2017 benefits enrollment guide

Understanding your options for retiree health and insurance benefits

Bank of America

Bank of America | Merrill U.S. Trust | Bank of America Merrill Lynch

How do I use this guide?

Annual Benefits Enrollment for retiree health and insurance benefits is Oct. 27 – Nov. 10.

This guide provides details on the retiree health and insurance options available to you and your family. When considering which plans are right for you, use your *Enrollment Worksheet* and *Health Plan Comparison Charts* enclosed with this guide to help you understand your choices.

Tip **If you don't do anything during Annual Benefits Enrollment**, the coverage shown on your *Enrollment Worksheet* will take effect for 2017.

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 4 for information.

What plans are available to me?

The medical plans available to you will vary depending on whether you or your family member(s) are eligible for Medicare.

Be sure to go over the requirements for enrolling a family member in each plan. During Annual Benefits Enrollment, you can add or remove a spouse/partner or eligible child from your coverage. Simply log on to **My Benefits Resources** (**mybenefitsresources.bankofamerica.com**) or call the Global HR Service Center at **800.556.6044** to let us know.

After Annual Benefits Enrollment, you must provide notification to the Global HR Service Center within **31 calendar days** of the date of your qualified status change, such as marriage, or to add a new family member to your coverage.

Refer to the *Bank of America Retiree Health and Insurance Summary Plan Description 2016* (2016 SPD) and subsequent Summaries of Material Modifications (SMMs) for additional information regarding dependent eligibility requirements, or call the Global HR Service Center.

If:	Then you and your family member(s) enroll in:
Neither you nor your family member(s) are eligible for Medicare	The same non-Medicare eligible plan
Either you or one or more of your family member(s) are eligible for Medicare, but not all covered family members are eligible for Medicare	Different plans: • Medicare-eligible plan • Non-Medicare eligible plan
Both you and your family member(s) are eligible for Medicare	The same Medicare-eligible plan

Tip

If you or your covered family member(s) are younger than age 65 and have a disability, you might be eligible for Medicare. For more information, call the Global HR Service Center at **800.556.6044**.

To help you compare your medical plan choices, take a look at the Summaries of Benefits and Coverage. To view them during Annual Benefits Enrollment, log on to **mybenefitsresources.bankofamerica.com** and click **Make Your 2017 Annual Enrollment Choices > Compare Medical Plan Details**.

What are my medical plan options if I'm not eligible for Medicare?

If you are **not eligible** for Medicare, these medical plans may be available to you depending on where you live.

Medical plan options
Health Maintenance Organization (HMO)
Exclusive Provider Organization (EPO)
Preferred Provider Organization (PPO)
High Deductible Health Plan (HDHP)

Prescription medication coverage

Prescription medication coverage is provided by CVS Health for all our non-Medicare retiree plans. Register at **caremark.com** to see if your local pharmacy participates.

Note: For Kaiser Permanente, Health Net, Group Health Cooperative, Health Plan Nevada, HMSA Hawaii and Triple-S Salud medical plans, prescription medication coverage is provided directly by the medical plan.

Refer to your enclosed *Health Plan Comparison Charts* for more information about the plans available to you in 2017, and your prescription medication coverage under those plans.

If you have questions about plan features or changes to a plan, contact the medical plan directly.

What are my medical plan options if I'm not eligible for Medicare?

If you enroll in the High Deductible Health Plan, you also may want to consider contributing to a Health Savings Account (HSA). See page 10 for information on how to enroll.

Tip If you already have an HSA, your current card can be used for any balance that rolls over from 2016 and new contributions you make in 2017. If your current card has expired, a new one will be mailed to you.

An HSA offers a unique, tax-advantaged way to save and pay for current or future eligible health care expenses. Use your HSA funds to pay for out-of-pocket expenses, such as:

- Medical, dental, vision and prescription medication copayments
- Deductibles and coinsurance
- Eligible medical expenses, including laser eye surgery, acupuncture, hearing aids and batteries
- Medicare premiums, once you become eligible for Medicare
- COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) coverage premiums
- Long-term care insurance premiums, subject to certain limits

The IRS may require you to prove that you used your health care account funds to pay for an eligible expense. Be sure to keep your receipts for your records.

Note: You can't contribute to an HSA if you're enrolled in Medicare.

Health Savings Account (HSA)

What is the maximum amount I can put in this account?

$3,400 Individual coverage

$6,750 Family coverage

If you'll be age 55 or older in 2017, you can make an additional $1,000 catch-up contribution.

What happens if I don't use the money during the year?

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 taxfree.

Who can use the funds that I contribute to the HSA?

Your spouse/partner and unmarried children who are dependent on you for primary financial support up to age 19 (or age 24 if a full-time student), and any qualified tax dependent (anyone you claim on your federal income tax return as a dependent) are eligible dependents under this account.

What are my medical plan options if I am eligible for Medicare?

If you **are eligible** for Medicare, you should enroll in both Medicare Parts A and B.

The charts to the right show the medical plans available to Medicare-eligible participants and how Bank of America's coverage works with Medicare. Bank of America's Medicare Supplement plans assume you have both Medicare Parts A and B and therefore will pay claims secondary to Medicare.

If you or your covered family members are eligible for Medicare and do not enroll, or use providers who do not accept Medicare, you will be responsible for paying the portion of medical expenses Medicare otherwise would have paid.

There are three types of Medicare coverage:

Tip If you are eligible for Medicare, you must enroll in it. You will then be eligible to also enroll in a Bank of America Medicare Supplement plan.

Medical plan	Coverage for medical services	Coverage for prescription medications
Comprehensive Medicare Supplement plan	Provides secondary coverage after Medicare	If you are enrolled in Medicare Part D prescription medication coverage, the plan provides secondary coverage.
High Deductible Medicare Supplement plan		If you are not enrolled in Medicare Part D prescription medication coverage, the plan provides primary coverage.
Medical Only Medicare Supplement plan	Provides secondary coverage after Medicare	No prescription medication coverage
Medicare Advantage plans	Replaces Medicare Parts A and B for medical services	Includes Medicare prescription medication coverage

Medical plan	Coverage for Medicare participants
Medicare Part A	Helps cover inpatient care in hospitals and skilled nursing facilities. It also covers hospice care and some home health care.
Medicare Part B	Helps cover doctors' services, outpatient hospital care and medical services that Medicare Part A does not cover, such as some services provided by physical and occupational therapists and some home health care. Medicare Part B helps pay for these covered services and supplies when they are medically necessary.
Medicare Part D	Helps cover prescription medication costs

What are my medical plan options if I am eligible for Medicare?

Bank of America Medicare Supplement plans provide secondary coverage after Medicare.

Medicare pays benefits for the covered service first.

After Medicare pays its share, your Bank of America Medicare Supplement plan pays a portion of the remaining cost of the service.

After Medicare and the Medicare Supplement plan pay their shares, you pay the remaining balance.

An example

Assume you have reached both the annual Medicare and Bank of America Medicare Supplement plan deductibles and your doctor orders an MRI scan with a retail cost of $750. Here is how the cost would be paid:

Medicare pays	**$600** (80% of $750)
Medicare Supplement plan pays	**$120** (80% of $150, the cost remaining after Medicare pays)
You pay	**$30**
Total	**$750**

What are my medical plan options if I am eligible for Medicare?

Medicare Advantage plans are private plans that contract with Medicare to provide the same health care services (and sometimes additional services) as those covered by Medicare Parts A and B.

Bank of America negotiates group contracts with these private plans on behalf of retirees.

Note: The federal government may change the costs of some Medicare Advantage plans during Annual Benefits Enrollment. You will be notified if the cost changes for the plan in which you enroll. Some Medicare Advantage plans are requesting substantial rate increases or changing 2017 coverage significantly. The Medicare Advantage plans and rates are regulated and approved by the Centers for Medicare and Medicaid Services (CMS).

When considering a Medicare Advantage plan, keep in mind:

- You must enroll in both Medicare Parts A and B.
- You may need to choose a primary care physician who will coordinate your care and refer you to specialists.
- Most services are covered at 100% after you pay a copayment.
- Care received outside the plan's network is not covered, except for emergencies. However, some plans provide "guest privileges" in other health plans if you are traveling or live part of the year in another state.
- Medicare prescription medication coverage is provided by the Medicare Advantage plan in which you enroll.

If you are currently enrolled in a Medicare Advantage plan and:	During enrollment you:
You wish to remain in your current Medicare Advantage plan	Do not need to do anything
You want to enroll in a different Medicare Advantage plan	Must follow the steps described on page 10
You decide to select another type of Bank of America medical plan for 2017	Complete and return the disenrollment form sent with your Confirmation Statement following your Medicare Advantage plan enrollment. Once the disenrollment form is approved, you will be enrolled in the medical plan you elected for 2017 during Annual Benefits Enrollment.
Your current Medicare Advantage plan will not be available in 2017	Will need to enroll in a new plan by logging on to **mybenefitsresources.bankofamerica.com** or call the Global HR Service Center

For instructions on how to enroll in a Medicare Advantage plan, see page 10.

What are my dental plan options?

MetLife will continue to be 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**.

Note: Retirees in Puerto Rico who elect the Triple-S Salud medical plan receive dental coverage as part of that plan.

MetLife Dental PPO	Aetna DMO (limited availability)
General dental expenses	**General dental expenses**
Annual deductible **$50** individual **$150** family The deductible is waived for preventive/diagnostic care and applies to basic and major expenses.	Annual deductible None
Annual maximum coverage per person (excludes orthodontia) **$1,500**	Annual maximum coverage per person (excludes orthodontia) There is no annual maximum.
Lifetime maximum for orthodontia (children under age 19) **$1,500**	Lifetime maximum for orthodontia (children starting treatment before age 20) 24 months active treatment plus 24 months retention per lifetime
Office visit copayment None	Office visit copayment **$5** per visit
Preventive care	**Preventive care**
Exams Plan pays **100%** of covered services, limited to two visits per calendar year.	Exams Plan pays **100%** of covered services, limited to four visits per calendar year.
Cleaning Plan pays **100%** of covered services, limited to two visits per calendar year.	Cleaning Plan pays **100%** of covered services, limited to two visits per calendar year.
Services (after deductible)	**Services**
Amalgam (silver) fillings You pay **20%** of covered services.	Amalgam (silver) fillings You pay **20%** of covered services.
Composite fillings You pay **20%** of covered services; limitations may apply.	Composite fillings You pay **20%** of covered services; limitations may apply.
Extractions You pay **20%** of covered services; uncomplicated, non-bony impactions.	Extractions You pay **20%** of covered services; uncomplicated, non-bony impactions.
Oral surgery You pay **20%** of covered services.	Oral surgery You pay **20%** of covered services for basic surgery; **50%** of covered services for major surgery.
Orthodontia You pay **50%** of covered services.	Orthodontia You pay **50%** of covered services.

What are my vision plan options?

We will continue to offer one vision plan with a choice between two vision carriers: EyeMed Vision Care® and VSP. Both carriers offer network coverage for eye care, eyeglasses and contact lenses.

You also have the option to use providers outside the EyeMed and VSP networks for some services.

Visit **eyemed.com** or **vsp.com** to see if your eye care provider is in-network.

	When you use a provider in the EyeMed or VSP network	When you use a provider outside the EyeMed or VSP network
Routine eye exams **(up to one exam per calendar year)**	You pay a **$10** copayment; the plan pays the rest.	You are reimbursed up to **$40** for EyeMed and up to **$50** for VSP.
Eyeglass lenses **(once per calendar year)**	Standard uncoated lenses are covered at **100%**, once per calendar year.	Your reimbursement depends on the type of lens prescription you receive.
Frames **(every other calendar year)**	Plan provides a **$130** frame allowance. EyeMed: **20%** discount thereafter	You are reimbursed up to **$55** for EyeMed and up to **$70** for VSP.
Contact lenses **(instead of eyeglasses)**	You pay nothing up to **$125** per calendar year.	You are reimbursed up to **$105** per calendar year.
LASIK surgery	Discounts are available.	Surgery is not covered.

When and how do I enroll?

The fastest and easiest way to enroll is online, through **My Benefits Resources**, Oct. 27–Nov. 10, 2016.

1. Log on to **mybenefitsresources.bankofamerica.com**.
2. Enter the Person Number mailed to you recently. If you have not created a password for this site, enter your Person Number and click **Register as a New User**.
3. From the Home tab, click **Make Your 2017 Annual Enrollment Choices**.
4. 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.

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

Or call the Global HR Service Center at **800.556.6044** to enroll.

Representatives are available:

Monday through Friday (excluding certain holidays), 8 a.m. to 8 p.m. Eastern. Have your enrollment elections ready when you call and enter your Person Number.

Once authenticated, say "Annual Enrollment" to speak to a Global HR Service Center representative, who will take your benefit elections and validate your dependent information.

Special service phone numbers:

- Hearing-impaired access: Dial **711**, then call **800.556.6044**.
- Overseas access: Dial your country's toll-free AT&T USADirect® access number, then enter **800.556.6044**. In the U.S., call **800.331.1140** to obtain AT&T USADirect access numbers. From anywhere in the world, access numbers are available online at **att.com/traveler** or from your local operator.

Be sure to review your Confirmation Statement of elections.
Whether you enroll online or by phone, you'll receive a confirmation statement of your elections. Be sure to review it carefully. You'll receive more information by mail to help you use your benefits, including ID cards, if applicable.

If you waive medical coverage
Certain retirees may be eligible to waive medical coverage and re-enroll during a future enrollment period or within 31 days of a qualified status change. You will be required to provide proof that you have been covered under another medical plan (other than Medicare) for 12 consecutive months before the date you wish to re-enroll. You will not be required to provide proof of other coverage if you want to re-enroll only in dental or vision coverage.

Note: Participants from certain legacy organizations or those enrolled in certain legacy medical plans may not drop medical coverage and re-enroll later. Call the Global HR Service Center at **800.556.6044** for information about applicable re-enrollment rules and restrictions.

Tip

You can change your elections as many times as you like during the Annual Benefits Enrollment period. In most cases, the choices you make during Annual Benefits Enrollment will remain in effect for the entire 2017 calendar year. If you have questions about the elections you made after enrollment has closed, contact the Global HR Service Center at **800.556.6044**.

What do I need to do after enrolling?

After you enroll in your benefits, you may have a few more steps to finish.

How to enroll in a Health Savings Account (HSA):

You can apply online for The HSA for Life® Health Savings Account with Bank of America Health Benefit Solutions, the service provider for our health care accounts.

To apply:

1. Go to **bankofamerica.com/benefitslogin**.
2. Under **Have a new account through your employer or health plan provider?**, select **Click here**.
3. Enter the Bank of America group ID: **BOARET**.
4. Follow the prompts to complete your HSA application.

Once approved, you will receive your welcome kit and Visa® debit card, which you can use to pay for eligible health care expenses from funds in your HSA. You should receive your materials about a week before your medical coverage becomes effective on Jan. 1, 2017.

To learn more, visit **bankofamerica.com/benefitslogin** or call Health Benefit Solutions at **866.791.0254** (TTY: **800.305.5109**).

If you elect a Medicare Advantage plan:

1. An enrollment form will be sent to you along with your Confirmation Statement. You will need to complete the enrollment form and return it directly to the Global HR Service Center in the return envelope provided to you.

   If you have any questions regarding the enrollment form, please contact the Global HR Service Center at **800.556.6044**.
2. Medicare Advantage plans must review and approve all enrollment requests. Until the Medicare Advantage plan approves your enrollment, you will receive interim coverage through the Comprehensive Medicare Supplement plan. You may be required to provide a Notice of Creditable Coverage to show proof that you have been covered under another medical plan (other than Medicare) for 12 consecutive months before the date you wish to re-enroll.

If you are enrolled currently in a Bank of America Medicare Supplement plan that covers prescription medications, you can request a personalized Notice of Creditable Coverage by calling the Global HR Service Center.

Once the Medicare Advantage plan approves your enrollment, the Global HR Service Center will update your medical coverage to reflect your enrollment in the Medicare Advantage plan. You will receive a Confirmation Statement from the Global HR Service Center.

Note: If your Medicare Advantage enrollment form is not completed and returned within 60 days, you and/or your eligible dependents will be enrolled in the Comprehensive Medicare Supplement plan for 2017. In addition, enrolled family members will be moved to the Comprehensive Medicare Supplement plan if other family members are enrolled in a Medicare Advantage plan.

How do I use my health care account to pay for coverage?

If you have a Medical Reimbursement Account (MRA) or a Health Care Savings Fund (HCSF) and are enrolled in a Bank of America medical plan, amounts from your MRA or HCSF are applied automatically to offset the cost of your coverage.

Your costs for the medical plans available to you are based on a number of factors, which may include your legacy organization, the plan you choose, the number of people you cover, the zip code you live in, when you were hired, your retirement date, and your years of service and age at retirement. Your contribution amounts are shown on your *Enrollment Worksheet* and become effective Jan. 1, 2017.

If you have an MRA or HCSF, here is how your *Enrollment Worksheet* will reflect the offset costs:

- **MRA or HCSF**
  This is the amount that will be applied from your MRA or HCSF to offset the cost of your coverage.
- **Your total contributions**
  This is your monthly payment for coverage, after amounts from your MRA or HCSF have been applied.

Even if you don't elect coverage under the bank's plan, you can use the full amount in your MRA and HCSF to pay for eligible health care expenses.

Your MRA or HCSF cannot be used to offset the cost of any COBRA premiums. If amounts remain in your MRA or HCSF after your account is used to offset the cost of your retiree health care coverage, you may use your account to pay for eligible health care expenses, such as deductibles, coinsurance and copayments.

In this case, you will receive a Visa debit card, which you can use to pay for such expenses. You should receive your card about a week before your coverage becomes effective on Jan. 1, 2017. If already enrolled, you should have received a debit card that is valid for four years.

Note: For additional important information about your MRA or HCSF, see page 14.

How do I pay for my retiree health and insurance coverage?

You have three options from which to choose when deciding how to pay for your retiree health and insurance coverage.

1

Automatic deduction from your pension plan annuity benefit (available for most retirees)

If you are receiving any pension benefits in the form of a monthly annuity, you can have your monthly health and insurance benefits payment deducted directly from your pension annuity check. Deductions for 2017 coverage will begin Jan. 1, 2017. If your monthly cost is more than your pension benefits, you will receive a monthly invoice for the balance.

Note: This option is not available if you have an MRA or HCSF (see page 11) or if you are a Merrill Lynch retiree; in those cases, you must select either direct debit or invoice billing.

2

Direct debit from a checking or savings account

You may elect to have your monthly health and insurance benefits payment deducted automatically from your bank account. To begin direct debit in January 2017, you will need to make your payment election by Dec. 1, 2016. If you choose this option, your 2017 payments will be deducted from your account on or around the first of each month, beginning in January 2017.

3

Invoice billing

If you do not request automatic deduction from your pension plan annuity benefit or direct debit from a bank account, you will receive a monthly invoice that will reflect the cost of your benefits from the Global HR Service Center. In mid-December, you will receive your first invoice for your 2017 health and insurance benefits payment for the month of January. After that, you will receive an invoice prior to the first of each month for the upcoming month's coverage.

Tip

You can make or change your payment option at any time:

- Log on to **mybenefitsresources.bankofamerica.com**, navigate to the **Billing and Payments** section on the Health and Insurance tab, and click **Change** next to Current Ongoing Payment Method
- Call the Global HR Service Center at **800.556.6044**

Changes you make to your payment method will become effective within 30 days of your new election.

Note: Your coverage will be terminated if the amount due is not paid by the designated due date. If you use a bill-pay service and the cost of your health and insurance coverage changes for 2017, please be sure to update the amount of your payment beginning Jan. 1, 2017.

Important notes about your benefits

Where to go for more information

- For information about medical, dental and vision coverage, contact your plan directly. You can find telephone numbers for plans available to you on your enclosed *Health Plan Comparison Charts* (only medical plans available to non-Medicare eligible retirees and dependents, as well as dental and vision plan options), or click **Health and Insurance Summary** on the Health and Insurance tab on **mybenefitsresources.bankofamerica.com**.
- If you or your dependents are eligible for Medicare, you can find telephone numbers for plans available to you on **mybenefitsresources.bankofamerica.com** (**Knowledge Center > Plan Information > Benefit Plan/Carriers Contact Information**).
- For plan information, you also may refer to the 2016 SPD and subsequent SMMs. Contact the Global HR Service Center to request a copy or if you have internet access, visit **mybenefitsresources.bankofamerica.com** (**Knowledge Center > Plan Information > Retiree Handbook**).

Dependent eligibility

Children

Your children qualify as your dependents if they are unmarried, depend on you for primary financial support and are:

- Under age 19
- Under age 24 and a full-time student enrolled in a high school or accredited college, university or similar educational institution (student verification required annually)
- Disabled by a physical or mental condition that began before age 19 (or before age 24 while a full-time student covered under a bank-sponsored medical plan)

Your eligible dependent child may be able to continue coverage after these ages if he or she is enrolled in a fully insured medical, dental and/or vision plan and lives in California, Florida, Georgia, Indiana, Louisiana, Maine, Maryland, New Hampshire, New Jersey, New Mexico, Texas, Utah, Virginia, Washington, Washington, D.C. or West Virginia. In addition, the HMSA Hawaii PPO plan and Triple-S Salud plan extend dependent child eligibility up to age 26 regardless of full-time student status. Please call the Global HR Service Center at **800.556.6044** for more details.

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

Most medical, dental and vision plans will cover either a spouse/partner or other adult dependent; however, the HMSA Hawaii PPO plan and Triple-S Salud plan only provide coverage to spouses/partners.

For information regarding health and insurance coverage for adult family members, visit **mybenefitsresources.bankofamerica.com** or call the Global HR Service Center at **800.556.6044**. 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 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.

Additional information about your MRA or HCSF

Under your MRA, HCSF and/or Retiree Health Reimbursement Arrangement (HRA), the IRS requires that each purchase is verified as an eligible health care expense. To ensure your Visa debit card remains active, you need to check your account online after each transaction to see if documentation is required to prove a charge is for an eligible health care expense, under the IRS definition. Since you are responsible for providing this proof when requested, remember to keep and be prepared to submit receipts and records for all transactions you make using your debit card. If you do not verify an outstanding purchase, your debit card may be deactivated and/or you might be taxed on the amount.

To check for any outstanding expenses, log on to **bankofamerica.com/benefitslogin**. If additional documentation for an expense is required, Receipts Required for Debit Card Transaction will appear in the Actions Needed section of your home page. Make sure each receipt is complete with the date, merchant/provider name, amount charged, prescription number (if applicable) and description of the item or service purchased. You can upload your receipt to Health Benefit Solutions or fax your receipt to **866.791.0252**. You are encouraged to check your account online after each transaction.

Note about health care reform and retiree health care accounts

If you have a balance in your retiree MRA, HCSF or HRA, you will be ineligible for federal assistance to help pay for the cost of individual coverage purchased through an exchange/marketplace. Refer to IRS Notice 2013-54 available at **www.irs.gov** for more information. You can find the list of eligible medical expenses by logging on to **bankofamerica.com/benefitslogin** and selecting **I Want To > View Qualified Expenses List**, in case you want to consider spending your health care account balance before purchasing individual coverage through an exchange/marketplace for 2017.

The Patient Protection and Affordable Care Act will not impact the plan coverage, eligibility or any subsidy provided by Bank of America for its retiree medical, dental and vision plans, except for the HMSA Hawaii PPO plan and Triple-S Salud plan. The bank will continue to monitor and evaluate changes resulting from health care reform legislation and will communicate any changes that affect you.

Special note for rehired retirees

If you are currently a retiree of Bank of America or one of the bank's legacy companies and are later re-hired by Bank of America, you will not be eligible to maintain your 2017 retiree medical coverage (including retiree health care accounts) while actively employed.

- If you are re-hired by the bank and are regularly scheduled to work 20 hours or more per week, you will become eligible for plans offered to active, benefits-eligible bank employees (including medical, dental, vision, health care accounts and life insurance, among others). When you retire again in the future, your retiree medical, retiree dental, retiree vision, retiree health care accounts and, if applicable, retiree life insurance coverage will be available to you again in retirement, subject to plan and eligibility rules.
- If you are re-hired by the bank and are a temporary employee or are regularly scheduled to work less than 20 hours per week, you will become eligible for medical plans and health care accounts offered to active, benefits-eligible bank employees; however, your retiree dental, retiree vision and, if applicable, retiree life insurance benefits will not be impacted. When you retire again in the future, your retiree medical coverage (including retiree health care accounts) will be available to you again in retirement, subject to plan and eligibility rules.

Please refer to the *Bank of America Employee Health and Insurance Summary Plan Description 2016* and subsequent updates, for additional information regarding plans offered to active, benefits-eligible bank employees. Please refer to the 2016 SPD and subsequent SMMs for additional information regarding plans offered to benefits-eligible bank retirees.

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.

Imputed income

The value of certain benefits is considered imputed income, which means that you pay taxes on the value of that coverage.

- 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 **mybenefitsresources.bankofamerica.com** or the Global HR Service Center at **800.556.6044**.)

If imputed income affects you in 2017, you will see it on a W-2 issued for 2017.

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 13 for more information about dependent eligibility.

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 Retiree Group Benefits Program and the terms and conditions of the benefit. 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.

Retiree life insurance options (if eligible)

Your coverage is based on certain provisions in place at the time you retired. If you are eligible for the life insurance benefit, your coverage will be listed on your *Enrollment Worksheet*.

If you are enrolled currently in life insurance, be sure to review your beneficiaries and make any updates. To check your current life insurance beneficiary designation, log on to **mybenefitsresources.bankofamerica.com**, hover over the Health and Insurance tab and select **Beneficiaries** to make and/or confirm your elections.

Summary of Benefits and Coverage — Availability Notice

As a result of the Patient Protection and Affordable Care Act, Bank of America is required to provide standardized Summaries of Benefits and Coverage (SBCs). The SBCs summarize, in a standard format, important information about the bank's health plans. This is another resource to help you compare your plan choices. To take a look at the SBCs during Annual Benefits Enrollment, log on to **mybenefitsresources.bankofamerica.com** and go to **Make Your 2017 Annual Enrollment Choices > Compare Medical Plan Details**. If you have specific questions about what's covered, call your medical carrier to ask about coverage for specific health conditions.

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

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 will always govern.

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 or were employed by Bank of America Corporation.

Throughout this guide, the term retiree is used to refer to individuals who were considered "retired" under the retirement policy in effect at the time they quit working for the company, including individuals who met the Rule of 60 when they stopped working for the company on or after Jan. 1, 2006. Your status as a retiree is determined under the retirement policy that was in effect at the time you stopped working for the company. Receiving this guide does not, in and of itself, mean you qualify as a retiree under the applicable company policy.

If you have questions about your status as a retiree or about retiree benefits, contact the Global HR Service Center at **800.556.6044**.

Note: If you are eligible for a plan not described in this guide, such as a continuing legacy plan, please consult your previous summary plan descriptions or contact the claims administrator directly for more information.

Women's Health and Cancer Rights Act

For Triple-S Salud and HMSA plans only

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 refer to your *Health Plan Comparison Charts* on **mybenefitsresources.bankofamerica.com** 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 Retiree Group Benefits Program (the "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the plan.

If you would like a copy of the plan's Notice of Privacy Practices, visit **mybenefitsresources.bankofamerica.com** or call the Global HR Service Center at **800.556.6044**.

Marketplace special enrollment windows related to COBRA

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

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

Fully insured retiree medical plans

Some fully insured retiree medical and Medicare Advantage plans may have other changes in coverage for 2017. Please contact the carriers with any questions.

Helpful contact information

Medical plans

Aetna
aetna.com
877.444.1012
TTY: 800.628.3323

Anthem
anthem.com
855.215.6079

Kaiser Permanente
kp.org
Phone numbers are listed on the back of your ID card if you're a member.

UnitedHealthcare
myuhc.com
877.240.4075
TTY: Dial 711, then 877.240.4075

Dental

Aetna*
aetna.com
877.444.1012
TTY: 800.628.3323

MetLife
metlife.com/mybenefits
800.942.0854
TTY: 888.245.2920

Vision

EyeMed Vision Care
eyemed.com
866.723.0514

VSP
vsp.com
800.877.7195
TTY: 800.428.4833

Health care accounts

Health Benefit Solutions
bankofamerica.com/benefitslogin
866.791.0254
TTY: 800.305.5109

Prescription coverage

CVS Health
caremark.com
800.701.5833
TTY: 800.231.4403

Additional questions

Global HR Service Center
mybenefitsresources.bankofamerica.com
800.556.6044
TTY: Dial 711, then 800.556.6044

Call the Global HR Service Center for questions about the process of enrolling online or by phone, or for questions about your benefit choices.

*Aetna DMO is only available in select markets.

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