BMO

Vision Summary Plan Description (SPD)

Employee Benefit Program of Bank of Montreal/Harris

Contents

About this Summary Plan Description

This document is the Summary Plan Description ("SPD") for the vision benefits portion of the Employee Benefit Program of Bank of Montreal/Harris (the "Plan"). Please read this SPD to help you understand and manage your benefits and keep it for future reference. This SPD only addresses the vision benefits portion of the Plan. Other portions of the Plan discuss other benefits. Those other portions are not covered by this SPD.

The information in this SPD is current as of January 1, 2023. As plan changes occur, this SPD will need to be revised periodically. Although the Company strives to keep the descriptions up to date, from time-to-time plan changes may not be incorporated immediately into the SPD. While this SPD summarizes the major provisions of this Plan, it does not provide you with every Plan detail. If there is any discrepancy or any oral representation that differs between this SPD from the legal Plan documents, the Plan document prevails.

If you have questions about the Plan or would like a complete copy of the Plan document, contact the Human Resources Centre (HRC) at 1-888-927-7700.

Eligibility

Employee

You are eligible to participate in the vision benefits portion of the Plan if you are a:

- full-time employee; or
- part-time employee scheduled to work 20 or more hours a week.

You are considered an "employee" only if you are specifically treated or classified as an employee on BMO Financial Corp. ("Company") records for purposes of withholding federal employment and income taxes. If the Company classifies you as an independent contractor, consultant, leased employee or similar type of non-employee, you are specifically excluded from participating in the Plan, even if a court, the Internal Revenue Service ("IRS") or another agency retroactively reclassifies you as an employee.

Eligible dependents

If you elect coverage for yourself, you may enroll your eligible dependents, which include:

- your legal spouse, unless you are legally separated or divorced. A legal spouse includes a same-sex or opposite-sex individual who is recognized as your spouse for purposes of federal tax laws (a common-law spouse is eligible if you legally establish the marriage in a state that recognizes common-law marriages and is recognized as your spouse for purposes of federal tax laws);
- your qualifying same-sex or opposite-sex domestic partner if your relationship satisfies certain criteria (see Domestic partner eligibility requirements in this section); and
- your children under age 26.

Children are defined as:

- your biological children;
- your adopted children or children placed with you for adoption;
- your stepchildren, regardless of where they live (includes stepchildren from your same-sex or opposite-sex legal spouse);
- foster children living with you;
- a child who is recognized under a qualified medical child support order as having a right to health care coverage, if the child meets the other eligibility requirements of the Plan for dependent coverage;
- any other child for whom you are the legal guardian and whom you support in a parent-child relationship; and
- your domestic partner's children if they qualify as your dependents for income tax purposes according to Section 152 of the IRS Code.

Non-duplication of coverage

Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

If you and your spouse or domestic partner are both BMO employees and eligible to enroll in the Plan, you may each enroll for individual coverage or one of you may enroll and cover the other. If you each enroll for individual coverage, only one of you may enroll your children as dependents.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law by a court or an administrator. A QMCSO recognizes the rights of a child to coverage for health care benefits. Under a medical child support order, the court or an administrative agency can require you to provide coverage to a child under the Medical, Dental or Vision Plans.

BMO will comply with the requirements for coverage outlined in a QMSCO. If BMO is notified that any of your children are covered by a QMSCO, you will be required to remain enrolled in BMO's Medical, Dental or Vision Plans, covering the applicable children, until the QMSCO is no longer valid. You may call the Human Resources Centre at 1-888-927-7700 for information regarding the procedures governing QMCSOs.

Extended coverage for disabled children

If you have an adult dependent child age 26 or over that is physically or mentally incapable of self-support, the child may continue to be eligible to be covered on the BMO Plan if certain conditions are met.

The Plan will cover the adult dependent child, as long as:

- the child is unmarried;
- the child is unable to be self-supporting due to a disabling condition;
- the child depends mainly on you for support;
- the child is considered your tax dependent;
- the child's disability existed prior to the child reaching age 26;
- you provide proof of the child's disability and dependency within 31 days of the date coverage would have otherwise ended because the child reached age 26; and
- you provide proof, upon request by the Plan, that the child continues to meet these conditions.

The proof may include medical records, determination of disability, and copies of your federal tax returns. If you do not supply the required documentation within 31 days of the child's 26th birthday or when requested, the child will not be eligible for benefits under the Plan.

Coverage will continue, as long as the enrolled adult dependent child continues to meet the conditions above, unless coverage is otherwise terminated in accordance with the terms of the Plan. You may also need to provide proof of continued disability from time to time to maintain coverage.

Verifying dependents

As a contingency for coverage under the Plan, you must submit documentation to demonstrate that all your covered dependents meet the Plan's eligibility criteria. You will need to submit the required documentation to Dependent Verification Services for all dependents you are covering on your Medical, Dental and/or Vision Plans. You must also provide documentation to demonstrate any other matters required by the Plan (not just for verifying dependents). Shortly after you choose to enroll your dependent(s) on your Medical, Dental and/or Vision Plans for the first time, you will be contacted by Dependent Verification Services to complete the verification process. If you do not complete the verification process within the allotted timeframe, any unverified dependents will be removed from your coverage effective the 1st of the month following the date

your final determination letter is sent from Dependent Verification Services. Failure of the dependent verification process is not a qualifying event, and COBRA will not be offered. Periodically the Plan will conduct follow-up verifications of all covered dependents to ensure ongoing eligibility for the Plan.

The documentation that is required to verify your dependents includes:

Dependent type	*Required documentation category 1*	*Required documentation category 2*
Spouse (1 document from each category required)	• Government-issued Marriage Certificate; or • Notarized Affidavit of common law marriage	• Joint federal tax return filed within prior 2 years; or • Proof of joint ownership within last 6 months
Domestic partner (1 document from each category required)	• Certificate of Domestic Partner registration; or • Notarized Affidavit of Domestic Partnership; or • Government-issued certificate of Civil Union Partnership	• Joint tax return filed within prior 2 years; or • Proof of joint ownership within last 6 months
Biological child (document from category 1 required)	• Government-issued Birth certificate including parent's names	
Adopted child (1 document from category 1 required)	• Government-issued Birth certificate; or • Adoption Certificate; or • Placement Agreement	
Step-child (documents from both categories required)	• Government-issued Birth certificate including parent's names	• Verification of parent's spouse relationship status to the employee (must satisfy documentation requirements for spouse)
Domestic partner's child (documents from both categories required)	• Government-issued Birth certificate including parent's names	• Verification of parent's partner relationship status to the employee (must satisfy documentation requirements for Domestic Partner)
Legal ward (documents from both categories required)	• Government-issued Birth certificate including parent's names	• Court ordered document of legal guardianship
Grandchild (all documents from both categories required)	• Grandchild's Government-issued Birth certificate including parent's names; and • Biological parent's Government-issued Birth certificate including parent's names	• Federal tax return filed within prior 2 years claiming grandchild as tax dependent

Dependent type	*Required documentation category 1*	*Required documentation category 2*
Foster child (documents from both categories required)	• Government-issued Birth certificate	• Foster care letter of placement
Disabled adult child (all documents from both categories required)	• Documentation listed above to prove child relationship status; and • Proof of disability document	• Federal tax return filed within prior 2 years claiming disabled adult child as tax dependent

Domestic partner eligibility requirements

Vision Plan eligibility is available to employees' domestic partners, whether same-sex or opposite-sex. Your domestic partner's children may also qualify as dependents under the Plan if they meet the same requirements that apply to all dependent children and they qualify as your dependents for income tax purposes according to Section 152 of the IRS Code.

Domestic partners
For your domestic partner to be eligible under the Plan, the two of you must meet all of the following requirements:

- you share a sole, committed relationship with each other that has existed for at least one year and is expected to last indefinitely;
- you are jointly responsible for each other's welfare and financial obligations;
- you share your principal place of residence;
- you are both at least 18 years old and mentally competent to consent to a contract;
- neither of you is married to, legally separated from or in another domestic partner relationship with anyone else; and
- you are not related to each other in a way that would prohibit a legal marriage from being recognized in the state in which you live.

The following documentation that demonstrates you meet the eligibility requirements is required. Two of the items listed must be provided, however, additional documentation may be requested if necessary to determine eligibility:

- federal and state tax returns
- domestic partnership agreement
- joint mortgage, lease or ownership of real estate property
- primary beneficiary designation for will, life insurance and/or retirement benefits
- assignment of durable power of attorney
- joint ownership of motor vehicle or investments
- joint checking or credit account
- joint responsibility for debts
- other document stating common residency

Domestic partner's children
If your domestic partner meets the requirements, then his or her children may also be considered eligible

dependents under the Plan. Children of domestic partners are subject to the same eligibility requirements that biological and adopted children must meet.

You can enroll your domestic partner's children only if they qualify as your legal tax dependents. As a result, premiums for coverage of all dependent children are made on a before-tax basis with no imputed income.

Qualifying for tax-dependent status

To qualify as a tax dependent, your domestic partner or domestic partner's children must meet the rules under Section 152 of the IRS Code. In addition, tax dependents must be claimed on your federal tax return. If your domestic partner qualifies under IRS Code Section 152, he or she may enroll as a *tax dependent*. Otherwise, your domestic partner may enroll as a *non-tax dependent*. You can enroll your domestic partner's children only if they qualify as your legal tax dependents.

Certification

When you enroll your domestic partner, you'll be asked to certify that your domestic partner meets the eligibility requirements. You'll also be asked to certify whether your domestic partner qualifies as a tax dependent. The Company assumes all employees will be truthful in making representations about both eligibility and tax status. While you won't be asked to provide proof of these matters when you enroll, the Company reserves the right to request proper documentation at its discretion.

If your domestic partner meets the domestic partner eligibility requirements, he or she can enroll as either a *tax dependent* or a *non-tax dependent*. The following chart summarizes the differences between *tax dependent* and *non-tax dependent* status.

Two options for domestic partner status		
Dependent type	*Tax-dependent status*	*Non-tax dependent status*
Who qualifies	Domestic partner who satisfies the requirements listed above and is your legal dependent for tax purposes as defined under IRS Code Section 152. Domestic partner's children if they meet eligibility requirements and qualify as your tax dependents.	Domestic partner who satisfies the requirements listed above but is not your legal dependent for tax purposes. Domestic partner's children are not eligible for coverage if they are non-tax dependents.
How premiums are deducted	Domestic partner's portion of the premium is deducted from your pay before taxes, just like your own premium.	Domestic partner's portion of the premium is deducted from your pay after taxes.
Impact on Flexible Spending Accounts	Your domestic partner's (and/or their qualifying children's) eligible vision expenses may be eligible under your Health Care Flexible Spending Account or Health Savings Account.	None of your domestic partner's expenses are eligible

Enrolling & changes

When coverage begins

Coverage under the Plan is not automatic; you must enroll. As a new employee or an employee who changes to benefit-eligible status, you have 31 calendar days (includes your hire date* or newly benefit-eligible date) to make your benefit elections. **Coverage begins on the first day of the month following 30 days from your date of hire or change in benefit eligible status date if you enroll within this 31-day period.**

*The benefit effective date for employees hired as part of an acquisition and/or merger may be different based upon the terms of the purchase agreement.

Once made, you generally cannot change your elections during the year. If you miss the 31-day deadline and want to enroll in the Plan during the year, you can do so only in limited situations; for example, if you experience a qualifying life event (see Qualifying life event for more information). If you have a qualifying life event you have 31 calendar days from the date of the event to enter any applicable coverage changes. Otherwise you must wait until the next annual enrollment to make coverage changes, which take effect the next January 1, or until you experience another qualifying life event.

Retroactive changes to benefits and deductions may be necessary in a few situations, such as late entry of a benefit change or missed payroll cutoff, therefore any missed benefit deductions from the benefit effective Date will be caught up on future payrolls.

Rehired employees

If you are an eligible employee rehired within 30 days of your termination date, your benefit elections in effect on the date of your termination are automatically reinstated back to the benefit end date. If you are an eligible employee rehired more than 30 days after your termination date, but within 13 weeks of your termination date, your benefit elections are effective on the first day of the month following your date of rehire and you must enroll within 31 calendar days of your rehire date. If you are an eligible employee with a rehire date greater than 13 weeks following your termination date, your effective date will be the same as a new employee and you must enroll within 31 calendar days of your rehire date. If you are an eligible employee rehired after the annual enrollment for the next calendar year, you must enroll or re-enroll to have coverage in the next calendar year.

Annual enrollment

During annual enrollment, held each fall, you can make changes to your benefit elections. The changes take effect the next January 1. If you have not enrolled in the Plan, you can do so during the annual enrollment period. Elections made during annual enrollment remain in effect throughout the calendar year; unless you experience a qualifying life event (see Qualifying Life Event for more information). In general, your elections remain in effect for future years unless you make a change, or you are notified by the Company of coverage changes.

Qualifying life event

There may be times that you experience an event in your life that would allow you to make mid-year changes to your benefit elections. The change you make in your elections must be consistent with your qualifying life event. For example, if you adopt a child, you can add your child as a covered dependent; however, you cannot drop your spouse/domestic partner from coverage under the Plan under the adoption event. Note that some qualifying life events are not applicable to particular benefits. When you make a change, or request a change, you must follow applicable Internal Revenue Service rules on what changes are allowed.

Life Event	Medical, Dental and/or Vision Plans	Spending Accounts	Supplemental LTD	Life Insurance	Other Voluntary Benefits
Birth/Adoption *Having a baby or finalizing an adoption with the court*	Enroll/Change tier	Enroll/Change election	Enroll – No waive	Enroll/Change tier – No waive	Enroll/Change tier
Acquired Guardianship	Change tier – No Waive	Enroll/Change election	Enroll – No waive	Enroll/Change Tier – No waive	Change tier – No waive
Death of Dependent/Child	Enroll/Change tier	Decrease only/No waive	Enroll – No waive	Enroll/Change tier	Change Tier – No waive
Death of Spouse/Domestic Partner	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change Tier – No waive
Divorce/Legal Separation	Enroll/Change Tier – No waive	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change Tier – No waive
Marriage	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier
Gain of Dependent/Child Eligibility *Your child becomes newly eligible for benefits through another employer or state*	Change tier – No waive	Change election	--	Enroll/Change tier	Change tier – No waive
Loss of Dependent/Child Eligibility *Your child involuntarily loses other benefits coverage through another employer or state*	Change tier – No waive	Change election	--	Enroll/Change tier	Change Tier – No waive
Gain of Spouse Benefits/Eligibility *Your spouse becomes newly eligible for benefits through another employer or state*	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier
Loss of Spouse Benefits/Eligibility *Your spouse involuntarily loses other benefits coverage through another employer or state*	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier
Start of Domestic Partnership	Enroll/Change tier	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier
End of Domestic Partnership	Enroll/Change Tier – No waive	Enroll/Change election	Enroll/Change tier	Enroll/Change tier	Enroll/Change tier – No waive
Other Life Events *(Turning 26, loss or gain of state coverage, etc.)*	**Call the Human Resources Centre (HRC) at 1-888-927-7700**				

Do not wait to initiate your life event

You may be required to provide documentation for your life event. It is important to note that you do not need to submit the documentation at the time you initiate the life event. Since you only have 31 calendar days (includes the event date) to change, add or cancel coverage, it is recommended that you initiate the life event immediately in the My Benefits & Retirement app. You may contact the Human Resources Centre at 1-888-927-7700 for assistance in making a qualifying life event change.

The effective date of coverage is the date of the qualifying life event, except in the case where you become a newly benefit eligible employee for coverage under the Employee Benefit Program of Bank of Montreal/Harris. The effective date for an employee newly eligible for benefits is the 1st of the month following 30 days from the date your increase in standard hours to over 20 hours/week occurred ("newly benefit eligible date"). You must make your benefit elections within 31 calendar days from your newly benefit eligible date.

How to change, add or cancel coverage

If you experience a qualified life event during the year, you have 31 calendar days from the date of the event to change, add or cancel coverage. Here's how:

1. Go to **Workday**, click on the **My Benefits & Retirement** app;
2. Depending on where you are connecting to Workday from, click on **Employees in Canada an US (on BMO Network)** or **Employees in Canada and US (off BMO Network);**
3. Click on **Log your life** event tile;
4. Choose the life event that corresponds to your event, enter the date your life event occurred and **follow the rest of the prompts** to make your election changes;
5. After you make the benefit election changes, **verify your benefits summary** to make sure everything is correct, and the changes are reflected as you intended. **Keep a copy for your records.**

If you miss the deadline, your next opportunity to enroll, change or cancel coverage is during annual enrollment, unless another qualifying life event occurs that would allow a change. You may file an appeal to request a change, but your right to add or drop coverage is not guaranteed.

Family and Medical Leave of Absence

You may be able to continue Plan coverage for up to 16 weeks during a leave of absence if that leave qualifies under the Family and Medical Leave Act of 1993 (FMLA) and you are eligible under the terms of FMLA.

To continue your coverage, you must continue paying your premiums while on FMLA leave. If your FMLA leave is paid, your premium contributions are deducted from your pay as usual, and your benefits coverage will continue without interruption during your leave. If any portion of your leave is unpaid, your benefits coverage will continue, and you will still owe premiums during the unpaid leave. Any missed deductions for your benefits will accumulate in arrears. When you return from leave, your regular deductions will resume, and any accumulated arrears will be collected at a rate of one additional deduction per pay until your arrears balance is zero. For longer periods of unpaid leave, you will be contacted to make payment arrangements for your unpaid premiums.

If, during your FMLA leave, you give notice that you are terminating employment, your coverage ends on the last day of the month in which your employment ends. If you do not return to work on your expected return date and do not notify the Company of your intent either to terminate or extend your leave, your coverage ends on the last day of the month in which your employment ends. Also, you cannot change your Plan coverage tier (e.g., employee only) while on FMLA leave, except at annual enrollment or if you have a qualifying life event or special enrollment event. For more information about FMLA leave, access the HR Intranet, Operating Procedures, Leaves of Absence – Family Medical can be found under *About Managing Life's Transitions.*

Maternity and Parental leave

If you are on maternity or parental leave your Plan coverage will continue during both the paid and unpaid portion of your leave.

- Your benefits coverage will continue during the first 16 weeks of paid maternity/parental leave. Premiums will continue to be deducted from your pay.
- If you choose to take unpaid maternity/parental leave, your benefits coverage will continue, and you will owe premiums. Your premiums will accumulate in arrears. When you return from leave, your regular deductions will resume, and any arrears will be collected at a rate of one additional deduction per pay until your balance is zero.

Military leave of absence

If you are on military leave, you can elect to continue Plan coverage for yourself and enrolled dependents for up to 24 months during your absence or, if earlier, until the day after the date you are required to apply for or return to active employment with the Company under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your contributions are the same as for active employees and you will be required to pay the active premiums.

Whether or not you decide to continue coverage during military leave, that coverage will be reinstated when you return to employment under USERRA. Your reinstatement will be without any waiting period.

If you take a leave of absence

You can continue your vision coverage while you are on an approved leave of absence. If you are on a paid leave, your premium is deducted from your pay as usual. If any portion of your leave is unpaid, your benefits coverage will continue, and you will still owe premiums during the unpaid leave. Any missed deductions for your benefits will accumulate in arrears. When you return from leave, your regular deductions will resume, and any accumulated arrears will be collected at a rate of one additional deduction per pay until your arrears balance is zero. For longer periods of unpaid leave, you will be contacted to make payment arrangements for your unpaid premiums. Your contribution amount is the same as when you were actively working and is subject to change each January 1.

If you become disabled

Your vision coverage, if applicable, may continue during your disability leave. Premium payments are deducted from any Short-Term Disability payments you may be receiving. If you are on Long Term Disability, you will be required to send in payment on an after-tax basis to continue your coverage. Please refer to the Disability SPD for detailed information regarding your benefits during your disability.

Retroactive cancellation of coverage

The Plan expects that you will provide complete and accurate information. If you or your dependents commit fraud against the Plan or make a misrepresentation, the Plan may take appropriate actions in response to such fraud or misrepresentation. The actions can include a loss of particular benefits or loss of all eligibility for the Plan.

Eligibility claims and appeals

There are two types of claims under this benefit program: eligibility claims and benefit claims. The claims and appeals process differ depending on which type of claim is involved (and, as described below, there is a different process for eligibility claims involving dependent verification). Benefit claims and appeals are handled by a Claim Administrator as described under Claiming benefits under the vision plan. This section details the process and timing around filing an eligibility claim or appeal.

An eligibility appeal is a claim to participate in a Plan option or to change an election to participate during the year. It may be a claim to start, add or stop participation in the Plan -- that is, it could be a claim related to enrollment in a Plan or eligibility for coverage in a Plan -- or a claim relating to the premium you are being charged for coverage under this benefit program. For instance, you may feel an error was made during annual enrollment that resulted in your being assigned incorrect coverage. In these situations, you should contact the Human Resources Centre (HRC) at 1-888-927-7700 to discuss your concerns.

As described below, the claim process differs depending on whether the claim involves cancellation of coverage or denial of enrollment due to failure to provide dependent verification or not.

Procedure for filing an eligibility claim involving dependent verification

If your dependent was not enrolled in the Plan or your dependent's coverage under the Plan was terminated due to your failure to provide any requested dependent verification information or documentation (e.g., failure to provide a marriage certificate for a spouse or failure to provide a birth certificate or proof of adoption for a child), you may file a claim with the Dependent Verification Services team. In order for a communication from you to constitute a valid claim, it must be in writing on a Dependent Verification Claim Initiation Form, include your name and employee ID, and be delivered, along with any supporting comments, documents, records, and other information to:

Dependent Verification Center – Claims and Appeals
PO Box 1434
Lincolnshire, IL 60069-1434

Your claim must be received by claims and appeals management within 60 days from the later of the coverage termination date or eligibility enrollment date.

The dependent verification center claims and appeals management team will respond to your claim in writing within 30 days of the date the claim is received. If claims and appeals management needs additional information in order to determine whether to grant your claim, they will notify you of the additional information needed. If you do not provide that information within 30 days, your claim will be considered invalid.

Please note that submitting an appeal does not guarantee that your dependent(s) will be reinstated on your coverage. As part of the appeal process, you will need to demonstrate that there was an extenuating circumstance that prevented you from being able to complete the verification process within the required timeframe or that an error occurred.

Procedure for filing an eligibility claim not involving dependent verification

If your claim does not involve dependent verification and the HRC does not resolve the issue to your satisfaction, you may file a claim. In order for a communication from you to constitute a valid claim, it must

be in writing, include your name and employee ID, and be delivered, along with any supporting comments, documents, records, and other information to:

BMO Financial Corp.
C/O Appeals
DEPT 14613
PO Box 64050
The Woodlands, TX 77387-4050
Fax: 1-866-894-6684

The eligibility administrator will review the appeal and the determination to your claim will be provided to you in writing within 30 days of the date the claim is received. If the eligibility administrator needs additional information in order to determine whether to grant your claim, you will be notified of the additional information needed. If you do not provide the requested information within 30 days, your claim will be considered invalid. If after review, the request is approved, you must pay any premium, or will be refunded premiums, retroactive to the date of the event and be consistent with the eligibility claim.

Appeal of a denied eligibility claim

If your eligibility claim is denied, you or your authorized representative may appeal that decision by submitting an appeal request in writing within 60 days of receiving the eligibility claim denial. In order for a communication from you to constitute a valid appeal, it must be in writing, include your name and employee ID, and be delivered, along with any supporting comments, documents, records or other information that you have not previously provided to:

BMO Financial Corp.
Benefits Administration Committee
395 N. Executive Drive
Brookfield, WI 53005

For a second level appeal you must be able to prove that your claim falls outside the usual Plan rules. In connection with your request for appeal, you may review pertinent Plan documents and submit issues and comments in writing. You may also submit additional information about your claim to the Committee to consider upon reviewing your appeal. Upon request, you will be provided with copies of all documents and information relevant to your claim free of charge.

The Benefit Administration Committee will respond to your appeal in writing of its final decision regarding your claim for benefits under the Plan within 60 days (or, 120 days if an extension is required) of the date the claim is received. If the Benefits Administration Committee needs additional information in order to determine whether to grant your claim, they will notify you. If you do not provide the requested information within 30 days, your appeal will be considered invalid. If after review, the Benefits Administration Committee approves the request, you must pay any premiums, or will be refunded premiums, retroactive to the date of the event and be consistent with the eligibility claim.

Limitation of action

You cannot bring any legal action against BMO Financial Corp., the Benefits Administration Committee (or any other claim administrator), or the Plan, unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against BMO Financial Corp., the Benefits Administration Committee (or any other claims administrator), or the Plan, you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against BMO Financial Corp., the Benefits Administration Committee (or any other claims administrator), or the Plan.

Mandatory venue

Any lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to the Plan must be brought in federal court in Cook County, Illinois. The federal courts governing Cook County, Illinois, along with the United States Supreme Court, have exclusive jurisdiction over all disputes arising out of or in any way relating to this Plan.

Plan cost

You pay the entire cost of contributions made to the Vision Plan. The amount of your premiums depends on which coverage level option you choose (based on which eligible dependents you enroll in your coverage). These premiums are subject to change each year.

Tax-saving advantage

You pay your portion of the cost of coverage with before-tax dollars deducted from the first two paychecks of each month. If there is a third pay period in the month, deductions will not be taken (exceptions may apply in certain circumstances such as missed deductions). Before-tax means that your premium is taken from your paycheck before Social Security, federal and most state taxes are deducted, thereby lowering your taxable income. This in turn lowers the actual cost you pay for coverage and the amount you pay in taxes.

If you enroll a tax dependent domestic partner, the additional premium is equal to that for a spouse. However, if you enroll a non-tax dependent partner, you pay the premium on an after-tax basis and it creates imputed income. For more information, see Domestic partner eligibility requirements, including the Two options for domestic partner status chart. Your domestic partner's children qualify for coverage only if they are your tax dependents, so children of a domestic partner are subject to the same before-tax rates as biological or adopted children.

Additional savings opportunities

Not all of your expenses are covered by the Vision Plan. Some of these extra expenses can be reimbursed tax-free if you make contributions to the Health Care Flexible Spending Account and/or a Health Savings Account. To learn more about the HCFSA, review the SPD.

To learn more about the HSA (available only if you enroll in the BMO Consumer Choice Plan), see the Health Savings Account Plan Details. If you enroll in the Consumer Choice Plan and sign up for a Health Savings Account, you have the option to also enroll in a Limited Purpose Flexible Spending Account, which allows you to take advantage of additional before-tax savings for eligible dental and vision expenses only.

To access your account(s): Go to Workday, click on the **My Benefits & Retirement** app, depending on where you are connecting to Workday from, click on **Employees in Canada and US (on BMO Network**) or **Employees in Canada and US (off BMO Network)**, click on **Reimbursement Accounts**.

Vision Plan

The Company's Vision Plan provides vision care for you and your eligible dependents. Regular eye exams can lead to overall good health. Comprehensive eye exams are often early indicators of some common health conditions, such as diabetes and hypertension. Early detection of such conditions plays a crucial role in providing preventive measures.

Vision benefits are administered by VSP Vision Care (VSP).

Keep in mind, you always have a choice of what vision care services you receive and who provides them, regardless of what the Vision Plan covers or pays.

Vision Plan at a glance

Below is a high-level look at the features and benefits of the Vision Plan.

Features	*In-network (VSP provider)*	*Out-of-network (non-VSP provider)*
Deductible	N/A	N/A
Eye exam every year	$10 copay	$45 allowance
Eyeglass lenses (covered every 12 months)	$20 copay • Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Single vision: $30 allowance Lined bifocals: $60 allowance Lined trifocal: $80 allowance
Lens enhancements	• $0 copay for standard progressive lenses, tinted lenses, scratch-resistant coating, UV protection • $50 copay for premium progressive lenses, custom progressive lenses • Average savings of 30% on other lens enhancements	Not covered except for $60 progressive lenses allowance
Eyeglass frames (covered every 24 months)	• $150 frame allowance • $170 featured frame brands allowance • 20% savings on the amount over your allowance • $80 Walmart®/Sam's Club®/Costco® frame allowance	$70 allowance
Contacts lens exam (fitting & evaluation)	Up to $60 copay	$120 combined allowance
Contact lenses every calendar year (instead of glasses)	$150 allowance	

Extra savings and discounts

- **Glasses and sunglasses:** 20% off additional glasses and sunglasses, including lens options from any VSP provider within 12 months of your last eye exam.
- **Retinal screening:** Guaranteed pricing on retinal screening as an enhancement to your eye exam.
- **Laser vision correction:** Average of 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

VSP Primary EyeCare Plan℠

With VSP's Primary EyeCare Plan you can receive additional follow-up medical eye care services form your VSP doctor, who knows your eyes best.

- Covered-in-full retinal screening (digital imaging of the inside of the eye) for members with diabetes who do not have diabetic eye disease. These retinal photographs help your doctor establish a baseline to monitor and track changes in your eyes over time.
- Additional exams and services that track and monitor diabetic eye disease progression.
- Treatment for dry eye, pink eye, eye injury, and foreign body removal.
- Exams and services to diagnose and monitor glaucoma and cataracts.
- Tests to diagnose sudden vision changes.

Finding a vision provider

The Vision Plan provides in-network benefits and out-of-network benefits. You may obtain vision services from the doctor of your choice. However, you generally receive the highest level of benefits when you use an in-network provider. In-network providers offer covered services at discounted prices and handle all claim filings. If you use an out-of-network provider, your benefits are subject to certain limits, and you may be responsible for paying for services when they are provided and filing a claim for reimbursement.

Network providers

Network providers are a group of optometrists or ophthalmologists organized to deliver vision care to members at reduced (discounted) rates. While you can use any provider you wish, you generally pay less if you use network providers because services are covered at a higher level.

For the most up-to-date listings of VSP providers in your area, visit www.vsp.com or call 1-800-877-7195.

After locating a network provider, call for an appointment. When you call, tell the provider you are a VSP member and give the following information:

- Your name and date of birth
- BMO Financial Group as the group that provides coverage
- Last four digits of your Social Security number

After you make an appointment, your provider and VSP verifies your vision coverage and eligibility for services. **There is no identification card for the Vision Plan.** You may print a member vision card if you would like to have a reference card once you have registered as a member on the VSP website at www.vsp.com.

Out-of-network providers

If you use an out-of-network provider, VSP will reimburse you up to the amount allowed by the Vision Plan as shown in the Vision Plan at a Glance Chart.

An out-of-network benefit is any vision treatment, service or supply provided by an optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider that does not have a contract with VSP. If you use an out-of-network provider, you pay the entire bill and then file a claim for reimbursement with VSP.

What's covered under the Vision Plan

See the Vision Plan at a glance chart for a brief summary of what the Plan covers. The Vision Plan is fully insured, if you elect Vision Plan coverage and would like an Evidence of Coverage document mailed to you, you may contact VSP and request a copy.

Your vision care benefits are designed to protect your visual wellness. You may have to pay extra if you choose certain cosmetic eyewear options. When you or your covered dependent selects any of the following additional items, the Vision Plan pays the basic cost of the allowed lenses or frames, and you pay the additional costs for the following items:

- Optional cosmetic processes
- Anti-reflective coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Certain limitations on low vision care.
- Necessary contact lenses are provided in place of all other lens and frame benefits under the Vision Plan.
- Using contact lens benefits exhausts all of your lens and frame benefits for the current benefit period. Future eligibility for lenses and frames is determined as if glasses were obtained in the current benefit period.

What's not covered by the Vision Plan

Services and material not covered under the vision benefits include:

- cosmetic materials;
- orthoptics or vision training and any associated supplemental testing;
- corneal refractive therapy (CRT);
- orthokeratology (a procedure using contact lenses to change the shape of the cornea to reduce myopia);
- refitting of contact lenses after the initial (90-day) fitting period;
- plano lenses (lenses with refractive correction of less than ± .50 diopter);
- two pair of glasses in place of bifocals;
- replacement of lenses and frames furnished under this Plan that are lost or damaged, except at the normal intervals when services are otherwise available;
- medical or surgical treatment of the eyes;
- corrective vision treatment of an experimental nature;
- plano contact lenses to change eye color cosmetically;
- artistically painted contact lenses;
- contact lens insurance policies or service contracts;
- additional office visits associated with contact lens pathology;
- contact lens modification, polishing or cleaning;
- costs for services and/or materials exceeding Plan benefit allowances;
- services or materials of a cosmetic nature; and
- services and/or materials not indicated on the schedule/evidence of coverage as covered Plan benefits.

Claiming benefits under the Vision Plan

In general, for vision services received from network providers, you do not have to submit a claim. Your provider files the claim for you. You pay the doctor only the copays and amounts that exceed the available vision coverage.

You may have to submit claims for vision care received from out-of-network providers (unless they file a claim for you). To file a claim, mail an itemized receipt and claim form to the Claim Administrator. Claim forms are available when you logon to the VSP website at www.vsp.com.

You typically have 12 months from the date of service to submit for reimbursement. Failure to submit your out-of-network claim within 12 months of the date of service may cause your claim request to be denied.

The address for claim submission is:

Vision Service Plan
Attn: Claims Services
PO Box 385018
Birmingham, AL 35238-5018

Requests for appeals

You have the right to appeal if:

- You do not agree with VSP's decision about your health care.
- VSP will not approve or give you care you feel it should cover.
- VSP is stopping care you feel you still need.

VSP normally has 30 days to process your appeal. In some cases, you have a right to a faster, 24-hour appeal. You can get a fast appeal if your health or ability to function could be seriously harmed by waiting 30 days for a standard appeal. If you ask for a fast appeal, VSP will decide if you get a 24-hour/fast appeal. If not, your appeal will be processed in 30 days. If any doctor asks VSP to give you a fast appeal, or supports your request for a fast appeal, it must be given to you.

If you want to file an appeal which will be processed within 30 days, do the following:

File the request in writing with VSP at the following address:
Vision Service Plan
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

Even though you may file your requests with VSP, VSP may transfer your request to the appropriate agency for processing. Your appeal request will be processed within 30 days from the date your request is received.

If you want to file a fast appeal, which will be processed within 24 hours, do the following

File an oral or written request for a 24-hour appeal. Specifically, state that "I am requesting an: expedited appeal, fast appeal or 24-hour appeal." Or "I believe that my health could be seriously harmed by waiting 30 days for a normal appeal."

To file a request orally, call **800.877.7195.** VSP will document the oral request in writing.

When the covered person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. The covered person should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], the covered person has the right to bring a civil action when all available levels of reviews of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the covered person disagrees with the outcome.

No action in law or in equity shall be brought to recover on the Plan prior to the covered person exhausting his/her grievance rights under the Plan and/or prior to the expiration of 60 days after the claim and any applicable documentation have been filed with VSP.

Coordination of benefits

Coordination of Benefits ("COB") applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for COB. VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

When coverage ends

Your coverage ends on the last day of the month in which any of these events occur:

- your employment with the Company ends for any reason,
- you become ineligible to participate (see Eligibility),
- you fail to pay premiums when due, or
- the Plan ends coverage for employees.

Your dependent's coverage ends on the last day of the month in which any of these events occur:

- your employment with the Company ends for any reason,
- you or your covered dependents become ineligible to participate (see Eligibility),
- you divorce or become legally separated from your spouse,
- you no longer share a sole, committed relationship with your domestic partner,
- you fail to pay premiums when due,
- the Plan ends coverage for employees, dependents and/or domestic partners, or
- failure of the dependent verification process.

You may be able to continue your coverage through COBRA. It is your responsibility to notify the Company of any change in your status or the status of any of your covered dependents that affects eligibility for coverage under the Plan within 31 days of the status change

Continuing coverage under COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the Vision Plan ends, you or your covered dependents may be eligible to temporary continue your coverage at your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your eligible dependent to lose coverage under the Plan.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- An Employee.
- An Employee's enrolled Dependent.
- An Employee's former Spouse.

Qualifying events for continuation coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

Who can continue coverage	*In what situations*	*For how long*
You, your spouse, your eligible children	• A reduction in your work hours (scheduled to work less than 20 hours a week) • Your termination of employment (except in cases of gross misconduct)	18 months*
Your spouse	• Your death • Divorce or legal separation • Employee's entitlement to Medicare (Part A, B, or both)**	36 months
Your eligible children	• Your death • Divorce or legal separation • Employee's entitlement to Medicare (Part A, B, or both)** • Children no longer meet the eligibility rule	36 months

**Coverage can continue for an additional 11 months if you or a covered dependent is determined to be disabled by the Social Security Administration within the first 60 days of COBRA coverage.*

***The covered employee's Medicare entitlement is a listed triggering event, but it will not be a qualifying event unless it causes a loss of plan coverage.*

Getting started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. The benefits provided under COBRA are the same as those provided to active employees; however, the Company no longer shares the cost with you. You pay the full health care premium, both employee and employer costs, plus a 2% administrative fee.

Under federal law, you have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. **If this election period is missed, you and your eligible dependent(s) will lose the opportunity to continue coverage under COBRA.**

You must make your first payment for continuation coverage within 45 days after the date of your election, and coverage is retroactive to the date your Plan coverage ended. If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

Notification requirements

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage. If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
- The date your enrolled Dependent would lose coverage under the Plan.
- The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60-day period, the affected Qualified Beneficiary **will lose the opportunity to continue coverage under COBRA**. If you are continuing coverage under federal law, you must notify the COBRA Administrator within 60 days of the birth or adoption of a child.

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify PayFlex of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage. **You must send this notice to:**

PayFlex Systems USA, Inc.
BENEFITS BILLING DEPARTMENT
P.O. BOX 953374
ST. LOUIS, MO 63195-3374

Disability

If you or a covered dependent is determined to be disabled by the Social Security Administration (SSA) during the first 60 days of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify PayFlex of that fact within 60 days of the later of 1) the SSA's determination of disability (the date of the SSA award letter); 2) the date of your qualifying event; 3) the date of your loss of coverage; or 4) the date you were notified of the requirement (the date of your qualifying event letter). The notification must also be provided before the end of the first 18 months of continuation coverage. Coverage exceeding the first 18-month continuation ends when the individual is no longer Social Security-disabled. **You are required to notify the Plan Administrator of any change in your disabled status.** you must notify PayFlex of that fact within 30 days of SSA's determination at the following address:

PayFlex Systems USA, Inc.
Benefits Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374

Second qualifying event

If more than one qualifying event occurs, a maximum of 36 months of COBRA continuation is available. The second qualifying event must occur during the first 18 months of COBRA. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify PayFlex within 60 days after a second qualifying event

occurs. **If you fail to alert the Plan administrator of your qualifying event within this 60-day period, you forfeit the right to continued coverage for yourself and your dependents.**

When COBRA coverage ends

COBRA continuation coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing COBRA, you or your dependent(s) becomes covered under another group health plan.
- The date, after electing COBRA, that you or your covered Dependent first becomes entitled to Medicare (Part A or B).
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date the Social Security Administration determines you are no longer disabled if you have qualified for the 11-month disability extension.

Additional information about COBRA coverage is available in the COBRA Continuation of Rights, located under Legal Notices at www.bmousbenefits.com.

Once you cancel your continued coverage, you cannot re-enroll.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer), the Health Insurance Marketplace or Medicaid within 30 days after your group health coverage ends because of a qualifying event. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you are eligible for the Retiree Medical Program and you elect COBRA health insurance coverage at the time of your retirement, you will forfeit your right to participate in the Retiree Medical Program.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

When does COBRA coverage become effective?
Once you enroll in COBRA coverage and make your first payment, coverage is effective retroactive to the date your active group health coverage ended.

When can I enroll?
You, your covered spouse, and/or your covered dependent(s) (covered qualified beneficiaries), have the right to choose COBRA coverage independently. If you or they decide to enroll, COBRA elections must be made within **60** days of the date that coverage is lost or within **60** days of the statement date on the COBRA Group Health Benefits Right of Continuation Coverage Election Notice you receive, whichever is later. If this election period is missed, you and your eligible dependent(s) will lose the opportunity to continue coverage under COBRA.

Why is COBRA coverage so expensive?
The monthly premiums for COBRA can come as a surprise if you're accustomed to your employer paying a portion of the cost of health insurance. When you choose COBRA coverage, you must pay the full monthly premium amount (the total of what you and your employer were paying for your coverage), plus a 2% administration fee, as allowed by law. In addition, your first monthly premium payment (due within 45 days of your COBRA enrollment) is likely to be higher than subsequent payments because it may include more than one month of coverage and is retroactive to the date that you lost your employer provided coverage.

When can I make changes to or drop my COBRA coverage?
Generally, you, your covered spouse, and other covered dependents have the same rights and restrictions as other plan participants to change your coverage during the year and at annual enrollment. In addition, you have the freedom to make election decisions independently from one another. Keep in mind that enrollment in a Health Care Flexible Spending Account (HCFSA) is limited to individuals participating in a HCFSA at the time of the qualifying event and continues only until the end of the current plan year.

If you want to make a change to or drop your COBRA coverage outside of the annual enrollment period, you may need to demonstrate proof of a qualified change in status (such as marriage, divorce, or the birth or adoption of a child). Make sure you notify the COBRA Administrator of your change in status within the required time period that is stated in the plan rules.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Administrative information

Plan identification

Plan name
This Summary Plan Description describes the Vision Plan portion of the Employee Benefit Program of Bank of Montreal/Harris. The Group Medical Plan of Bank of Montreal/Harris is also called the Medical Plan or Plan in this Summary Plan Description. The Plan, a group health plan subject to the Health Insurance Portability and Accountability Act (HIPAA), provides medical, prescription drug, mental health and chemical abuse, dental, vision, Flexible Spending Accounts and before-tax premium benefits. Separate Summary Plan Descriptions describe the Medical, Dental, Flexible Spending Accounts, Employee Assistance Program and Life and Disability portions of the Employee Benefit Program of Bank of Montreal/Harris Plan.

Plan number
507

Employer Identification Number
51-0275712

Plan year
January 1 – December 31

Plan sponsor
BMO Financial Corp.
Employee Benefit Program of Bank of Montreal/Harris

Plan administrator
Benefits Administration Committee

The Plan sponsor and Plan administrator can be contacted at:

BMO Financial Corp.
Benefits Administration Committee
111 West Monroe Street, 7W
Chicago, IL 60603
Human Resources Centre (HRC): 1-888-927-7700

The Plan administrator has complete discretionary authority to make all determinations under the Plan, including eligibility for benefits and factual determinations, and to interpret the terms and provisions of the Plan. It is the principal duty of the Committee to see that the terms of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan. To the extent not delegated to another named fiduciary or to a claims administrator, the Committee shall have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. The Committee shall have discretionary and final authority to interpret the terms of the Medical Plan regarding matters for which it is responsible as set forth above and its decisions shall be final and binding on all parties. The Plan administrator has delegated to the Claim Administrator the discretionary authority to make decisions regarding the interpretation and application of Plan provisions, to make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Plan and to make claims and final

appeals determinations under the Plan. Benefits under the Plan will only be paid if the Plan administrator or the Claim Administrator, as applicable, determines in its discretion that the claimant is entitled to them.

Plan trustee

The Plan trustee for The Employee Benefit Program of Bank of Montreal/Harris (except for the accident insurance plans and cafeteria plan) is:

BNY Mellon
One Mellon Center, Suite 1315
Pittsburgh, PA 15258-0001

Agent for service of legal process

The Plan administrator is the agent for legal process against the Plan. Legal process may also be served upon the Plan trustee.

Type of funding

Medical, Dental and Vision Plan contributions are made by the Company and participating employees. The following portions of the Medical and Dental Plans are self-insured and funded through a trust, with various companies acting as claims administrators:

- Blue Cross and Blue Shield
- Express Scripts (Prescription Drug)
- UMR (Medicare Secondary Plan)
- Delta Dental

The Plan trust name is the Employee Benefit Trust of Bank of Montreal/Harris.

The Vision Plan is considered fully insured. Employee contributions are used to pay the premiums to the provider and the provider pays all benefit claims. The Vision Plan premiums are also funded through the trust.

The BMO Financial Group U.S. Retiree Medical Program is funded through participant and employer contributions (previously contributed to the Employees' Retirement Plan of the Bank of Montreal/Harris under a 401(h) arrangement) which are deposited to the BNY Mellon BMO Retiree Medical Processing Account. If you are a former M&I employee, retiree, long-term disability participant or key retiree* and are eligible for the Plan based upon the legacy M&I Retiree Medical Eligibility provisions, funding is made through participant contributions which are deposited to the M&I Retiree Health Benefits Trust account and employer contributions which were funded into the M&I Retiree Health Benefits Trust at the time of the BMO merger. Benefits for key retirees* are funded through a Rabbi Trust and special key retirees* are funded by employer purchase of insurance or payments from the employer's general assets.

* *Key retirees are defined as individuals who receive funding based on a specific individual merger related agreement. Special key retirees are defined as individuals who receive funding based on their individual agreement.*

BNY Mellon acts as trustee for the BMO Financial Group U.S. Retiree Medical Program for funds deposited into the BNY Mellon Trust. BMO Financial Corp. acts as trustee of the M&I Retiree Health Benefits Trust and the Rabbi Trust. Independent third parties administer claims submitted under the Plan.

Claims administrators and service providers

Claims Administrator	*For*	*Address for filing claims*
Blue Cross and Blue Shield of Illinois www.bcbsil.com **Member Services:** 1-888-979-4516	Medical benefits and pre-certification under the Blue Cross and Blue Shield Consumer Choice Plan	Blue Cross and Blue Shield PO Box 805107 Chicago, IL 60680-4112
Express Scripts www.express-scripts.com **Member Services:** 1-877-795-2926	Retail and home delivery medications	Express Scripts PO Box 14711 Lexington, KY 40512
Delta Dental of Illinois www.deltadentalil.com **Member Services:** 1-800-323-1743	Dental benefits	Delta Dental of Illinois PO Box 5402 Lisle, IL 60532
Smart-Choice **Human Resources Centre (HRC):** 1-888-927-7700	Flexible Spending Accounts and Health Savings Account (HSA) administration	Smart-Choice Accounts PO Box 64009 The Woodlands, TX 77387-4009
WealthCare Saver	Health Savings Account Custodian	Within Workday, click on the **My Benefits & Retirement** app, under **Reimbursement Accounts** select Health Savings Account. This will direct you to the Smart-Choice platform to access your Health Savings Account.
UMR www.umr.com **Member Services:** 1-877-561-0366	Retirees who are Medicare eligible because of age or disability	UMR Claims Appeal PO Box 30541 Salt Lake City, UT 84130-0541
VSP Vision Care **Member Services:** 1-800-877-7195	Vision benefits	Send completed VSP Member Reimbursement Form and a legible copy of your itemized receipt(s) to: VSP Vision Care PO Box 385018 Birmingham, AL 35238-5018

Service provider	*For*	*Address*
Alight Solutions –HR Benefits **Human Resources Centre (HRC):** 1-888-927-7700	Processes eligibility and provides customer service to covered individuals	Alight Solutions –HR Benefits DEPT 14613 PO Box 64050 The Woodlands, TX 77387-4050
Dependent Verification Center	Submitting initial Dependent Verification documents	Dependent Verification Center PO Box 1401 Lincolnshire, IL 60069-1434

COBRA administrator	*For*
PayFlex Systems USA, Inc Benefits Billing Department PO Box 953374 St. Louis, MO 63195-3374 **Member Services:** 1-888-678-7835	COBRA continuation coverage www.payflex.com Employer ID: 139888

Future of the Plan

The Company intends to continue the Plan indefinitely. However, the Company reserves the right to amend, modify, replace or terminate the Plan or part of the Plan at any time for any reason. The Company takes such action through Board of Directors' resolutions or through an administrative committee or other persons authorized by the board of directors. In such case, you would be properly notified of any changes, and all changes would be subject to the Plan's provisions and applicable laws. Keep in mind, health care benefits do not vest like retirement plan benefits. If the Plan is terminated, you will not receive any further benefit under the Plan other than payments of benefits for losses or covered expenses incurred before the Plan was terminated.

Privacy information

During the administration of the Plan, certain Company employees and claims administrators may come into contact with what is considered "protected health information" under the Health Insurance Portability and Accountability Act (HIPAA).

As part of our compliance efforts, we have previously provided a privacy notice to employees that describe the Plan's use and disclosure of your protected health information, as well as your rights and protections under the HIPAA privacy law. If you would like to receive another copy of the privacy notice, or just need more information, please contact the Privacy Officer, Director of US Benefits, by emailing BMOHR.USBenefits@BMO.com.

If you are enrolled in the Vision Plan, contact VSP if you have questions about your privacy rights. You may contact them at the following address, telephone number, or email:
VSP Global
Attention: Privacy Specialist
3333 Quality Drive, MS-163, Rancho Cordova, CA 95670
916-858-7432, HIPAA@vsp.com

Your rights under ERISA

As a participant in the Employee Benefit Program of Bank of Montreal/Harris, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive information about our Plan and benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated Summary Plan Descriptions. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue group health plan coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent actions by plan fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide all of the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedure as described in this SPD. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at 1-866-444-3272.

No employment guarantee

This document does not create a contract of employment between BMO Financial Corp. (the Company) and any employee. Being a participant in the Plan does not grant any current or future employment rights. And Plan participation is not a condition of employment.

Glossary of terms

If you have any questions about the Glossary of terms, please contact member services for VSP.

ASSIGNMENT OF BENEFITS
A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.

CLAIM ADMINISTRATOR
Means VSP

CLIENT
Means BMO Financial Corp.

COORDINATION OF BENEFITS
Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.

COPAYMENTS
Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.

COVERED PERSON
An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.

ENROLLEE
An employee or member of Client who meets the criteria for eligibility established by Client.

PLAN OR PLAN BENEFITS
The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the Schedule of Benefits and additional benefit rider (if applicable).

OPEN ACCESS PROVIDER
Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

PLAN ADMINISTRATOR
The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.

POLICY
The contract between VSP and Client upon which this Plan is based.

SCHEDULE OF BENEFITS
The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.

VSP PREFERRED PROVIDER

An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.