resources, 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.

**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 or call the Global HR Service Center.
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 click Complete Enrollment. You will see a Confirmation Statement, which you should print for your records.

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.
Important notes about your benefits

For more information about plans described in this guide, visit the Medical plan details section on HR Connect > Benefits > Medical plans > 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 (2017 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 My Benefits Resources > Wellness tab > Quick Links.

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, 2016, your PYCC for 2017 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, 2016:
- 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 2016 or 2017 will not affect the PYCC amount used to determine your pay tier.

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, 2015, draw paid in 2015 and any benefits-eligible cash incentives, which include most commission pay and annual incentives earned for 2015 and paid before July 2016.

For employees in the GWIM line of business: ABBR is based on your benefits-eligible compensation earned in 2015, plus any benefits-eligible cash incentives, which include most commission pay and annual incentives earned for 2015 and paid before July 2016.

You can find your 2017 PYCC or ABBR

1. Log on to mybenefitsresources.bankofamerica.com 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, 2015, will not change the PYCC amount used to determine your pay tier.

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

Tobacco users pay more

For 2017, 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 $75 per month higher ($900 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 2017 will be set to “yes” automatically.

This means your per-pay-period costs for medical coverage in 2017 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 Benefits Enrollment, you’ll be asked to provide your tobacco-user status separately from the tobacco-user status of your spouse/partner.

Note for medical coverage only: If you or your covered spouse/partner currently use tobacco products but intend to quit in 2017, you must indicate this when you enroll and you will not pay the higher tobacco-user rate.

In addition, 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 Benefits 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 PYCC, 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 HRA, Health FSA and 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 an 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.

If you have selected the Consumer Directed medical plan with the HRA, you may only submit claims for reimbursement from your HRA for yourself and those dependents currently covered under your Bank of America medical plan, per IRS rules.
Important notes about your benefits

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 Comprehensive PPO Plan and the Consumer Directed Plan. For more information, refer to the 2016 Summary Plan Description (SPD) and subsequent Summaries of Material Modifications (SMMs) on HR Connect > Benefits > Health > Medical plans > Resources.

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 eligible health care expenses, you may need to verify that your debit card transactions were not 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.

• 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 2016 SPD on HR Connect > Benefits > Health > Medical plans > Resources. If you add a dependent to your coverage for 2017, 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/partner
Generally, your spouse/partner is eligible to be covered under our plans.

The U.S. Treasury and IRS guidelines 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.
Important notes about your benefits

Qualified status change
For details on what’s considered a qualified status change, visit HR Connect > Benefits > Health > Eligibility & enrollment > 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 2017 will be set to “yes” automatically. This means your per-pay-period cost for associate supplemental life insurance coverage in 2017 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.

When you first become eligible to enroll in supplemental life insurance (for example, when you’re hired or if you switch from part-time working less than 20 hours to full- or part-time status), you may elect supplemental coverage of one, two or three times your annual base pay and eligible bonus, plus to a maximum that is less than $500,000, without providing a Statement of Health. You must enroll within 31 days of becoming eligible.

If you initially elect supplemental coverage that’s greater than three times your annual base pay and eligible bonus, or if you elect coverage that is greater than or equal to $500,000, you must provide a Statement of Health that’s satisfactory to the insurance company.

During future Annual Benefits Enrollment periods or when you have a qualified status change (as described in the Eligibility and enrollment section), you’ll need to provide a Statement of Health if you:

• Elect supplemental coverage for the first time
• Increase supplemental coverage by more than one level
• Elect supplemental coverage that’s greater than or equal to $500,000. (This doesn’t apply if your coverage goes above $500,000 because of a change in salary.)

Dependent life insurance
Tobacco users pay a higher rate for spouse/partner dependent life insurance coverage. If your spouse/partner has acknowledged previously that he or she is a tobacco user when electing spouse/partner life insurance or medical coverage, the acknowledgment for 2017 will be set to “yes” automatically. This means your per-pay-period costs for spouse/partner dependent life insurance coverage in 2017 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 Benefits Enrollment, if you elect coverage for the first time, increase coverage by more than one level or elect coverage over $50,000, your spouse/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/partner’s Statement of Health is approved by the insurance company. Until a Statement of Health is approved, or if your spouse/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 Benefits 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 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 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 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 an increase in coverage. A disease or injury is a pre-existing condition if, during the six months before your effective date of an increase in 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

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 2016 SPD, which is available on HR Connect > Benefits > Health > Medical plans > Resources.

- Retiree life insurance: You will have imputed income if your company-paid retiree life insurance coverage exceeds $50,000.
- Dependent life insurance: Some participants may have imputed income on their dependent life insurance coverage (for coverage of more than $2,000).
- Coverage for a partner: The value of coverage for your partner and/or your partner’s children who are not your tax dependents is considered imputed income for purposes of medical, dental and vision to the extent you are not paying the full value of such coverage on a post-tax basis. (If you are enrolling your partner and/or your partner’s children whom you can claim as your dependents on your federal income tax return, you must do so through the Global HR Service Center. If you are enrolling your partner and/or your partner’s children whom you cannot claim as your dependents on your federal income tax return, you may do so through either My Benefits Resources or the Global HR Service Center.)

**Eligible bonus amount**

For associate supplemental life, AD&D and LTD insurance coverage amounts for 2017, your eligible bonus amount consists of any performance-based, benefits-eligible cash incentives and special equity awards earned for 2015 and paid by June 30, 2016. Your eligible bonus amount remains fixed for the plan year.

**Lifetime maximum**

A lifetime maximum, or the most the plan will pay for benefits, applies to some medical and dental services. Please check with your plan’s insurer or claims administrator regarding any benefit limits.

**Falsification of information**

If you or an enrolled dependent knowingly submit false information when enrolling in, changing or claiming health and insurance benefits, or if you fail to notify the Global HR Service Center that an enrolled dependent is no longer eligible for coverage, participation for you and your dependents may be immediately, retroactively and permanently canceled. In addition, the insurance company may deny coverage. Pending claims may not be paid, and you must reimburse the plan for any previous claims incurred that should not have been paid.

In addition, you may be asked to provide proof of dependent eligibility at a future date. The bank reserves the right to audit your dependent enrollment information at any time. See page 21 for more information about dependent eligibility.
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 SBC, log on to My Benefits Resources and go to Enroll in your benefits > Medical View/Change > Compare Medical Options. 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.

Important notes about your benefits

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 $500 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 coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or 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 2017, 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 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 Benefits 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 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, coinsurance and copayment provisions applicable to other such medical and surgical benefits provided under the plan.

Please use the Compare Medical Options tool on My Benefits Resources for deductibles, coinsurance 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 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 2017. 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.
**Medical plans**

- **Aetna**
  aetna.com/bankofamerica
  877.444.1012

- **Anthem**
  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 Health**
  caremark.com
  800.701.5833
  TTY: 800.231.4403

**Dental**

- **Aetna**
  Aetna DMO is only available in select markets.
  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

**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

- **Global HR Service Center**
  My Benefits Resources
  800.556.6044

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

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