Supporting you and your family during the moments that matter

2015 benefits enrollment guide
How to use this guide

Annual Enrollment for your health and wellness benefits is Oct. 3–16.

This guide provides details on the health plans and insurance options available to employees who earn less than $100,000 in performance year cash compensation (see page 20).

Since this guide lists new or expanded benefits that will take effect on Jan. 1, 2015, it also serves as a legal document called a Summary of Material Modifications (SMM). In an SMM (see page 29), we outline the programs that have been changed since we issued the Bank of America Employee Health and Insurance Summary Plan Description 2013 (2013 SPD) and the Bank of America Employee Health and Insurance 2014 Summary of Material Modifications.

This means that the information in the 2013 SPD and changes outlined in later SMMs, including this guide, describes your 2015 benefits.

These legal documents can be found on Flagscape > HR, Benefits & Career > Compensation & Benefits > Health & Insurance.

Tip

If you don’t do anything during Annual Enrollment, all of your elections from 2014 will continue automatically in 2015, if you’re still eligible for them, except for purchased time off (PTO), which you have to elect every year.

Remember to take action during Annual Enrollment if you want to ...

Make changes to your current benefit elections
- Do you want to change your health, dental or vision plan?
- Do you want to purchase supplemental life or disability insurance?
- Do you want to purchase time off in 2015?
- Do you want to enroll in prepaid legal services?

Add or remove family members
- Do you need to change which family members are covered on your health plan or insurance benefits?

Learn how to save money
- Do you want to keep the credit to your health plan premium by completing both the health screening and health assessment questionnaire?
- Do you want to save money by contributing to a health care account?
What’s inside this guide ...

Need help with questions about which plans are right for you?

Counselors at the Benefits Education & Planning Center can help answer any questions you may have on the topics covered in this guide. To fit your schedule, the BEPC has added extra hours during Annual Enrollment. Oct. 3-16, 2014, call from 8 a.m. to 9 p.m. Eastern, Monday through Friday, and 9 a.m. to 4 p.m. Eastern on Saturdays.
We’re expanding some of our benefits and programs in 2015

Enhanced autism coverage
Our Aetna plans provide resources and support for family members with autism, and, in 2015, we’re adding coverage for applied behavior analysis (ABA). See page 21 for more information.

Health FSA and Limited Purpose FSA rollover
If you have unused funds at the end of the year in a Health Flexible Spending Account (Health FSA or the Limited Purpose FSA), up to $500 will automatically roll over to be used for eligible expenses the following year. See page 9 for more information.

Limited Purpose FSA
On page 22, you’ll see that we’re introducing this new account that can work alongside your Health Savings Account (HSA). You can use the Limited Purpose Health Flexible Spending Account (FSA) to pay for eligible dental and vision expenses and preserve your HSA as an investment account for other health care expenses, even into retirement.

Expanded preventive care services
In keeping with U.S. health care reform, in-network preventive care continues to be available at no cost to you, even if you haven’t met your annual deductible (see page 29). Some new preventive care services will be available in 2015, including:

• Medications for the prevention of breast cancer if you’re determined to be at high risk
• Lung cancer screenings if you’re determined to be at high risk
• Gestational diabetes screening
• Screening for tobacco use and programs to help you stop

Prepaid legal
For less than $200 a year, you can enroll in prepaid legal, offered through Hyatt Legal Plans. The program, outlined on page 16, provides access to experienced attorneys for common legal issues, such as real estate matters, family services, civil lawsuits, wills, estate planning and more.

Child care reimbursement
We’re expanding eligibility of our Child Care Plus® program so that there no longer is a base salary maximum. If your total family income is $100,000 or less, you may be eligible for a monthly reimbursement of up to $240 per child for certain child care expenses in 2015. To learn more, see the Child Care Reimbursement page on Flagscape®.
Your wellness activities can help you learn more about your health and save money

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

The results of the health screening and health assessment 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 health plan and be used to provide you with important information about your health.

Did you know?

73,000
Number of employees and family members who worked with a health coach or nurse on a plan to improve their health.

221,000
Number of employees, spouses and partners who completed the 2014 wellness activities and learned more about their health.

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

First, complete your health screening.

Then, complete your health assessment questionnaire.

$500
You complete both wellness activities by Feb. 28, 2015

$500
Your spouse/partner completes both wellness activities by Feb. 28, 2015

Total credit to your annual medical plan premium

Up to $1,000

If you and your spouse/partner choose not to complete the wellness activities, your per-pay-period costs for medical plan coverage will go up by about $40 (or about $20 per adult), beginning in April 2015.

For more information on how to complete the wellness activities, check out the online wellness guide on Employee Resources at Home (bankofamerica.com/employee).

Tip

Your health screening results and your health assessment questionnaire must be submitted by the deadline to be considered completed.
Things to consider for 2015

For 2015, your medical plan premiums aren’t changing. That means if you’re in the same pay tier and choose to keep the same plan that covers the same people, your per-pay-period costs won’t change.*

Also, the major features of the medical plans available to you will be the same as they were in 2014. This includes deductibles, copayments or coinsurance, and out-of-pocket maximum amounts.

Did you know?

Per-pay-period costs for medical coverage are determined by tiers that use your performance year cash compensation (see page 20). Those 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

*Assuming you complete both wellness activities, didn’t move and didn’t start using tobacco.

Should you consider changing your health plan?

Remember, if you don’t take action during Annual Enrollment, you’ll stay in your current health plan for 2015. However, if you answer “yes” to any of the questions below, you may want to make a change.

Quick quiz

Did your pay increase and possibly change your pay tier?

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

Do you expect to need more or less medical care in 2015 than you did in 2014?

Tip

Starting Oct. 3, 2014, you can log on to mybenefitsresources.bankofamerica.com and use the Medical Expense Estimator Tool to estimate out-of-pocket expenses. You can find out how to log on and enroll on page 17 of this guide.
Here’s some information about how our health plans work

What will I pay out of my paycheck?

Annual premium

The annual cost to purchase health insurance is spread across the year, so you pay a portion of it in each pay period. Amounts differ based on your pay tier, the plan you elect and the number of people you cover.

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. Generally, for all other covered care, including visits to the doctor, you’ll pay this amount before the bank 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 bank pays the rest.

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

Out-of-pocket maximum

This is the most you’d pay for covered medical services in a calendar year. Think of it as your financial safety net. Once you meet it, the bank covers the full cost of additional covered care.

Did you know?

On average, the bank pays the majority of our employees’ total health care costs — including premiums and out-of-pocket costs.

On average in 2013, the bank paid 65% of employees’ health care costs.
### Your health plan options, which have not changed for 2015

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Traditional Plan</strong></td>
<td>$1,200 per individual $2,400 per family</td>
<td>$1,200 per individual $2,400 per family</td>
</tr>
<tr>
<td><strong>Consumer Directed Plan</strong></td>
<td>$1,200 per individual $2,400 per family</td>
<td>$1,200 per individual $2,400 per family</td>
</tr>
<tr>
<td><strong>Consumer Directed High Deductible Plan</strong></td>
<td>$2,250 employee only $4,500 per family</td>
<td>$2,250 employee only $4,500 per family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$500 per individual $1,000 per family</td>
<td>$1,000 per individual $2,000 per family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>In network You pay 20%</td>
<td>Out of network You pay 40%</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
<td>In network $2,000 per individual $4,000 per family</td>
<td>Out of network $4,000 per individual $8,000 per family</td>
</tr>
<tr>
<td><strong>Preventive services</strong></td>
<td>In network No cost to you according to government guidelines.</td>
<td>Out of network You pay the full negotiated rate until you meet the deductible, then you pay coinsurance.</td>
</tr>
<tr>
<td><strong>Office visits</strong></td>
<td>In network $15 copayment for primary care $25 copayment for specialist</td>
<td>Out of network You pay the full negotiated rate until you meet the annual deductible, then you pay coinsurance.</td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
<td>In network Generic: $5 copayment Preferred brand: $25 copayment Non-preferred brand: $50 copayment</td>
<td>Out of network You pay 40% coinsurance.</td>
</tr>
<tr>
<td><strong>Health care account</strong></td>
<td>Health Flexible Spending Account (Health FSA)</td>
<td>Health Flexible Spending Account (Health FSA)</td>
</tr>
<tr>
<td><strong>Health Savings Account</strong></td>
<td>Health Savings Account (HSA)</td>
<td>Limited Purpose Health Flexible Spending Account (Limited Purpose FSA)</td>
</tr>
</tbody>
</table>

- Preventive drugs: You pay 20% coinsurance.
- Other drugs (non-preventive): You pay the full negotiated price until you meet the annual deductible, then you pay coinsurance.
### 2015 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 FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which plans is this account available for?</td>
<td>Consumer Directed Plan</td>
<td>Consumer Directed High Deductible Plan</td>
<td>Consumer Directed High Deductible Plan</td>
</tr>
<tr>
<td>Comprehensive Traditional Plan</td>
<td>Consumer Directed Plan</td>
<td>To save for future health care expenses, but also to pay for eligible health care expenses now.</td>
<td>This health care account has to be paired with an HSA and you can only use it for eligible vision and dental expenses.</td>
</tr>
<tr>
<td>What would I use this account for?</td>
<td>Any eligible health care expense</td>
<td>The IRS does not allow employee contributions to an HRA.</td>
<td></td>
</tr>
<tr>
<td>What is the maximum amount that the bank and I combined can put in this account?</td>
<td>$2,500</td>
<td>$3,350</td>
<td>$2,500</td>
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<tr>
<td>What does the company put in?</td>
<td>The IRS pretax contribution limit</td>
<td>Employee-only coverage</td>
<td>The IRS pretax contribution limit</td>
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<tr>
<td></td>
<td>$250</td>
<td>$6,650</td>
<td>$2,500</td>
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<tr>
<td>When are the funds available?</td>
<td>This amount does not count against the IRS limit of $2,500.</td>
<td>Cash compensation is less than $50k, you will receive $250 plus.</td>
<td>The bank does not contribute to this account.</td>
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<td></td>
<td>For employees making less than $50,000 in cash compensation and who enroll in a medical plan paired with a Health FSA.</td>
<td>Cash compensation is less than $50k, to less than $100k</td>
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<td></td>
<td>Any bank contribution is available at the beginning of the year.</td>
<td>Employee-only coverage</td>
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<td>Employee plus spouse/partner OR Employee plus child(ren) coverage</td>
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<td>Cash compensation is $50k to less than $100k</td>
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<td>Employee-only coverage</td>
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<td>Employee plus spouse/partner OR Employee plus child(ren) coverage</td>
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<td>Family coverage</td>
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<td>Employee plus spouse/partner OR Employee plus child(ren) coverage</td>
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<td>$800</td>
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<td>Family coverage</td>
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<td>What happens if I don't use the money during the year?</td>
<td>You can roll over up to $500 in unused funds to pay for eligible expenses in the next year.</td>
<td>Unused funds will roll over to the next year. Also, if you have more than $1,000 in your HSA, you can invest it, and any growth is generally tax free. You can take HSA funds with you when you leave the company or retire.</td>
<td>You can roll over up to $500 in unused funds to pay for eligible expenses in the next year.</td>
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</table>
Do you need to change which family members are covered under your plans?

During Annual Enrollment, you can add a child, spouse or partner to your coverage or remove a family member who is no longer eligible.

Simply log on to mybenefitsresources.bankofamerica.com or call the Global HR Service Center at 1.800.556.6044 to let us know.

Keep in mind: Beginning Jan. 1, 2015, if you add an adult to your health plan, you’ll need to verify he or she is eligible to be on your plan.

Under the Comprehensive Traditional Plan or Consumer Directed Plan:

If you or your family member meet the individual annual deductible, coinsurance begins just for that person. If two people on the plan have costs that combine to meet the family deductible, coinsurance begins for everyone on the plan.

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

The Consumer Directed High Deductible Plan works differently:

If anyone covered under your plan meets the family annual deductible, or two or more family members combine to reach it, all your family members on the plan will pay the coinsurance rate.

If anyone covered under your plan meets the out-of-pocket maximum, or two or more people combine to meet it, 100% of the costs for all your family members on the plan are covered.

For a detailed list of what’s considered a qualified status change, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Compensation & Benefits > Health & Insurance.
Dental plan options

The costs for these plans will be available on mybenefitsresources.bankofamerica.com when Annual Enrollment begins on Oct. 3, 2014.

### General dental expenses

<table>
<thead>
<tr>
<th>Plan</th>
<th>Annual deductible</th>
<th>Annual maximum coverage per person (excludes orthodontia)</th>
<th>Lifetime maximum for orthodontia (children starting treatment before age 20)</th>
<th>Office visit copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aetna Dental PPO</strong></td>
<td>$50 individual</td>
<td>$1,500</td>
<td>$1,500</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>$150 family</td>
<td>mutually applies to basic and major expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Aetna DMO (limited availability)</strong></td>
<td>None</td>
<td>There is no annual maximum.</td>
<td>24 months active treatment plus 24 months retention per lifetime</td>
<td>$5 per visit</td>
</tr>
</tbody>
</table>

### Preventive care

<table>
<thead>
<tr>
<th>Service</th>
<th>Covered services</th>
<th>Covered services</th>
<th>Covered services</th>
<th>Covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Cleaning</td>
<td>100%</td>
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</table>

### Basic services

<table>
<thead>
<tr>
<th>Service</th>
<th>Covered services</th>
<th>Covered services</th>
<th>Covered services</th>
<th>Covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam (silver) fillings</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>Composite fillings</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
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<tr>
<td>Extractions</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
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<tr>
<td>Oral surgery</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
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<tr>
<td>Orthodontia</td>
<td>You pay 50%</td>
<td>You pay 50%</td>
<td>You pay 50%</td>
<td>You pay 50%</td>
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### Orthodontia

<table>
<thead>
<tr>
<th>Orthodontia</th>
<th>Covered services</th>
<th>Covered services</th>
<th>Covered services</th>
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<td>You pay 50%</td>
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</table>

For more information, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Compensation & Benefits > Health & Insurance. Supporting you and your family during the moments that matter — 2015 benefits enrollment guide.
Vision plan options

The costs for these plans will be available to you when Annual Enrollment begins on Oct. 3, 2014.

All benefits-eligible employees automatically have access to the Aetna Vision Discount Program as an alternative to the Aetna Vision Plan. This offers discounts for routine eye exams, eyeglasses, LASIK surgery, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories.

**Tip**

Exams and other services

Routine vision exams
- Routine eye exam: $10 copayment limited to one exam per calendar year
  - Standard contact lens fit and follow-up: $0 copayment
  - Premium contact lens fit and follow-up: 10% discount off retail price, then apply $55 allowance per calendar year

Lenses and frames

**Single vision**
- Plan pays 100% of covered services, limited to standard uncoated plastic lenses once per calendar year
- $130 frame allowance limited to once every other calendar year, 20% discount thereafter

**Bifocal**
- Plan pays 100% of covered services, limited to standard uncoated plastic lenses once per calendar year
- $130 frame allowance limited to once every other calendar year, 20% discount thereafter

Contact lenses

Medically necessary prescription lenses for specific eye conditions that would prohibit the use of glasses
- Plan pays 100% of covered services; prior approval is needed for medically necessary contacts

Elective prescription lenses
- $125 allowance for contact lenses in lieu of eyeglasses, once per calendar year; members may use their $125 allowance either in network or out of network in a single claim; 15% discount applied to conventional contacts

Out of network

Routine vision exams
- Up to $40 reimbursement limited to one exam per calendar year

**Single vision**
- Plan pays up to $40 lens reimbursement limited to once per calendar year
- $50 frame reimbursement limited to once every other calendar year

**Bifocal**
- Plan pays up to $60 lens reimbursement limited to once per calendar year
- $50 frame reimbursement limited to once every other calendar year

Medically necessary prescription lenses for specific eye conditions that would prohibit the use of glasses
- Up to $210 reimbursement limited to once per calendar year; prior approval is needed for medically necessary contacts

Elective prescription lenses
- $125 allowance for contact lenses in lieu of eyeglasses, once per calendar year; members may use their $125 allowance either in network or out of network in a single claim

For more information, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Compensation & Benefits > Health & Insurance.

Supporting you and your family during the moments that matter — 2015 benefits enrollment guide
Here are a few life insurance benefits we provide at no cost to you

**Associate life insurance**
We provide company-paid basic life insurance, at no cost to you, equal to one times your annual base pay or ABBR (rounded up to the next $1,000) up to a maximum of $2 million.

**Annual base pay x 1**
Rounded up to the next $1,000, up to a maximum of $2 million.

**Business travel accident insurance**
At no cost to you, the company provides business travel accident insurance equal to five times your annual base pay up to a $3 million maximum to protect 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. We also provide coverage of $150,000 for your spouse or partner and $50,000 for each child who may be accompanying you on an authorized trip or relocation.

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

**Short- and long-term disability**
After you’ve worked one continuous year for the bank, the company provides short-term disability benefits to you for up to 26 weeks from the date of your disability. If you are unable to work for an extended period of time due to a qualifying illness or injury, the company provides you long-term disability insurance at 50% of your pay.

**Short-term disability (STD)**
Up to **100%** weekly base pay or ABBR

**Long-term disability (LTD)**
**50%** weekly base pay or ABBR

For full-time employees only. Part-time employees also can see rates and purchase LTD coverage during Annual Enrollment on My Benefits Resources®.

**Tip**
During Annual Enrollment, log onto mybenefitsresources.bankofamerica.com to ensure you’ve designated a beneficiary for all of your life insurance coverage. After you log on, mouse over the Health & Insurance tab and select Beneficiaries to make and/or confirm your elections.

For more information, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Compensation & Benefits > Health & Insurance.
Here are a few additional life insurance benefits you can purchase

**Should you consider purchasing additional life insurance?**

If you answer “yes” to any of the questions below, you may want to consider the life insurance options available to you.

<table>
<thead>
<tr>
<th>Quick quiz</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you need more than the company-paid basic life insurance to meet your survivors’ needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do others depend on your income?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you have significant additional expenses if your spouse/partner were to die?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would your survivors lack financial resources if you were to die?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Associate supplemental life insurance**

You may elect to purchase associate supplemental life insurance on a post-tax basis from one to eight times the sum of your annual base pay and eligible bonus amount or ABBR (rounded up to the next $1,000) up to a maximum of $3 million. Evidence of insurability may be required.

**Dependent life insurance**

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

**Child life insurance**

The following coverage options are available for children:
- $5,000/child
- $10,000/child
- $15,000/child
- $20,000/child
- $25,000/child

**Spouse/partner life insurance**

The following coverage options are available for your spouse/partner (evidence of insurability may be required):
- $10,000
- $25,000
- $50,000
- $75,000
- $100,000
- $125,000
- $150,000

For more information, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Compensation & Benefits > Health & Insurance.
Below are a few other coverages you can purchase

**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 AD&D insurance on a pretax basis. You can elect coverage from one to eight times the sum of your annual base pay plus eligible bonus or ABBR.

**Annual base pay + eligible bonus x 1-8**

**Long-term disability (LTD) insurance**
You may elect to purchase additional coverage on a post-tax basis.

Predisability earnings generally mean the amount of salary or wages you were receiving from the company on the day before a period of disability started, calculated on a monthly basis. Pre-existing conditions and actively-at-work provisions apply to long-term disability insurance.

- **60% base + eligible bonus**
- **60% base**
- **50% base (for part-time employees)**

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

- **Spouse/partner**
  - **60% your coverage amount**
  - Up to a maximum of $600,000

- **Each child**
  - **20% your coverage amount**
  - Up to a maximum of $50,000

For more information, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Compensation & Benefits > Health & Insurance.
## Family care and other benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>What we offer</th>
<th>Who’s eligible</th>
<th>Actions you can take</th>
</tr>
</thead>
</table>
| **Dependent care flexible spending account** *(Dependent Care FSA)* | • You can pay for eligible dependent care expenses with pretax dollars, including:  
  • Adult day care centers  
  • Babysitters  
  • 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. | • Children under age 13 and anyone who is a dependent under IRS rules or is mentally or physically incapable of taking care of himself or herself.  
• Employees in New Jersey and Pennsylvania can’t make pretax contributions, per state regulations.  
• Employees in Puerto Rico, Guam and the U.S. Virgin Islands are not eligible.  
• Employees scheduled to work less than 20 hours are not eligible for the Dependent Care FSA. | • 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 because dependent care expenses, including those from Child Care Plus and back-up care, are tax free up to $5,000. Anything over that is taxable income. |
| **Purchased time off** *(PTO)* | • You may purchase time off from work beyond your annual vacation allotment.  
• You can pay for a minimum of four whole hours and a maximum of your weekly scheduled hours, up to 40, shown as weekly scheduled hours on the payroll system. | • All U.S.-based employees who are scheduled to work at least 20 hours, except those in bands 0–3, commissioned employees or employees working in Puerto Rico. | • Receive permission from your manager before you purchase time off.  
• If you have PTO for 2014, your 2014 election will not continue into 2015, so you’ll need to make a new election for 2015 during Annual Enrollment. |
| **Prepaid Legal** *(New)* | • You have access to experienced attorneys for many personal legal services and unlimited advice through Hyatt Legal Plans. The plan covers:  
  • Wills  
  • Real estate matters  
  • Small claims  
  • Family services  
  • Most network attorney fees are covered by the plan. | • All active, U.S.-based full- and part-time employees (scheduled to work at least 20 hours a week). | • Elect coverage for $16.50 per month divided across your paychecks.  
• Enroll in prepaid legal only during Annual Enrollment. You must remain in the plan for the full year. |
How to enroll Oct. 3–16

Online

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

When you're logged on to the bank's network:
1. Log on to myHR® and enter your Standard ID and password.
2. Click on the My Benefits & Pay tab.
3. To launch My Benefits Resources, click on Launch (located within the Health and Insurance box).
5. 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 can print for your records.

If you're not logged on to the bank's network:
1. Log on to mybenefitsresources.bankofamerica.com using your Person Number and password. If you don't know your Person Number, you can use the Person Number Lookup tool on Flagscape.
2. From the Home tab on My Benefits Resources, select Make Your 2015 Annual Enrollment Choices.
3. When you're finished, confirm your choices by clicking Complete Enrollment. Your elections will not be saved unless you click Complete Enrollment. You will see a Confirmation Statement, which you can print for your records.

If you need assistance, use the online support option Live Help, available on the Contact Us page.

By phone

If you don't have Internet access, call the Global HR Service Center at 1.800.556.6044 to enroll. Representatives are available Monday through Friday (excluding certain holidays) between 8 a.m. and 8 p.m. Eastern. Have your enrollment elections ready when you call and enter your Person Number. Once authenticated, say 'Annual Enrollment' to speak to a Global HR Service Center representative, who will take your benefit elections and validate your dependent information.

Special service phone numbers:
- Hearing-impaired access: Dial 711, then call 1.800.556.6044
- Overseas access: Dial your country's toll-free AT&T USADirect® access number, then enter 1.800.556.6044. In the U.S., call 1.800.331.1140 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.

What if you need to make changes after Annual Enrollment ends?

- Your Annual Enrollment elections will last for the entire 2015 calendar year unless you experience a qualified status change during the year.
- Any health care account contribution you receive from the bank will not change, even if you have a qualified status change.
- If you decline coverage during Annual Enrollment, but need to enroll following a qualified status change, you may be eligible for a prorated health care account contribution.

To fit your schedule, the Benefits Education & Planning Center has added extra hours during Annual Enrollment Oct. 3-16, 2014, call from 8 a.m. to 9 p.m. Eastern, Monday through Friday, and 9 a.m. to 4 p.m. Eastern on Saturdays, to speak with a counselor about any questions you may have on the topics covered in this guide.
Here’s what you can do throughout the year to manage your health

**Medical**
Get connected with a dedicated Condition Management nurse or other clinical resource free of charge to help with a chronic medical condition. Call a health concierge to learn more.

Access confidential counseling to help cope with work, personal and family issues like stress, grief and conflict.

If you’re pregnant, sign up for the Beginning Right® Maternity Program to access maternity nurses throughout your pregnancy and after your baby is born.

Don’t forget to add your new baby to your plans within 31 days.

**Family**

Call the Informed Health Line to speak with a registered nurse 24/7.

Log on to the Aetna DocFind® (through aetnanavigator.com) or kp.org (Kaiser Permanente members) to search for a doctor, hospital or other provider online.

Access your medical information through the Personal Health Record on Aetna Navigator (aetnanavigator.com) (or through My Health Manager on kp.org).

**Wellness**
Build healthier habits with the help of a dedicated Healthy Lifestyle Coach (or Wellness Coach for Kaiser Permanente members).

Sign up for Get Active! to take steps toward a more active lifestyle.

Learn more about your health by completing your health screening and health assessment questionnaire.

**Saving and investing**
Use the money in your health care account to pay your eligible out-of-pocket costs and track your spending through Bank of America Health Benefit Solutions™ (bankofamerica.com/benefitslogin).

Plan, budget and save with the Aetna Cost of Care Tool on Aetna Navigator (aetnanavigator.com).

Visit CVS Caremark’s website (caremark.com) to estimate prescription drug costs and learn more about generic options.

Contact your Aetna Health Concierge at 1.877.444.1012 for any insurance and health-related questions.

Use the Aetna Member Payment Estimator Tool on aetnanavigator.com to estimate out-of-pocket costs before going to the doctor. (Kaiser Permanente also provides cost-estimating tools to help you manage your health care costs and save money at kp.org).
Helpful contact information

**Health plans**
- Aetna
  - aetnanavigator.com
  - 1.877.444.1012
  - TTY: 1.800.628.3323
- Kaiser Permanente
  - kp.org
  - Phone numbers are listed on the back of your ID card if you’re a member.

**Health care accounts**
- Benefit Solutions
  - bankofamerica.com/benefitslogin
  - Additional questions
  - 1.866.791.0254

**Prescription coverage**
- CVS Caremark
  - caremark.com
  - 1.800.701.5833
  - Hearing Impaired Access:
  - 1.800.231.4403

**Additional questions**
- Benefits Education & Planning Center
  - 1.866.777.8187
  - TTY: 1.888.896.6708
- Global HR Service Center
  - mybenefitsresources.bankofamerica.com
  - 1.800.556.6044
- Contact information for other programs can be found on Flagscape and on Employee Resources at Home
  - bankofamerica.com/employee
A few additional notes about wellness/health plans

Wellness

Health screening and health assessment questionnaire
If you are pregnant, or it is medically inadvisable or unreasonably difficult for you to participate in the health screening and/or health assessment questionnaire based on a medical condition, you may submit a 2015 Health Care Provider Medical Waiver Form 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(s) that is not covered by the deadline in order to maintain the wellness credit. The form is available in the online wellness guide on Employee Resources at Home (bankofamerica.com/employee).

Health

Performance year cash compensation (PYCC)
Your 2015 performance year cash compensation (or cash compensation) is your base salary as of Dec. 31, 2013 (or your date of hire, if later), plus any benefits-eligible cash incentives such as most cash commissions and any annual cash bonus, earned for 2013 and paid by June 30, 2014. Your performance year cash compensation is used to determine your pay tier for medical benefits. This amount also is used to determine how much the bank will contribute to your health care account.

Annual Benefits Base Rate (ABBR)
For employees in all lines of business except Global Wealth & Investment Management (GWIM): ABBR is based on your annual base salary as of Dec. 31, 2013, draw paid in 2013 and any benefits-eligible cash incentives, which includes most commission pay and annual bonus earned for 2013 and paid before July 2014.

For employees in the GWIM line of business: ABBR is based on your benefits-eligible compensation earned in 2013, plus any benefits-eligible cash incentives, which includes most commission pay and annual incentives earned for 2013 and paid before July 2014.

Beginning Oct. 3, you can find your 2015 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, 2013, 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.

New ABBR roles
For 2015, Bank of America calculated an ABBR for employees in certain roles as of June 30, 2014 (determined by compensation plan structure and identified by job code). A base salary may not adequately represent cash compensation for employees in these roles.
GWIM:
• Financial Advisor (FA)
• Senior Consultant
• Investment Associate/Analyst (IA)
• Practice Management Development FA (PMD/TFA/BFA)
• Producing Manager (RD, ARD or other Producing Manager)
Home Loans (HL):
• Senior Home Loan Manager (SM006)
• Home Loan Manager (SM007/SM008)
• Retail Sales Manager (SM182)
• Reverse Sales Manager (SM096)
• Wholesale Lending Account Executive (BF024)
• Senior Mortgage Loan Officer (SM172)
• Joint Venture Builder Mortgage Loan Officer (SM183)
• Mortgage Loan Officer (SM009)
• Reverse Mortgage Loan Officer (SM031)
• Mortgage Loan Associate (SM171)
• Mortgage Loan Specialist (SM111)

Tobacco users pay more
For 2015, adults who have used tobacco in the last 12 months and are covered under the 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 2015 will be set to “yes” automatically.
This means your per-pay-period costs for medical coverage in 2015 will reflect the tobacco-user rate. You can change your acknowledgment to “no” if you have quit using tobacco since your last enrollment and have not used any tobacco products in the past 12 months. During Annual Enrollment, you’ll be asked to provide your tobacco-user status separately from the tobacco-user status of your spouse or partner.

Note for medical coverage only: Tobacco users may still have the option of paying the lower rate. If you, your covered spouse/partner or other adult dependent uses tobacco, and are unable to meet the non-tobacco user standard, you may still qualify for the lower rate. Contact the Global HR Service Center for information on the steps and forms you’ll need to complete during Annual Enrollment to qualify for the lower rate. You also can visit the Knowledge Center on mybenefitsresources.bankofamerica.com for forms you may need.
A few additional notes about health plans

**Prescription drug coverage**
As before, non-formulary drugs won’t be covered by the Aetna health plans. A formulary is a list of brand name and generic drugs that are both cost-effective and safe. To see the formulary list, log on to coremark.com and select View drug list and formulary from the right-hand column.

Prescription drug copayments and coinsurance currently count toward the out-of-pocket maximum under the Consumer Directed High Deductible Plan, and, beginning in 2015, will also apply to the following plans:

- **Aetna Comprehensive Traditional and Consumer Directed Plans**
  - Members who choose a brand name drug when a generic is available will pay the applicable brand copayment or coinsurance, as well as the difference in cost between the brand and generic drug. The difference paid between the brand and generic costs will not count toward the out-of-pocket maximum. Note: Out-of-network pharmacy claims also count toward the out-of-pocket maximum.

- **All Kaiser Permanente Comprehensive Traditional and Consumer Directed Plans**
  - All of your out-of-pocket costs for all covered medical and prescription drug expenses count toward your out-of-pocket maximum.

- **HMSA Hawaii plan**
  - Prescription drug copayments will count toward a separate prescription drug out-of-pocket maximum of $3,600 for individual and $4,200 for family.

- **Kaiser Permanente plans**
  - Coverage for certain Kaiser Permanente plans in certain markets may be different.

**ABA: Enhanced autism coverage**
For 2015, Aetna health plans will cover ABA and speech, physical and occupational therapy for children diagnosed with an autism spectrum disorder.

For ABA:
- Precertification is required prior to services being rendered.
- Ongoing reviews for medical necessity take place at specific intervals throughout the child’s treatment (intervals vary based on the child’s needs and the target behaviors that are being addressed through therapy).
- ABA providers must be independently licensed professionals such as clinical social workers, clinical psychologists, or masters level therapists, or they must be behavior analyst certified by the Behavior Analyst Certification Board.
- ABA may be provided in an office setting, in the home or in another community setting outside of the classroom. Services provided in the classroom setting are not covered.
- If your current ABA provider is not part of the Aetna network, contact an Aetna Health Concierge to review your options, including: inviting your provider to join the network, making plans for a gradual transition to an in-network provider through the transition of care process, or using your out-of-network benefits.

**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 an foster children under age 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 reenroll in an HRA-eligible plan or leave the bank after meeting the Rule of 60. HRA-eligible plans include the Comprehensive Traditional Plan and the Consumer Directed Plan. For more information, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Compensation & Benefits > Health & Insurance.
A few additional notes about health plans

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

- 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)**

**How it works**
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. An expense is incurred when you actually receive a service or make a purchase, not when you receive or pay a bill.

**Limited Purpose Health Flexible Spending Account (Limited Purpose FSA)**

**Eligibility**
- All U.S.-based, benefits-eligible employees who are enrolled in the Consumer Directed High Deductible Plan and are making contributions to the Health Savings Account can contribute to a Limited Purpose FSA.
- Eligible dependents for this account include your spouse, children up to age 26 and any other person who is a qualified tax dependent (i.e., anyone you claim on your federal income tax return as a dependent).

**How it works**
You can enroll during Annual Enrollment or as soon as you become eligible. You may elect to contribute from $1 per pay period up to the applicable annual IRS limit for pretax payroll contributions, which is $2,500 for 2015 (applies to employee contributions only). Contributions to your Limited Purpose FSA are deducted automatically from your paycheck before most taxes are withheld. The amount deducted is based on the amount you elect to contribute divided by the number of pay periods in the year. The amounts you contribute reduce your wages for purposes of both income and employment taxes, including Social Security and Medicare taxes. Reducing your Social Security taxes could reduce your Social Security Benefit slightly when you retire.

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 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.

**Important:** Once Annual Enrollment ends, you cannot change your election unless you experience a qualified status change.

**Eligible expenses include:**
- Prescribed dental and vision products
- Preventive dental care, orthodontia, eyeglasses, contact lenses and laser eye surgery
- Copayments, coinsurance and deductibles under dental and vision plans

**Access your account**
You can access the full amount you elected to contribute to your account on Jan. 1 of the plan year, or the effective date of your benefits coverage. You may access your account in two ways:

- You receive a health care Visa debit card linked to your account, which you can use to pay for all eligible health care expenses (see Using your health care Visa debit card).
- You also can pay for eligible health care expenses using cash, check or another approved method and then submit a claim for reimbursement by using the Enter New Claim feature on the Benefit Solutions portal (bankofamerica.com/benefitslogin) or by contacting Benefit Solutions at 1.866.791.0254.

**Using your health care Visa debit card**
Your health care Visa debit card provides easy access to your Limited Purpose FSA and your HSA balances. You will receive a single debit card for both products. Funds to pay for your qualified dental and vision expenses will be deducted from your Limited Purpose FSA first, and then from your HSA. You can use your HSA funds to pay for other qualified health care expenses including medical care, copayments, coinsurance, deductibles and prescribed health care products. Do not throw away your debit card when you have used all the funds in your account; the card is valid for four years and can be reused when new funds are added to your account.
A few additional notes about health plans

If you have lost your card or need a replacement, contact Benefit Solutions at 1.866.791.0254 or request a new card at bankofamerica.com/benefitslogin (go to Order Debit Cards under Common Requests).

It is your responsibility to ensure that all purchases made using your health care Visa debit card are for eligible dental and vision expenses ("Eligible expenses include" on the previous page). Keep all your receipts and other records each time you use your debit card. Some purchases made at the point of sale are verified automatically as eligible health care expenses, as defined by the IRS, while others may require documentation to prove the eligibility of the expenses.

You are responsible for checking your account on the Benefit Solutions portal each time you use your debit card to see if you are required to provide a valid receipt that includes date of the expense/service, merchant/provider name, amount charged and the description of the product or service and proves the eligibility of a purchase. If a receipt or documentation is required, you may scan and upload the receipt online to Benefit Solutions at bankofamerica.com/benefitslogin, or choose to fax or mail the receipt to Benefit Solutions. Contact Benefit Solutions at 1.866.791.0254 for more information.

If you do not have valid documentation, contact your provider to see if this information is available. If not available, you may submit valid documentation for another eligible health care expense of the same amount or greater that you paid for using cash, check or another means (other than your health care Visa debit card).

If a transaction has been denied as ineligible or you are unable to provide the required receipt showing the charge was for an eligible health care expense, you may be required to reimburse the plan for the amount charged to your debit card.

The IRS requires Bank of America to take measures to resolve any outstanding transactions that have not been proven to meet the definition of an eligible expense. These measures include, but are not limited to:

- Deactivation of your health care Visa debit card until proper documentation is received
- Taxing you on the value of any outstanding transactions

Health FSA and Limited Purpose FSA year-end rollover change

You can carry over an unused balance of up to $500 in your Health FSA balance, including for the Limited Purpose FSA, to the following plan year, if you have an active Health FSA as of Dec. 31 of the current plan year. You can use the rollover balance for eligible expenses incurred in the new plan year. The rollover will occur automatically as soon as administratively possible after the claims run-out period (March 31). During the run-out period, you will need to submit an online or manual claim to access any of the carryover dollars. Carryover balances are not available for your debit card transactions before March 31 of the new plan year.

The rollover is automatic, but you can elect to decline the carryover, by contacting the Global HR Service Center before the end of the current plan year.

The carryover will be applied automatically to the Health FSA or Limited Purpose FSA, depending on your medical plan election. For example, if enrolled in the Comprehensive Traditional Plan with Health FSA in 2015 and then, you enroll in the Comprehensive High Deductible Health Plan with the Health Savings Account for 2016, any unused balance up to $500 in your old Health FSA will rollover automatically to a Limited Purpose FSA, to be used for eligible dental and vision expenses in 2016.

Consumer Directed Health Plan (CDHP) Video Guide credit

The CDHP Video Guide will be discontinued for 2015 (effective Jan. 1, 2015), as will the $100 health care account credit for completing the CDHP Video Guide.
A few additional notes about who is eligible for our plans

For detailed information about dependent eligibility, refer to the 2013 SPD on Flagscape > HR, Benefits & Career > Benefits & Compensation > Health & Insurance.

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 domestic 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, regardless of whether the state in which they live recognizes their marriage. This ruling took effect on Sept. 16, 2013, and applies to all federal tax provisions 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 mybenefitsresources.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.

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.

Employee Assistance Program (EAP)
The EAP will be moved under the umbrella of “Resources For Living (RFL).” Beginning Jan. 1, 2015, the new website is mylifevalues.com. Enter the username: RFL4ME and password: EAP4HELP. Privacy Notices are available online at www.aetna.com/legal-notices/privacy/information-practices.html.
A few additional notes about 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 2015 will be set to “yes” automatically. This means your per-pay-period cost for associate supplemental life insurance coverage in 2015 will reflect the tobacco-user rate. You can change your acknowledgment to “no” if you have quit using tobacco since your last enrollment and have not used any tobacco products in the past 12 months.

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

If evidence of insurability is required, the increased coverage does not begin until after your evidence of insurability is approved by the insurance company. If you fail to provide evidence of insurability when required, you will be assigned the highest coverage available without evidence of insurability. Once evidence of insurability is approved, coverage is effective the first of the month following the date the evidence of insurability 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 2015 will be set to “yes” automatically. This means your per-pay-period cost for spouse/partner dependent life insurance coverage in 2015 will reflect the tobacco-user rate. You can change his or her acknowledgment to “no” if he or she has quit using tobacco since his or her last enrollment and has not used any tobacco products in the past 12 months.

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

Long-term disability insurance (LTD)

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

If your predisability 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 increased benefit is payable for any disability that is caused by or contributed to by a pre-existing condition that starts before the end of the first 12 months following the effective date of your increased coverage. And, if you are not actively at work on the date your coverage increases, your increased coverage will take effect on the date you are again actively at work.

The maximum monthly benefit, together with all other income benefits, is $30,000.

Imputed income

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

Eligible bonus amount

For associate supplemental life, AD&D and LTD insurance coverage amounts for 2015, your eligible bonus amount consists of any performance-based, benefits-eligible cash incentives and special equity awards earned for 2013 and paid by June 30, 2014. Your eligible bonus amount remains fixed for the plan year.

Grandfathered sick time

For legacy BankAmerica employees with grandfathered sick days (GFS) who live in a state that offsets short-term disability leave (STD), sick time will only be deducted from your GFS balance for the portion of disability paid for by the bank. Sick time paid by the state will not be decremented from your GFS balance. For example, if the state pays 60% of your disability and the bank pays 40%, we will only decrement the 40% paid by the bank. GFS will also be automatically used to keep your STD benefits at 100% when your coverage drops to 70%.
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, go to My Benefits Resources > Knowledge Center > Plan Information. If you have specific questions about what’s covered, call either Aetna or Kaiser Permanente to ask about coverage for specific health conditions.

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

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

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

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bank of America and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. For 2015, 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 may pay secondary to a Medicare drug plan in certain situations as described below.

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

• If you just want medical coverage through Bank of America, without drug coverage, you may be eligible to enroll in the Medical Only Medicare Supplement plan if you become Medicare-eligible while receiving LTD benefits or a Medicare-eligible retiree.

• If you do not elect a Bank of America medical plan that includes prescription drug coverage, and do not enroll in a Medicare prescription drug plan when first eligible, you may pay more for Medicare prescription drug coverage later.

• If you enroll in a Bank of America medical plan that covers prescription drugs, you probably should not enroll in a Medicare prescription drug plan as well. However, if you do enroll in both a Bank of America medical plan that covers prescription drugs and a Medicare prescription drug plan, you will have prescription drug coverage through two plans. It is important that you understand:
  – If you are an active employee, your prescription drug coverage through Bank of America will pay primary on prescriptions covered through Medicare. This means that if the Bank of America plan is less generous than your Medicare prescription drug plan, your Medicare prescription drug plan will pay an additional amount. However, if the Bank of America plan is just as generous, the Medicare prescription drug plan will not provide any additional prescription drug coverage.
  – If you are not an active employee (if you are on long-term disability (LTD) or are a retiree, for example), your prescription drug coverage through Bank of America will pay secondary on prescriptions covered through Medicare. This means that if the Medicare plan is less generous than your Bank of America prescription drug plan, your Bank of America prescription drug plan will pay an additional amount. However, if the Medicare plan is just as generous, the Bank of America prescription drug plan will not provide any additional prescription drug coverage.

• Your monthly contributions for coverage under the Bank of America plan will not be reduced if you enroll in a Medicare Part D prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Bank of America coverage, be aware that you and your dependents generally will be able to get this coverage back within 31 days of a qualified status change or during Annual Enrollment. Please call the Global HR Service Center at 1.800.556.6044 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 1.800.556.6044. 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.

For more information about your options under Medicare prescription drug coverage:

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.
2015 Summary of Material Modifications (SMM)

There are a number of plan changes described in this guide that constitute your 2015 Summary of Material Modifications. These include:

- Expanded preventive care services (page 4)
- New Limited Purpose FSA (page 9)
- New HSA limits and catch-up contributions (page 9)
- New definition of performance year cash compensation and 2015 ABBR calculation and roles (page 20)
- 2015 eligible bonus amounts for associate supplemental life (page 14 and page 25), AD&D and LTD coverage (page 15 and page 25)
- Prescription drug copayments and coinsurance counting toward the out-of-pocket maximum (page 21)
- Enhanced autism coverage for Aetna plans (page 21)
- FSA year-end rollover change (page 23)
- Consumer Directed Health Plan Video Guide credit discontinued (page 23)
- Employee Assistance Program name change (page 24)
- Expanded benefits eligibility for medical coverage and health care accounts (page 24)
- Grandfathered sick time decrements methodology (page 25)
- HIPAA Certificates of Creditable Coverage no longer required (page 28)
- Marketplace special enrollment windows related to COBRA (page 28)
- Changes to Kaiser Permanente, HMSA Hawaii and Triple-S Salud medical plans (page 28)

This SMM supersedes and replaces any prior communications, policies, rules, practices, standards and/or guidelines to the contrary, whether written or oral. Receipt of this summary does not entitle you to a benefit from the health and insurance plans. In order to be entitled to a benefit from the health and insurance plans, you must meet all requirements for such benefit.

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 or this SMM.

If there is any discrepancy between the information in this SMM and the terms of the official plan documents, the official plan documents govern.